

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH IN CANADA: BRIDGING THE GAP BETWEEN RESEARCH FINDINGS AND PUBLIC POLICY

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In spite of an accumulated body of evidence and Canada's own expertise on the topic, there is currently a policy vacuum on social determinants of health, as the costs and delivery of health care services have come to dominate the public debate. Whereas Canada was a leader in the 1970s and 1980s, it has now fallen behind countries such as the United Kingdom, Finland and Sweden. If we continue to ignore these broader policy issues, promoting healthy lifestyles and increasing spending on medical care are unlikely to succeed in maintaining and improving the health of Canadians. Establishing a social determinants of health task force to consider the findings and implement their implications would be a valuable first step in this direction.

En dépit des preuves accumulées pour démontrer leur importance décisive, et de l'expertise canadienne même en ce domaine, la question des déterminants sociaux de la santé est trop souvent passée sous silence, alors que le financement et la prestation des soins de santé en sont venus à dominer le débat public. Alors qu'il était à l'avant-garde en ce domaine dans les années 1970 et 1980, le Canada est maintenant dépassé par plusieurs pays comme le Royaume-uni, la Finlande et la Suède. Or, on ne pourra améliorer durablement la santé des Canadiens en se limitant à augmenter les dépenses de santé et à promouvoir de saines habitudes de vie. L'établissement d'un groupe de travail chargé de faire le point sur les déterminants sociaux liés à la santé et de mettre en œuvre ses conclusions serait un pas dans la bonne direction.

In late 2002, 400 social and health policy experts, community representatives and health researchers from Canada met at York University in Toronto at a conference entitled "Social Determinants of Health Across the Life-Span" to consider the state of ten key social determinants of health across Canada, explore the implications of these conditions for the health of Canadians, and outline policy directions to strengthen these social determinants of health. At the same time, Roy Romanow's *Building on Values: The Future of Health Care in Canada* was released. Despite submissions to the Commission that stressed the importance of the social determinants of health for the health of the population and maintaining the sustainability of the health care system, there was nary a mention of these issues

in the Commission's final report, in contrast with Michael Kirby's report, *The Health of Canadians - The Federal Role*, released earlier. In this article I will outline why the social determinants of health are so important and consider reasons for the continuing gap between what is known about the social determinants of population health and governmental action on these issues. I will provide examples of nations that have incorporated thinking about social determinants of health into national policy directions.

While there has been profound improvement in health in industrialized nations over the past century, wide disparities in population health continue to exist between nations and among citizens within nations. Some analysts

hypothesize that access to improved medical care is responsible for such differences, but best estimates are that only 10-15 percent of increased longevity since 1900 is due to improved care. More recently, differences in lifestyle behaviours such as tobacco use, diet and physical activity have been presented as the prime determinants of health. But studies conducted as early as the mid 1970s, which have been reinforced by numerous more recent studies, find these risk factors account for only a small proportion of variation in incidence among individuals in heart disease, cancers and diabetes. There are additional factors that predict health and illness. What are these?

Nonmedical and non-lifestyle factors that affect health go by a variety of titles. The "Ottawa Charter for Health Promotion" identifies the prerequisites for health as being peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health Canada accepted direction from the Canadian Institute for Advanced Research in outlining determinants of health, many of which are societal determinants. The determinants it came up with are income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development and health services.

A World Health Organization working group more recently identified ten social determinants of health: the social [class health] gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. The organizers of the York University "Social Determinants of Health" conference synthesized these formulations to identify ten key social determinants of health that are especially relevant to

Canadians: early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, the social safety net, social exclusion, and unemployment and employment security.

The evidence that these social determinants of health are of more importance to the health of Canadians than biomedical and lifestyle factors is clear. As one example, adverse socio-economic circumstances during childhood are repeatedly found to be more potent predictors of the incidence of cardiovascular disease and diabetes than later life circumstances and lifestyle behaviours,

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facts not touched upon by the Romanow, Kirby or Manzankowski reports. The weight of the evidence indicates that social determinants of health 1) have a direct impact on health of individuals and populations, 2) are the best predictors of individual and population health, 3) structure lifestyle choices, and 4) interact with each other to produce health.

Canadian policy-makers should be aware of these findings. Canada has been a world leader in developing the implications of these findings through the health promotion and population health concepts. In 1974 the federal government's report, *A New Perspective on the Health of Canadians* (the Lalonde report), saw health and illness as being determined by human biology, environment, lifestyle, and health care organization. The document was important in that it identified determi-

nants of health other than the health care system.

Another Canadian government document, *Achieving Health for All: A Framework for Health Promotion* (the Epp report, 1986), identified a prime goal of reducing inequities between income groups by influencing the social determinants of health when it stated that all policies with a direct bearing on health need to be co-ordinated. The list of policy areas is long and includes, among others, income security, employment, education, housing, business, agriculture, transportation, justice and technology. The 1999 Health Canada document, *Taking Action on Population Health: A Position Paper For Health Promotion and Programs Branch Staff*, states:

There is strong evidence indicating that factors outside the health care system significantly affect health. These "determinants of health" include income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.

Documents published by the Canadian Public Health Association (CPHA) tell a similar story. In 1986, its *Action Statement for Health Promotion in Canada* identified advocating for healthy public policies as the single best strategy to affect the determinants of health. Priority areas mentioned include reducing inequalities in income and wealth, and strengthening communities through local alliances to change unhealthy living conditions. In 2000, the CPHA endorsed an action plan that recognized the profound influence of poverty on health and identified ways to reduce its incidence. These developments influenced health policy thinking around the

world, including recently that of the US National Policy Association and the Centres for Disease Control and Prevention.

In spite of this accumulated knowledge, Canadians continue to be told—with some notable exceptions—by governments, health care providers, disease associations, public health units, and media—that lifestyle choices are both a threat to and the salvation of their health. What is not mentioned is that the evidence for this is contested and that biomedical interventions and lifestyle choices are a small factor in whether individuals stay healthy or become ill. Not surprisingly, research indicates that the Canadian public has little awareness of the importance of the social determinants of health.

The reasons for governmental inaction on the social determinants of health are relatively easy to ascertain but much more difficult to redress. In the context of building healthy public policy to influence the social determinants of health, the Kirby report discusses the difficulties of implementing policies requiring intersectoral action as well as longer time frames to assess effectiveness. Social determinants of health thinking require various ministries to co-ordinate policy-making and implementation. Federal and provincial ministries of health appear to be the ideal venues for such co-ordination but, as Gill Walt points out in *Health Policy: An Introduction to Process and Power* (1994) in regards to national governments, “The Ministry of Health is often described as the Cinderella among ministries. In the hierarchy it will usually come after the Ministries of finance, defence, foreign affairs, industry, planning, and education...” And in a statement that applies to both federal and provincial ministries, she adds: “The problems of policy co-ordination are exacerbated by intersectoral rivalry and territorial jealousy: each ministry is, in the end,

arguing its own case for a slice of the government budget against each other’s sector’s claims.”

In addition to organizational issues related to governmental functioning, policy discussions on the importance of nonmedical and non-lifestyle determinants of health are increasingly rare. Indeed, in its submission to the Romanow Commission,

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the Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information commented that

[I]n recent years, as the costs and delivery of health care have dominated the public dialogue, there has been inadequate policy development reflecting these understandings [on determinants of health]. In fact, 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.

The policy vacuum on social determinants of health exists within a broader context. The decline of the social welfare state in Canada and elsewhere—described by Gary Teeple in *Globalization and the Decline of Social Reform* (2000)—is driving neoliberal approaches to federal and provincial policy-making that fundamentally conflict with strengthening the social determinants of health.

Teeple argues that forces that led to the development of the welfare state at the end of World War II, and in the process strengthened the social determinants of health, were strong national identities, the need to rebuild Western

economies, the strength of labour unions within national labour boundaries, the perceived threat of socialist alternatives and a consensus for political compromise to avoid economic cycles of boom and bust. These forces led to more equitable distribution of income and wealth through social, economic and political reforms such as progressive tax structures, social pro-

grams and governmental structures that mitigated conflicts between business and labour, among others.

These forces are now in decline. Since the early 1970s, a fundamental change has occurred in national and global economies. The rise of transnational corporations that easily shift investments across the globe serves to pressure nations into acceding to their demands for changes that reverse reforms associated with the welfare state, thereby reducing labour costs and maximizing profits.

Indeed, government policy-making in Canada seems intent on weakening the social determinants of health. Federal program spending as a percentage of GDP is now at 1950s levels, and government policies have increased income and wealth inequalities, created crises in housing and food security, and increased the precariousness of employment.

Political pressure on federal, provincial, and local governments to conform to these shifting ideological sands blends well with the persistent bias of health workers in favour of individualistic, biomedical and lifestyle approaches to health. The media also prefers easy-to-understand biomedical and lifestyle headlines. The social-determinants-of-health approach is lost among such ideological imperatives.

In 1991 we, as Canadians, were profoundly healthier than were our neighbours to the south. But since then, there have been profound changes in the distribution of income and other policy domains in Canada that are directly relevant to the social determinants of health. Recent health indicators are mixed with an increase in death rates from diabetes and mental illness among Canadians, while

health determinants. While repeating the contested notion that lifestyle issues are the leading causes of chronic disease in Canada—ignoring the effects of material deprivation associated with living in absolute and relative poverty; psycho-social stress associated with income, food, and housing insecurity; and adopting unhealthy behaviours as a means of coping with such distress—the report states: “As a first

The CPHI submission to the Romanow Commission argued for establishing governmental mechanisms to promote intersectoral cooperation in support of various social determinants of health. It stated that

There is a need for intersectoral (governments working with the private and voluntary sectors) and intergovernmental mechanisms for collaborative action to address some of the major health issues discussed later in this brief. The United Kingdom provides a useful example: a Cabinet Council includes Ministers for Health, Social Security, Treasury, Education & Employment, Home Office, Agriculture, Fisheries & Food, Trade & Industry, Environment, Transport & the Regions and International Development to address crosscutting initiatives to improve health—so-called ‘joined-up’ government.

Through this Council the United Kingdom has developed national strategies to address major disease entities such as cancer, heart disease, injuries and mental health. But, of more importance, they have also developed national strategies to eliminate child poverty, enhance early child development, raise the minimum wage, increase funding for education and health services, reduce unemployment, improve housing and reduce crime in poorer neighbourhoods and address fuel poverty.

Participants in the “Social Determinants of Health Across the Life-Span” conference in Toronto—as part of its Toronto Charter for a Healthy Canada—stated that

The federal government should establish a Social Determinants of Health Task Force to consider the findings and work to implement the implications of the material presented at this Conference. The Task Force would operate to identify and

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deaths from cardiovascular disease continue to decline.

The Romanow Commission report repeats the contested notion that the lifestyle factors of tobacco use, diet and physical inactivity—what UK sociologist Sarah Nettleton calls the “holy trinity of risks”—are the main causes of chronic disease in Canada. Only a few paragraphs are devoted to broader determinants of health. Recommendations for promoting health naively exhort governments to support Canadians in making healthy lifestyle choices.

The Romanow Commission report (unlike the Kirby report) neglects to stress the important issue of developing a strategy for developing healthy public policy to strengthen various social determinants of health. Indeed, in calling for the establishment of a Canadian Health Council, the report fails to mention any role for it in coordinating and supporting government action to address the social determinants of health.

The Kirby report has an excellent presentation of what is known about the importance of the social determinants of health. It recognizes that the burden of disease would be reduced by building public policy to support

step, all policies and programs established by the federal government should be assessed in terms of their impact on the health status of Canadians. A follow-up report ... will set out its findings and recommendations on the potential for, and the implications of, healthy public policy in Canada.”

The Mazankowski report, *A Framework for Reform*, acknowledged the importance of a variety of social determinants of health such as income and education, but chose to emphasize Albertans making “healthier lifestyle choices.” Not surprisingly, considering its ideological bent, the Alberta government enthusiastically endorsed the healthier lifestyle choice agenda.

Gary Teeple argues that the powerful forces associated with economic globalization and the internationalization of capital are systematically dismantling the welfare state, a trend that has health consequences for the majority of the world’s people. Nevertheless, policy developments in Europe demonstrate the social determinants of health can be strengthened within a nation (see the description of policy directions undertaken by Sweden and Finland, below).

advocate for policies to support population health by all levels of governmental operation.

The follow-up Kirby report on developing healthy public policy should call for such a mechanism.

But, is a healthy national public policy possible in Canada? The simple answer is yes. Nations such as Sweden and Finland are not as wealthy as Canada but have, for years, systematically incorporated thinking about the social determinants of health into their national policy agendas.

The current National Swedish Health Policy contains numerous action areas to improve population health. These activities are the responsibility of the National Institute of Public Health. The six main strategies outlined are

- *Increase social capital in the Swedish society.* This includes efforts to decrease social inequality, counteract discrimination of minority groups and promote local democracy.
- *Promote better working conditions.* The most important issues are to decrease long-term negative stress, promote employees' influence at work and achieve more flexible working hours.
- *Improve conditions for children and young people.* Improve social support for families with children. Support and strengthen health-promoting schools.
- *Improve the physical environment.* Co-ordinate the work for sustainable environment with the struggle for improved health.
- *Promote healthy lifestyles.* Solidarity with those who are most vulnerable to lifestyle risks.
- *Provide good structural conditions for public health work at all societal levels.* Support to and co-ordination of research and education in public health science.

In summary, the Swedish public health goals are relatively few and their structure is not very sophisticated compared with other countries.

However, there are two significant qualitative aspects of the Swedish policy, which may be of interest: 1) The targets are formulated in terms of the determinants of health, and 2) very thorough work has been carried out in order to achieve consensus of and raise political support for the targets. The preliminary strategies and goals are supported by five of six political parties in the Swedish parliament.

In the Swedish case study included in *Reducing Inequalities in Health: A European Perspective* (2002), Burström, Diderichsen, Östlin and Östergren point out that

For many years Sweden has pursued equality-oriented health and social policies, active labour market policies and family-oriented policies that have resulted in higher levels of workplace participation, less income inequality, lower poverty rates and smaller socioeconomic inequalities in the distribution of poverty than in most other countries.

The result, as expected, is that "Compared to many other countries, Sweden has low mortality rates, high life expectancy, and favourable health indicators across all socioeconomic groups."

In *Strategies for Social Protection 2010* (2001), the Finnish Ministry of Social Affairs and Health outlines preventive social policy that 1) supports growth and development of children and young people, 2) prevents exclusion, 3) supports personal initiative and involvement among the unemployed, and 4) promotes basic security in housing. Population health can be promoted and social exclusion reduced by:

- Improving efficiency and co-operation among primary, specialized and occupational health care organizations
- Providing support for the general functional capacity of people of differing ages
- Promoting lifelong learning
- Promoting wellbeing at work

- Increasing gender equality and social protection, which provides an incentive to work
- Giving priority to preventive policy, early intervention, and actions to interrupt long-term unemployment
- Reducing regional welfare gaps
- Promoting multiculturalism
- Controlling substance abuse
- Promoting active participation in international policy-making
- Providing adequate income security as the key to building social cohesion

It should be noted that as early as 1986, four general targets were set for the population's health under the Health for All program: Adding years to life, through a decline in premature

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deaths; adding health to life, by showing a decline in chronic diseases, accidents and other health problems; adding life to years, by promoting good health and functional capacity for longer in life, with welfare to match; and reducing health disparities between population groups, producing smaller health differences between genders, socio-economic categories and people living in different regions.

The Finnish *Government Resolution on the Health 2015 Public Health Programme* (2001) concluded that progress had been made on all four goals. Life expectancy for women had risen six years since the beginning of the 1970s and that for men about seven. Infant mortality continues to be well below the EU average. Mortality rates among the over 65s has also declined considerably. Incidence of heart attacks, strokes, hypertension, rheumatoid

arthritis and many infectious diseases has fallen. Dental caries have decreased substantially, especially among young people. The percentage of under-55s on disability pension has also declined. Research shows that Finns in general, and especially middle-aged and older people, feel healthier on average than peers in the 1970s. Finally, mortality differences between the genders and different parts of the country have lessened.

Canadian policymakers have repeatedly stated their commitment to maintaining and improving the health of Canadians and sustaining the health care system. Supporting the social determinants of health is an important means of doing so. Alternative approaches to promoting healthy lifestyle choices and increasing spending on medical care are unlikely to accomplish these goals in the absence of actions focused on these

broader policy issues. Policy-makers should be aware of these facts. It is time for governments to act upon these social determinants of health or else to inform Canadians as to the reasons why they are unwilling to do so.

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THE TORONTO CHARTER FOR A HEALTHY CANADA

It is therefore resolved that: *Governments at all levels* review their current economic, social, and service policies to consider the impacts of their policies upon these social determinants of health. Areas of special importance are the provision of adequate income and social assistance levels, provision of affordable housing, development of quality childcare arrangements, and enforcement of anti-discrimination laws and human rights codes. It is also important to increase support for the social infrastructure including public education, social and health services, and improvement of job security and working conditions;

Public health and health care associations and agencies educate their members and staff about the impacts of governmental decisions upon the social determinants of health and advocate for the creation of positive health promoting conditions. Particularly important is their joining current debates about Canadian health and social policy directions and their impacts upon population health;

The media begin to seriously cover the rapidly expanding findings concerning the importance of the social determinants of health and their impacts upon the health of Canadians. This would strike a balance between the predominant coverage of health from a biomedical and lifestyle perspective. It would also help educate the Canadian public about the potential health impacts of various governmental decisions and improve the potential for public involvement in public policymaking; and that

Immediate Action: As a means of moving this agenda forward, the conference recommends that Canada's Federal and Provincial/Territorial governments immediately address the sources of health and the root causes of illness by matching the \$1.5 billion targeted for diagnostic services in the *Romanow Report on the Future of Health Care in Canada* by allocating an equal amount towards two essential determinants of health for children and families: 1) affordable, safe housing; and 2) a universal system of high quality educational childcare; and

Long-Term Action: Similar to governmental actions in response to the *Acheson Inquiry into Health Inequalities in the United Kingdom*, the federal government should establish a *Social Determinants of Health Task Force* to consider the findings and work to implement the implications of the material presented at this Conference. The *Task Force* would operate to identify and advocate for policies to support population health by all levels of governmental. The federal and provincial governments would respond to these recommendations in a formal manner through annual reports on the status of these social determinants of health.

The full Charter is available at: www.socialjustice.org

Social Determinants of Healthâ€, Canadian evidence is included and supplemented by international evidence. It is recognized that there may be additional information not captured in this document, including particular exclusions of topics summarized elsewhere (e.g., long-term care facilities) and from developing countries. Relevant results are reviewed and data extracted for synthesis.Â The Public Health Agency of Canada has expanded its list of risk factors to include social and economic circumstances that increase risk for COVID-19 infection and severe outcomes.Â In Canada, Black populations have higher rates of obesity, hypertension and diabetes as well as difficulty accessing health care, such as access to a regular doctor. Â Socioeconomic status, residential schooling in the current health and social conditions of Indigenous peoples, the links in the causal chain are not well understood, and there are many potential intermediate factors between residential school attendance and its effects on subsequent generations [14]. The consequences of residential schooling for Indigenous peoples in Canada have been known for some time, having been documented by the accounts of former attendees [15, 16].Â Although we distinguish specific types of health outcomes resulting from personal experiences and the intergenerational impacts of residential schooling, it is important to acknowledge that these outcomes do not occur independently, but exist in complex relationships with other effects [24]. CTSA-Public Health System and Health Department Partnerships. Critical Factors and Facilitators. Lessons Learned, Barriers, Gaps, and Challenges. Summary. Limitations.Â Although social determinants of health account for approximately 60% of health outcomes [Reference McGovern, Miller and Hughes-Cromwick4], the United States spends a significantly lower percentage of its gross domestic product (GDP) on social services as compared to similar countries with better health outcomes [Reference Bradley and Taylor5], and only 5% of U.S. national health expenditures.Â A primary challenge to addressing the research-policy-practice gap is the lack of sustainable...