Dennis Raphael writes tellingly about the social determinants to health, mapping the connection between good social policy and positive social outcomes and, sadly, the equally strong connection between bad policy, or no policy, and bad outcomes for Canadians. As Raphael notes, decades of research and hundreds of studies keep pointing this out but Canadians remain largely unaware of the connection.

One of the reasons for that is that social workers, who work where policy and practice meet, do not often participate in the national or provincial discussion. As you read this article, consider the following questions. Why do we not work within a workplace mandate for advocacy? How is this discouraged? Are we protecting ourselves from yet another source of workplace stress? Do we blame the victims?

Robert Hart, BCASW Advocacy Committee

INTRODUCTION
The primary factors that shape the health and well-being of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health (SDH). The importance to health of living conditions was first established in the mid-1800s and has been enshrined in Canadian government policy documents since the mid-1970s. In fact, Canadian contributions to the SDH concept have been so extensive as to make Canada a “health promotion powerhouse” in the eyes of the international health community. Recent reports from Canada’s Chief Public Health Officer, the Canadian Senate, and the Public Health Agency of Canada continue to document the importance of the SDH. But this information—based on decades of research and hundreds of studies in Canada and elsewhere—tells a story that is still unfamiliar to most Canadians. Canadians are largely unaware that our health is shaped by how income and wealth are distributed, whether or not we are employed, and if so, the working conditions we experience. Furthermore, our well-being is determined by the health and social services we receive, along with our access to quality education, food and housing, and other factors.

Contrary to the assumption that Canadians have personal control over these factors, in most cases these living conditions are—for better or worse—imposed upon us by the quality of the communities, housing situations, work settings, health and social service agencies, and educational institutions we have access to. There is much evidence that the quality of the SDH Canadians experience helps explain the wide health inequalities that exist. How long Canadians can expect to live and whether they experience cardiovascular disease or adult-onset diabetes is very much determined by their living conditions. The same goes for the health of their children; differences among Canadian children in surviving beyond their first year of life, in experiencing afflictions such as asthma and injuries, and whether they fall behind in school, are strongly related to the SDH they are exposed to.

Research is finding that the quality of these health-shaping living conditions is strongly determined by decisions that governments make in a range of different public policy domains. Governments at the municipal, provincial/territorial, and federal levels create policies, laws and regulations that influence how much income Canadians receive through employment, family benefits or social assistance, along with the quality and availability of affordable housing, the kinds of health and social services and recreational opportunities we can access, and even what happens when Canadians lose their jobs during economic downturns. These experiences also provide the best explanations for how Canada compares to other nations in overall health. Canadians generally enjoy better health than Americans, but do not do as well as when compared with other nations that have fully developed public policies that strengthen the SDH. The World Health Organization sees health-damaging experiences as resulting from “a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”.

Despite this evidence, there has been little effort by Canadian governments and policy-makers to improve the SDH through public policy action. Canada compares unfavourably to other wealthy developed nations in its support of citizens as they navigate the life span. Our income inequality and poverty rates are not only growing but are among the highest for wealthy developed nations. Canadian spending in support of families, persons with disabilities, older Canadians and employment training is also among the lowest for these same wealthy developed nations.
THE ROLES OF INSECURITY AND STRESS
Canadians who suffer from adverse social and material living conditions also experience high levels of physiological and psychological stress. Stressful experiences arise from coping with conditions of low income, poor quality housing, food insecurity, inadequate working conditions and insecure employment, as well as various forms of discrimination based on Aboriginal status, disability, gender or ethnicity. The lack of supportive relationships, social isolation, and mistrust of others further increases stress.

At the physiological level, chronic stress can lead to prolonged biological reactions that strain the body physically. Research evidence is convincing that continuous stress weakens resistance to diseases hormonal and metabolic systems function. Physiological tensions provoked by stress make people more vulnerable to many serious illnesses, notably cardiovascular and immune system diseases, and adult-onset diabetes.

At the psychological level, stressful and poor living conditions can cause continuing feelings of shame, insecurity and worthlessness. In adverse living conditions, everyday life often appears unpredictable, uncontrollable and meaningless. Uncertainty about the future raises anxiety, reinforces a sense of hopelessness or exhaustion that makes everyday coping even more difficult. People who experience high levels of stress often attempt to relieve these pressures by adopting unhealthy coping behaviours, such as the excessive use of alcohol, smoking, and overeating carbohydrates. Damaging behaviours can be seen as responses to adverse life circumstances even though they make the situation worse in the long run. Stressful living conditions make it extremely hard to make positive health changes; most of a person’s energy is directed toward coping with day-to-day life.

KEY SOCIAL DETERMINANT: INCOME AND ITS DISTRIBUTION
Income is perhaps the most important social determinant of health. Level of income shapes overall living conditions, affects psychological functioning and influences health-related behaviours such as quality of diet, extent of physical activity, smoking, and excessive alcohol use. In Canada, income determines the quality of other SDH, such as food security, housing and other basic prerequisites of health. More equal income distribution has proven to be one of the best predictors of a society’s overall health.

Income is especially important in societies which provide fewer important services and benefits as a matter of right. In Canada, public education until grade 12, necessary medical procedures, and public libraries are funded by general revenues. Child care, housing, post-secondary education, recreational opportunities, and resources for retirement must be paid for by individuals. By contrast, many wealthy developed nations provide these services as citizen rights.

Low income predisposes people to material and social deprivation. The greater the deprivation, the less likely individuals and families are to be able to afford the basics such as food, clothing, and housing. Deprivation also contributes to social exclusion by making it harder to participate in cultural, educational and recreational activities. In the long run, social exclusion affects health and limits a person’s ability to live a fulfilling day-to-day life.

A recent report by the Organisation for Economic Co-operation and Development (OECD) identified Canada as one of the two wealthy developed nations (among 30) showing the greatest increases both in income inequality and poverty from the 1990s to the mid-2000s. Canada is now among those OECD nations with higher income inequality. From 1985 to 2005, 60% of Canadian families experienced a decline in their market income in constant dollars, while the top 20% of Canadian families did very well.

Increasing income inequality has led to a “hollowing out” of the middle class in Canada, with significant increases from 1980 to 2005 in the percentages of Canadian families who were either poor or very rich. The percentage of Canadian families who earned middle-level incomes declined from 1980 to 2005.

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But the percentage of very wealthy Canadians increased, as did the percentage of people near the bottom of the income distribution range.

Increasing wealth inequality in Canada is even more troubling. Wealth is probably a better indicator of long-term health outcomes because it is a better measure of financial security than income. From 1984 to 2005, the bottom 30% of Canadian families had no net worth and moved into greater debt over this period. By contrast, the net worth of the top 10% of Canadian families in 2005 was $1.2 million, an increase of $659,000 in constant dollars from 1984.

PUBLIC POLICY IMPLICATIONS
Social workers need to engage in public policy discussions about how to strengthen the SDH. They can do this through their professional associations or as citizens. Below are some key issues where their involvement can make a difference:

• There is an emerging consensus that income inequality is a key health policy issue that needs to be addressed by governments and policy-makers.
• Increasing the minimum wage and boosting assistance levels for people unable to work would provide immediate health benefits for the most disadvantaged Canadians.
• Reducing inequalities in income and wealth through progressive taxation is a highly recommended policy option shown to improve health.
• A greater degree of unionization in workplaces would help reduce income and wealth inequalities in Canada. Unionization helps to set limits to profit-making that comes at the expense of employees’ health and well-being.

Social workers are ideally positioned to see the effects of adverse SDH upon Canadians. There is increasing evidence they are willing to join in public policy debate around how to strengthen the SDH. Public dialogue and advocacy activities need to be maintained and even increased. Without such efforts, there will be a continuing decline in the SDH, along with the unnecessary suffering that results from preventable illnesses and disease.

1 This article is adapted from J. Mikkonen and D. Raphael’s Social Determinants of Health: The Canadian Facts. Toronto: School of Health Policy and Management, 2010.

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