

The Social Determinants of Health: An Overview of the Implications for Policy and the Role of the Health Sector

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Introduction

In late 2002, 400 social and health policy experts, community representatives, and health researchers met at York University at a conference entitled “Social Determinants of Health Across the Life-Span”. The purpose of the conference was to consider the state of key social determinants of health (SDOH) across Canada, explore the implications for the health of Canadians, and discuss policy directions to strengthen these social determinants of health.

Following the conference, Health Canada contracted with Peggy Edwards to prepare:

- *summaries of a series of research papers and presentations on nine SDOH (see Appendix A)*
- *an overview paper that ties all of the issues together under a population health approach.*

This overview is based on the papers and presentations from the conference, including an overview presentation by Dennis Raphael. All of the papers are rich in content and ideas, but not totally inclusive. In some cases, the authors and presenters chose to focus on a particular aspect of the issue. No attempt was made to move beyond the data base and population groups covered in the original papers and presentations. For example, some presenters included data related to Aboriginal peoples or new immigrants; others did not.

There are additional social determinants of health (such as peace, social support and family violence) that are not covered by the summaries. There are also other basic determinants of health (such as genetic endowment and the physical environment) that interact with the SDOH to provide the broad picture of why some people are healthy and others are not. Some discussion of the role of the health care system as a SDOH is included in this overview; however, there is no summary of this, because a full, referenced paper was not available. It should be remembered, however, that universal access to medical care is an important aspect of the SDOH. Without this, Canadians who become ill or injured would be forced to spend a large share of their income on treatment, leaving little money for other SDOH, such as housing and food.

This overview summarizes and interprets the conference papers as they relate to the implications for policy and the role of the health sector in terms of nine SDOH and the interactions among them:

- *income inequality*
- *social inclusion and exclusion*
- *employment and job security*
- *working conditions*
- *contribution of the social economy*
- *early childhood care*
- *education*
- *food security*
- *housing.*

The reader can find more in-depth information on each of these topics by reading the individual summaries and/or accessing the original papers and presentations. Please see Appendix B for some definitions of the above terms as used in the conference papers.

Current Situation

A wealth of evidence from Canada and other countries supports the notion that the socioeconomic circumstances of individuals and groups are equally or more important to health status than medical care and personal health behaviours, such as smoking and eating patterns (Evans et al., 1994; Frank, 1995; Federal/Provincial/Territorial Advisory Committee on Population Health, 1999). The weight of the evidence suggests that the SDOH have a direct impact on the health of individuals and populations, are the best predictors of individual and population health, structure lifestyle choices, and interact with each other to produce health (Raphael, 2003). In terms of the health of populations, it is well known that disparities—the size of the gap or inequality in social and economic status between groups within a given population—greatly affect the health status of the whole. The larger the gap, the lower the health status of the overall population (Wilkinson, 1996; Wilkinson and Marmot, 1998).

Canada has been a world leader in research related to the SDOH. Yet, according to the Canadian Population Health Initiative of the Canadian Institute for Health Information: “Canada has fallen behind countries such as the United Kingdom and Sweden and even some jurisdictions in the United States in applying the population health knowledge base that has been largely developed in Canada” (CPHI, 2003).

All of the conference papers describe a discouraging picture of increased disparities in the SDOH across Canada over the last 15 to 20 years. Many factors have contributed to the growing gap, including some government policies, with some exceptions — most notably in Quebec where some recent policies (such as universal \$5 a day child care and increases in social housing) have been enacted to improve the SDOH.

Income Inequality

- Between 1997 and 2000, Canadians enjoyed increases in personal incomes as a result of higher levels of employment (particularly among full-time workers) and wage growth. However, the poverty rate among all Canadians—with the notable exception of seniors—is still higher than it was in pre-recession 1989. The failure to reduce poverty levels to at least 1989 levels points to the trend of growing income inequality in Canada. The poverty gap—the gap between the poverty line and the average income of poor families or persons below the line—increased over the last decade, even as the economy boomed. (Scott, 2002).
- Incomes have become more polarized. Taxes and transfers have helped to offset this growing inequity; however, the pattern of increasing disparity is still evident when looking at after-tax income. For example, the income share of the bottom 20% of families in 2000 from earnings and investments was 2.8%, compared to 45.1% among top quintile families—that is, 16.1 to 1. After transfers and taxes, the income share of the bottom quintile was 7.3%, compared to 38.8%—a ratio of 5.3 to 1 (Scott, 2002).

Job Security and Working Conditions

- Globalization, slow growth in the ‘70s and recessions in the early ‘80s and ‘90s resulted in workforce rationalization, layoffs and the emergence of new styles of work, including increases in temporary, part-time, casual, contract and self-employment. Today, only one-half of all working Canadians has a single, full-time job that has lasted six months or more; only one in two is eligible for employment insurance due to changes in the requirements and these new styles of work (Tremblay, 2002). Less than half of non-unionized workers have access to employer-sponsored benefits and pensions (Jackson, 2002). Thus, half of working Canadians are experiencing income and job insecurity. These “precarious workers”, who are often young parents, cannot afford to go the dentist, nor to take their children there. Frequent short-term unemployment is high, with limited access to income support from employment insurance.

- Increased pressure for competitiveness in a global market and changes in the nature of work has led to high levels of workplace stress and related health problems linked to long working hours, job insecurity, physical injuries such as repetitive strain, decreases in worker participation and control, and problems related to work-family balance (Jackson, 2002; Polanyi, 2002).

Housing and Food Security

- In the 1990s, the federal government and most provinces stopped providing social housing. At the same time, some provinces reduced social assistance rates (by as much as 22% in one province). This has led to a housing crisis among renters and the growing ghettoization of residential neighbourhoods in large cities. Low-income individuals and families—especially Aboriginal, new immigrant and sole parent families—have been hit particularly hard. In November 2001, the federal and provincial governments made a unanimous agreement to build significantly more social housing units. One year later, the National Housing and Homelessness Network reported that outside of Quebec (which has committed itself to funding 2900 new units this year) no province has made a serious commitment to building new affordable housing (NHHN, 2002). In addition, several provinces had still not signed the bilateral agreement (Bryant, 2002). Meanwhile homeowner wealth increased from 29 times that of renters in 1984, to 70 times in 1999 (Statistics Canada, 1999). When rents take 30 to 50% or more of one's income, there is little money left for food, recreation, transportation and the other necessities of life.
- The 1998/99 National Population Health Survey revealed food insecurity among 10.1% of Canadian households, representing 3 million people, including 678,000 children. The odds of reporting food insecurity increased with declining income and reliance on social assistance. Prevalence was greatest among lone mothers with children (Che and Chen, 2001). In the 1994 National Longitudinal Survey on Children and Youth (NLSCY), families headed by single-mothers were eight times more likely to report that their children were hungry, compared to other families. Children from families receiving welfare were 13 times more likely to experience hunger than non-welfare families (McIntyre, Walsh and Connor, 2001).

Education and Care in Early Life

- Although 65 to 85% of mothers are in the labour force, there are only regulated child care spaces for about 12% of Canadian children. Despite the growing evidence of the positive effect of high quality early childhood education and care (ECEC) on child development and future health, total spending on ECEC has dropped in recent years in every province except Quebec (Friendly, 2002).
- Since its inception in the late 19th century, universal public schooling in Canada has prepared the young for the responsibilities of adult citizenship. Today, public schools in Canada are under stress due to budget cutbacks, labour conflicts, and increased needs for special education, and language and cultural diversity. Failure to respond to these challenges puts public schooling at risk. This, in turn, endangers the health of Canadians and the well-being of the social structure (Ungerleider and Burns, 2002).
- Disadvantaged children and youth do not perform as well in school as advantaged young people. For Aboriginal people, rates of high school graduation and attendance at post-secondary schools are well below the rest of Canada. Children in low-income families are more likely to exhibit developmental delays and delinquent behaviours. Relative level of disadvantage is also important. Societies with larger gradients in socioeconomic status are more likely to encounter developmental problems in disadvantaged children (Keating, 2002).

Social Exclusion

- There is evidence of growing social exclusion in Canadian society, particularly for Aboriginal people, racialized groups and immigrants from countries other than Europe. For example, Aboriginal people and racialized groups are more than twice as likely to live in poverty and three times as likely than the average Canadian to be unemployed, despite the high credentials of many immigrants. Previous trends that saw immigrants forge ahead after a few years in Canada have reversed. Studies show that visible minority immigrants (who are now the majority of new Canadians) are at high risk for persistent poverty. Members of minority groups often encounter institutionalized racism in the health care and justice systems. The incarceration rate of Black males has increased over 200% in the last 10 to 15 years. These findings are mirrored in reports from several provinces on the experiences of Aboriginal people with the justice system (Galabuzi, 2002).

- Social exclusion is exacerbated by gender, age, ability, sexual orientation, race ethnicity and religion. For example, women from racialized groups make up almost all of the workers in the garment industry that employs contingent workers in Canada's low paying and often unsafe "sweat shops" (de Wolff, 2000).

Most people in difficult living situations face more than one disadvantage. Shaw and colleagues argue in *The Widening Gap: Health Inequalities and Policy in Britain* that "Health inequalities are produced by the clustering of disadvantage — in opportunity, material circumstance, and behaviours related to health across people's lives." (Shaw et al, 1999).

Taking Action on the Social Determinants of Health

The situation described above exists within a broader context, including:

- the decline of the social welfare state, which supported progressive tax structures, and social and employment programs to protect workers, families and people who needed assistance
- the rise of transnational corporations that pressure nations and businesses into reducing costs and maximizing profits at the expense of the worker
- the decline of institutional and government structures that mitigated against social exclusion and conflicts between business and labour
- the recessions of the early '80s and '90s, which led to the systematic cutting of budgets and rapid policy changes in the health, social and education sectors, in order to reduce deficits
- the growth of market-driven political ideologies that see the individual as responsible for his or her place in the market economy and little or no room for governments to provide social protection for individuals and groups that require assistance.

Yet, within these global shifts, countries such as Finland and Sweden have systematically incorporated equality-oriented action on the SDOH into their national and regional policy agendas, while simultaneously enjoying economic growth (Raphael, 2003). Within Canada, there are jurisdictions at the provincial and local level that provide examples of successful policy and program changes that improve the SDOH and the economy and labour market at the same time (Vaillancourt et al, 2002). An analysis of the various actions suggested in the conference papers suggests that Canadian policy-makers might consider adopting six key strategies to improve the SDOH and the resulting health status of the population. Improved health will inevitably lead to improvements in productivity and reductions in the cost of treatment for illness and injuries.

Six Key Strategies to Enhance the Social Determinants of Health

1. Adopt a framework for social inclusion to guide the implementation of policies and practices that reduce inequities related to income, race, gender, ethnicity, geographic location, age, ability and sexual orientation.
2. Promote full employment, job security and healthy working conditions for all Canadians. Make employment insurance available to workers in precarious jobs that need it most.
3. Protect universal access to a high quality health system that recognizes and addresses mental,

social and spiritual health, and includes strong, adequately funded infrastructures for health promotion, disease prevention and health protection.

4. Protect and maintain Canada's high quality public education system, expand programs in early childhood education and care, and increase opportunities for meaningful experiences in lifelong learning and employment training.
5. Uphold and ensure the right of all Canadians to adequate housing and food.
6. Reduce income disparities by ensuring minimum wages and levels of social assistance that allow all Canadians to access the basic necessities for healthy living in Canada, and by enacting tax transfers and social, health, labour and education policies that help create a level playing field for individuals and families that require support at various times in their lives.

The next section deals with the role of the health sector in addressing these six broad strategies.

The Role of the Health Sector

Despite clear evidence that the SDOH affect health and illness, the health sector has been reluctant to champion policies that improve social conditions because areas of social and economic policy largely fall outside of the health department's jurisdiction. There has been a reluctance to "step on toes" and to explore ways of collaborating across sectors. Yet the health sector has at least three key roles to play in addressing disparities in the social determinants and the strategies outlined above:

1. **Leader.** In some cases, the health sector has a direct leadership role to play in addressing the health and long-term care needs of certain population groups, and as a large employer of many workers.
2. **Influencer.** In many cases, the health sector can act as an influential catalyst, advocate, mediator and collaborator in finding win-win situations that convince other sectors to develop public policies and assign public resources to improving the SDOH.
3. **Communicator and knowledge broker.** In all cases and at all levels, the health sector can communicate with the public and with decision-makers about the impact of policies in labour, finance, housing and other sectors on the health, well-being and productivity of Canada's citizens. The sector can also serve as a knowledge broker in building and sharing our understanding about the value of and mechanisms for reducing disparities in the SDOH, and subsequently in health status.

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Appendix A

List of Papers, Authors and Presenters

Income Equality

Paper and main speaker

Katherine Scott

Senior Policy Analyst, Canadian Council on Social Development

Respondent

Richard Lessard

Director of Public Health, Régie régionale de la santé et des Services sociaux de Montréal-Centre

Employment Security

Paper and main speaker

Diane-Gabrielle Tremblay

Professor and Research Director, Télé-université and Canada Research Chair in Social and Organizational Challenges of the Knowledge Economy

Respondent

Andrew King

National Health, Safety and Environment Coordinator, United Steelworkers of America

Employment and Working Conditions

Paper and main speaker

Andrew Jackson

Senior Economist, Canadian labour Congress, Ottawa

Respondent

Michael Polanyi, Assistant Professor, Saskatchewan Population health Research and Evaluation Unit, and Faculty of Kinesiology and Health Studies, University of Regina

Contribution of the Social Economy

Paper and main speaker

Yves Vaillancourt

Directeur, Laboratoire de recherche sur les politiques et les pratiques sociales, and Professor, School of Social Work at the Université du Québec in Montreal

Respondent

Pat Armstrong

Chair in Health Services and Nursing Research, Canadian Health Services Research Foundation and Canadian Institutes of Health Research, and professor, Department of Sociology, York University.

Early Life

Paper and main speaker

Martha Friendly

Coordinator and Director, Childcare Resource and Research Unit, Centre for Urban and Community Studies, University of Toronto.

Respondent

Gina Browne, Professor, Nursing and Clinical Epidemiology and Biostatistics, and Director, System-Linked Research Unit, McMaster University.

Education

Paper and main speaker

Charles Ungerleider

Professor, Sociology of Education, University of British Columbia and former Deputy Minister of Education for the Province of British Columbia.

Respondent

Daniel Keating

Atkinson Professor of Early Child Development and Education, Department of Human Development and Applied Psychology at the Ontario Institute for Studies in Education, University of Toronto.

Food Security

Paper and main speaker

Lynn McIntyre

Professor, Faculty of Health Professions, Dalhousie University.

Respondent

Valerie Tarasuk

Associate Professor in the Department of Nutritional Sciences, Faculty of Medicine, University of Toronto.

Housing

Paper and main speaker

Toba Bryant


Post-doctoral fellow, Centre for Health Studies, York University.

Respondent

Sharon Chisholm, Executive Director, Canadian Housing Renewal Association, Ottawa.

Panelist

Cathy Crowe, Street Nurse, Toronto



Social Exclusion

Paper and main speaker

Grace-Edward Galabuzi

Researcher, Centre for Social Justice and Doctoral Candidate, Department of Political Science, York University

Respondent

Ronald Labonte, Director, Saskatchewan Population Health and Evaluation Research Unit and Professor, Community Health and Epidemiology, University of Saskatchewan, Professor, Kinesiology and Health Studies, University of Regina.

SDOH: Research and Policy

Paper and main speaker

Dennis Raphael

Associate Professor, School of Health Policy and Management, York University, Toronto.

Appendix B: Relevant Definitions Used in the Papers and Summaries

Housing

Canada Mortgage and Housing Corporation (CMHC) uses the term ‘core need’ to track the number of households unable to access adequate rental accommodation in their community. The term measures affordability, suitability of accommodation and adequacy (Layton, 2000).

Early Childhood Education and Care

Early childhood education and care” (ECEC) describes an integrated, multifunctional approach to policies and services that is inclusive of all children and parents, regardless of employment or socioeconomic status. In Canada, this definition encompasses child care centres and other regulated care services — such as family child care in private homes — whose primary focus is to allow mothers to participate in the paid labour force. It also includes kindergartens, nursery schools and preschools, whose primary purpose is early childhood education (Friendly, 2002).

Employment Security and Insecurity

Employment or job insecurity is largely subjective—something an individual feels, given his or her personal job situation, perception of risk and the overall economic situation. The validity and relevance of traditional objective measures of employment security is sometimes questionable in today’s knowledge economy and changed labour market. For example, the unemployment rate no longer offers a correct measurement of the true supply of labour or insecurity because it fails to take into account the new diversity of employment status (casual, temporary, reduced-time, part-time, etc.) and other factors such as caregiving (Tremblay, 2002).

Food Insecurity

In developed societies, *food insecurity* is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so" (Davis and Tarasuk, 1994). Food insecurity includes problems in obtaining nutritionally adequate and safe foods due to a lack of money to purchase them, or the limited availability of these foods in geographically isolated communities (Campbell, 1991).

Social Economy

In Quebec, the term “social economy” is widely used and refers to a vast array of groups, mostly non-profit organizations including advocacy groups, voluntary organizations and other community-based organizations, including cooperatives. The term is not widely used in English Canada but is most close to the term “voluntary and community sector” (which includes organizations dealing with both voluntary and paid work) The mission of these organizations is to provide empowering services to members and community and not profit-oriented (Vaillancourt, Aubrey, Tremblay and Kearney, 2002).

Social Exclusion

Social exclusion describes the structures and dynamic processes of inequality among groups in society. In the Canadian context, social exclusion refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion.

Working Conditions

Jackson (2002) has identified the following working conditions have been identified as central to whether a job is healthy or not:

- job and employment security
- physical conditions at work
- work pace, control and stress
- working time (number of hours)
- opportunities for self-expression and individual development at work
- participation and relationships at work
- work-life balance.