# SOCIAL DETERMINANTS OF HEALTH & EQUITY

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**&**

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# What determines our health?

- Traditional health sciences or biomedical approach
- Social determinants of health approach

Raphael et al. *Health Policy*, 2008

# The traditional approach

Biomedical / epidemiological lens

Health is determined by:

- Genetic and biological factors
  - Sex, age, genetic make up, physiological interactions
- Individual behaviours
  - Alcohol use, smoking, unprotected sex, drug use, non-adherence to treatment and medical care

# The traditional approach – limitations

- Reductionist
  - Focus on specific objective factors neglects the influence of wider social factors (**social constructs**)
  - Focus on objectivity (male/female; black/white) neglects their inherent social subjectivity (gender; race)
- Judgmental – what ‘should be’ vs. ‘what is’
- Health is considered an individual v social issue (neoliberalism)

# Social determinants of health (SDoH) approach – WHO definition

- The circumstances in which people are born, grow up, live and age, and
- The systems that are put in place to deal with health, illness and wellbeing

http://www.who.int/social_determinants/en/

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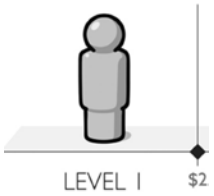
# Where we live has a HUGE impact on our health!


Born in Montreal
Life expectancy: 82


Born in Iqaluit, Nunavut
Life expectancy: 73



Born in Uttar Pradesh, India
Life expectancy: 64

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# Social determinants of health (SDoH) approach – alternate definition

- Nonmedical factors influencing health
- Includes heath related knowledge, attitudes, beliefs and behaviours (downstream determinants), that in turn are shaped by wider social structures (upstream determinants)

Braveman *Annu Rev Public Health*, 2011

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# Examples of SDoH

Age

Income

Education

Work and living conditions

Early life and development

Gender

Race and ethnicity

Culture

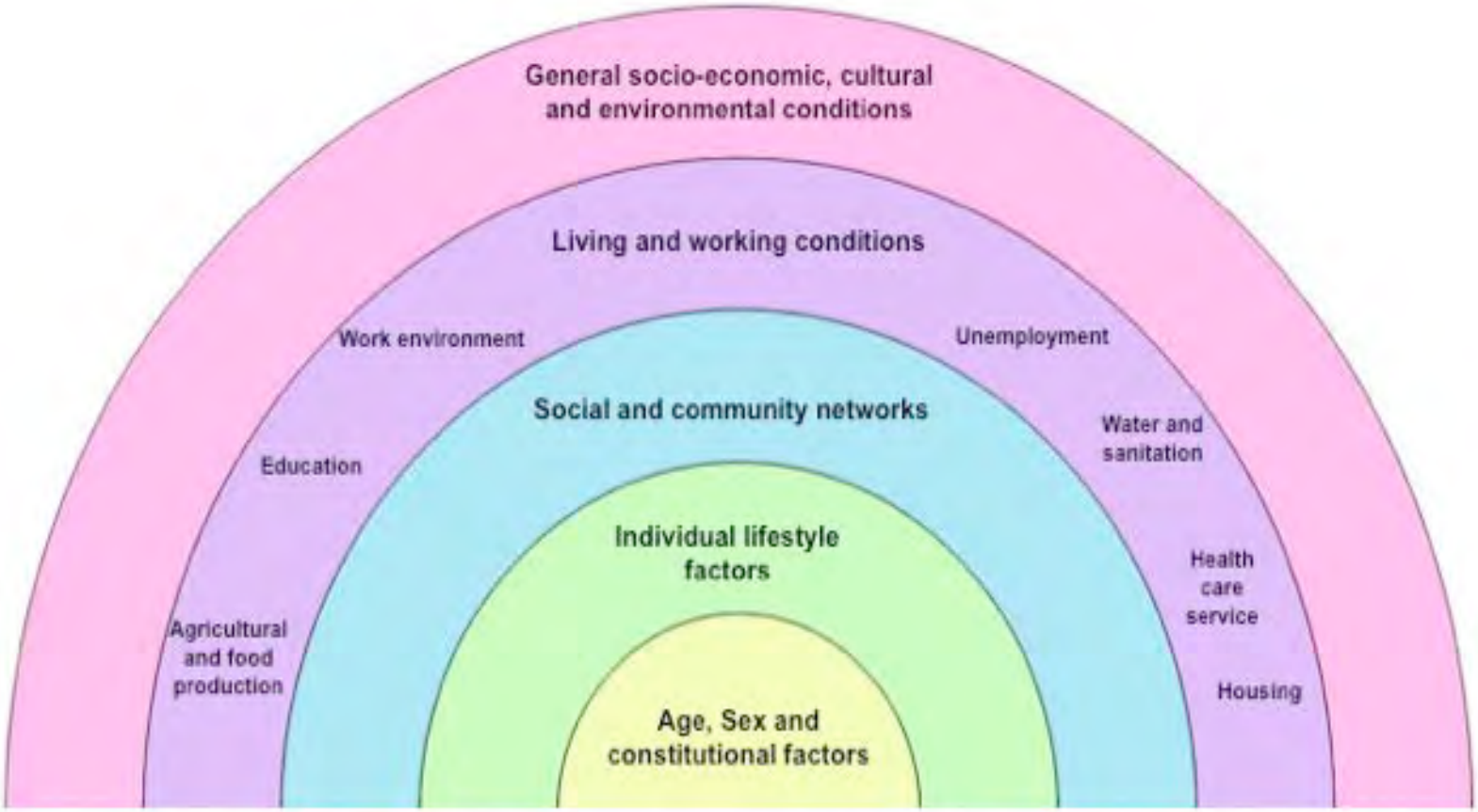
Access to health care services

Social environment – social support, capital, networks

Physical environment – housing, community, (urban/rural) infrastructure, air quality, climate changes

Politics and governing (social and health) policies

# SDoH – multiple layers and influences




Dahlgren & Whitehead 1991

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# SDoH – complete definition

- Structural conditions and determinants of every day life, including:
  - Circumstances in which we are born, grow up, live and age, and
  - Systems that are put in place to deal with health, illness and wellbeing
- Shaped by wider, intersecting structural forces → economics, social policies, and politics (social structures)
- Result in health inequities

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# What are social structures?

- Systematic and organized pattern of relationships, institutions, categories (social constructs) and practices that define our society
- The context in which these practices occur and develop (e.g., politics, economics, social policies, cultural norms)
  - Social structures can offer opportunities *or* establish constraints at the individual level → facilitate or limit individual behaviour (e.g., due to unequal distribution of money, power, resources)
- They are often established, ubiquitous and covert

# Examples of social structures (socioeconomic, political and environmental changes) affecting health

- Civil rights
- Political stability / conflict / persistent impact of colonialism
- Environmental degradation
- Climate change
- Population growth (carrying capacity)
- Migration, displacement, urbanization
- Racism, patriarchy
- Governance (decision-making)

→ Closely linked to SDoH

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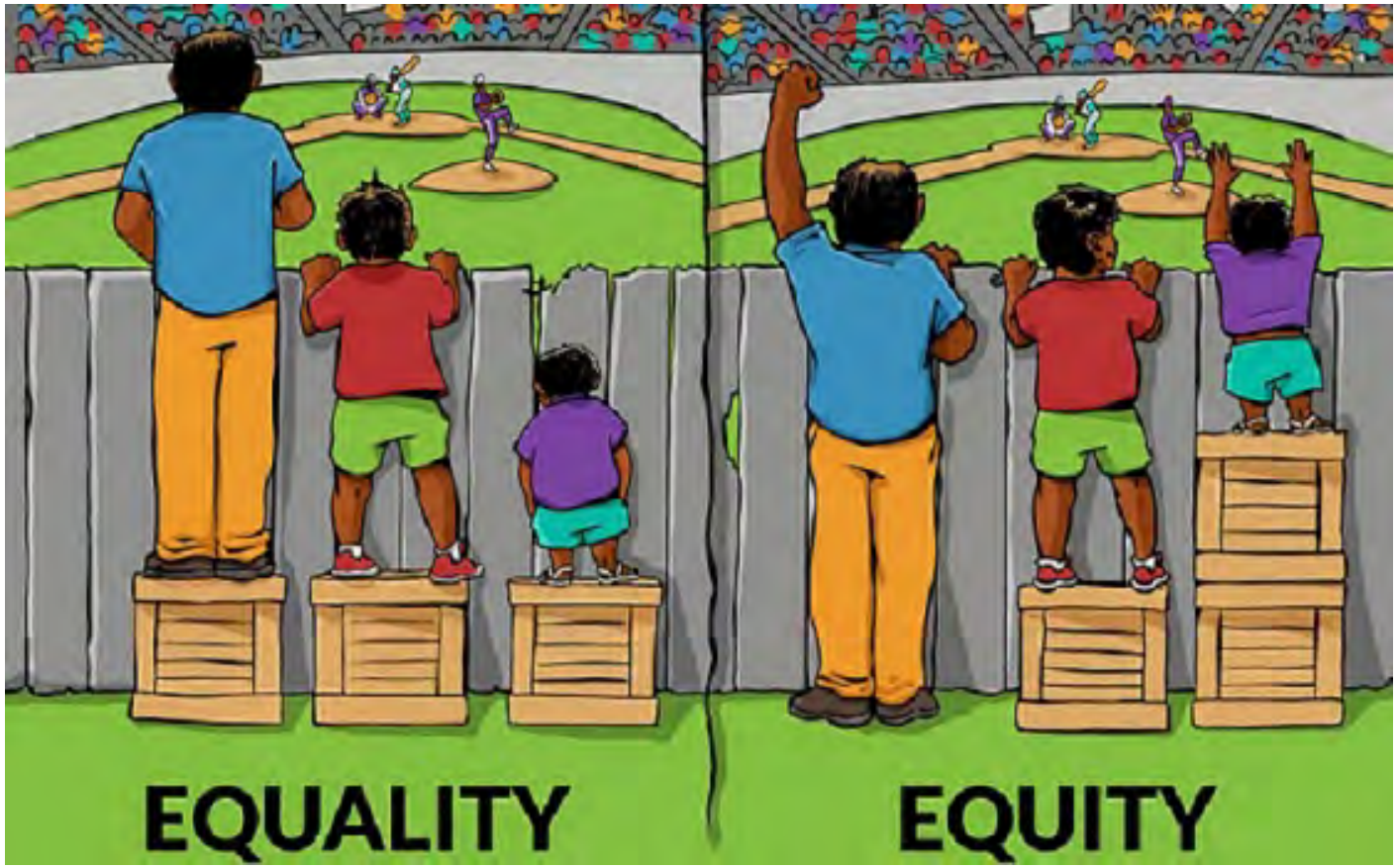
# What are health inequities?

- Systematic, unfair and avoidable inequalities or differences in health status between groups of people
- Arise between societies (local/national) and within societies (global)

# Equality vs equity




https://www.publichealthnotes.com/equity-vs-equality/

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# Evidence of social inequalities in health

# Basic examples

- Poor access to nutritious food → more susceptible to disease, less likely to recover
- Poor living conditions (e.g., sanitation, overcrowding) → more susceptible to infections
- Poor life circumstances → more susceptible to low paying, high risk work
- Poor traffic laws → road traffic injuries


FACT
FUL
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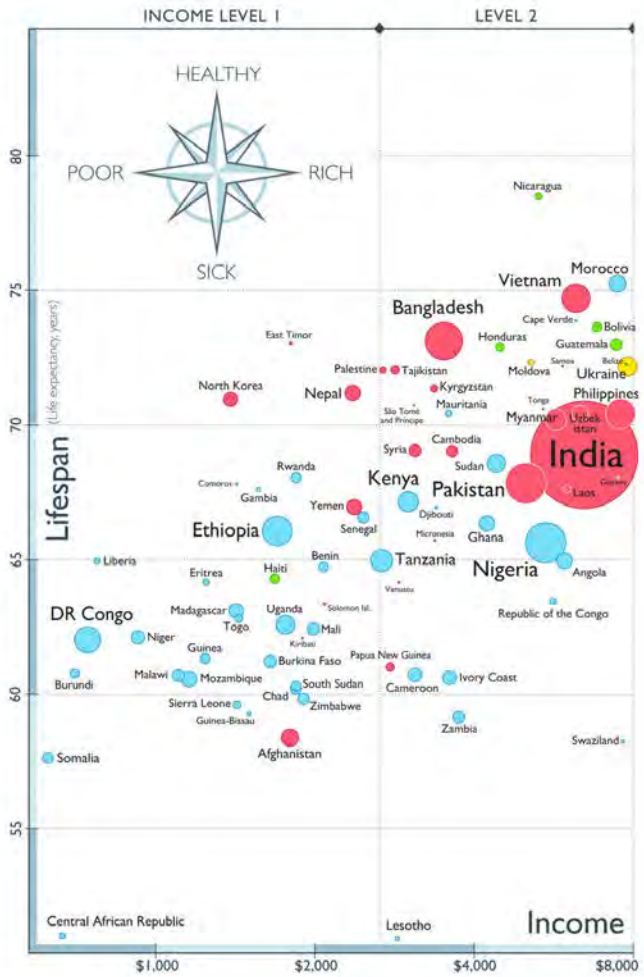
Ten Reasons We're Wrong About the World—and Why Things Are Better Than You Think
Hans Rosling with Ola Rosling and Anna Rosling Rönnlund


INCOME LEVEL 1
LEVEL 2
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(Life expectancy, years)
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Morocco
Bangladesh
Cape Verde
Bolivia
East Timor
Honduras
Guatemala
Palestine
Tajikistan
Moldova
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Kyrgyzstan
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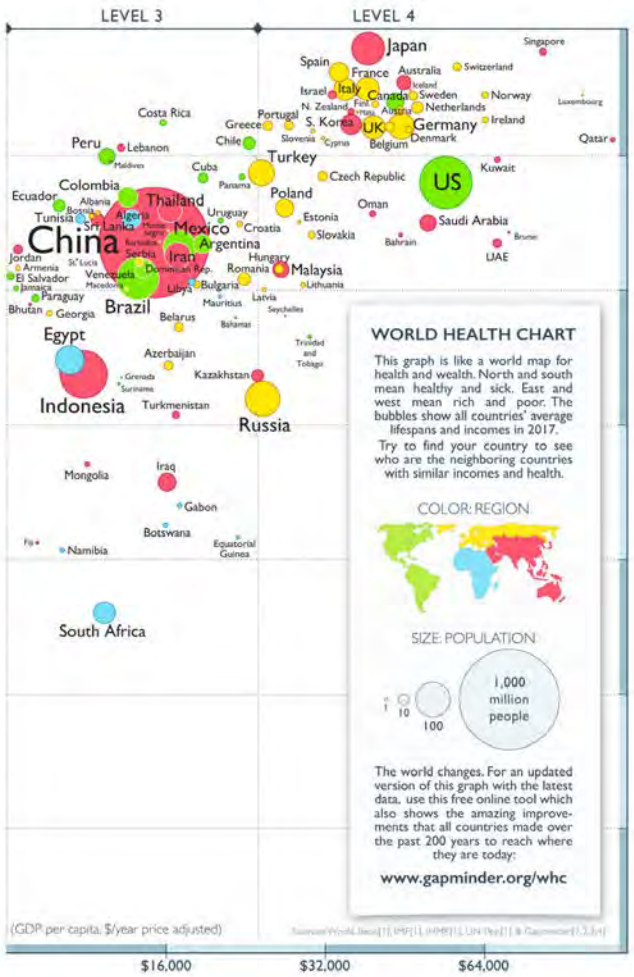
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LEVEL 4
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Turkey
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Azerbaijan
Trinidad and Tobago
Grenada
Kazakhstan
Indonesia
Turkmenistan
Russia
Mongolia
Iraq
Gabon
Botswana
Equatorial Guinea
Namibia
South Africa
WORLD HEALTH CHART
This graph is like a world map for health and wealth. North and south mean healthy and sick. East and west mean rich and poor. The bubbles show all countries' average lifespans and incomes in 2017.
Try to find your country to see who are the neighboring countries with similar incomes and health.
COLOR: REGION
SIZE: POPULATION
1
10
100
1,000 million people
The world changes. For an updated version of this graph with the latest data, use this free online tool which also shows the amazing improvements that all countries made over the past 200 years to reach where they are today:
www.gapminder.org/whc
(GDP per capita, $/year price adjusted)
$16,000
$32,000
$64,000

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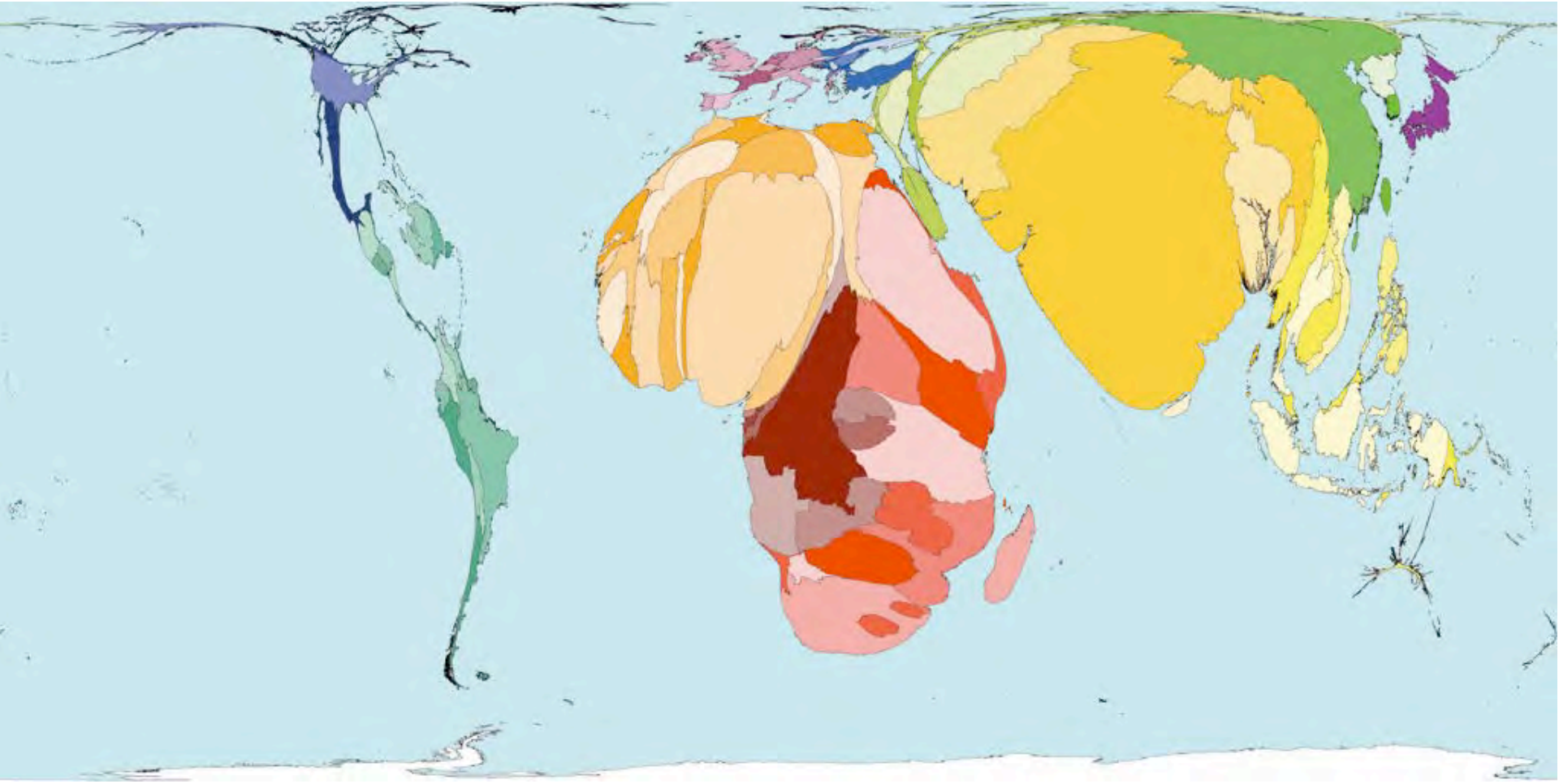
# The world by land area

www.worldmapper.org

# The world by preventable death

www.worldmapper.org



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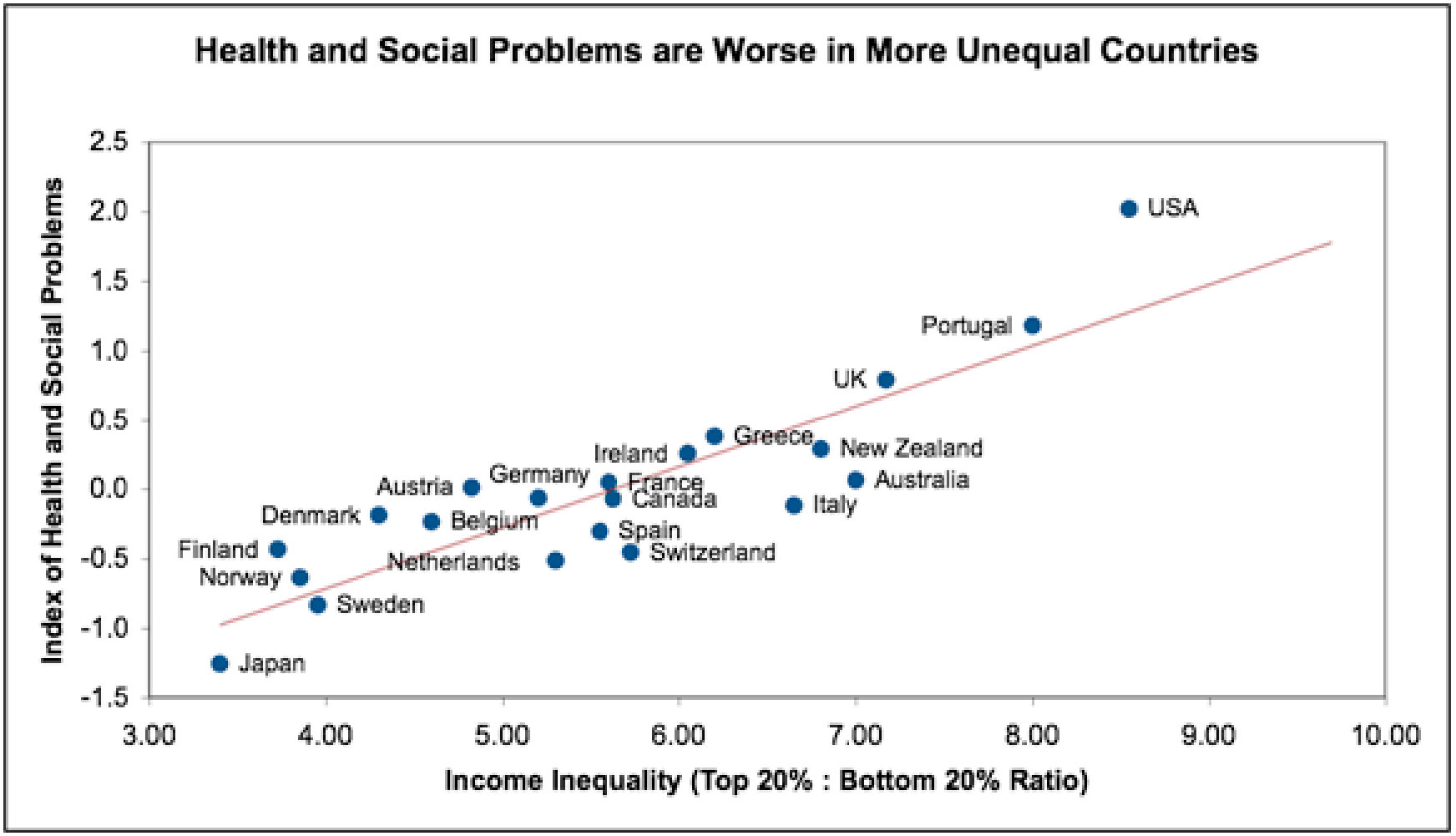


Inequality.org, data from WB and OECD

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# SDoH Visualization Tool

http://www.healthdata.org/data-visualization/sdh-viz

To explore relationships between

- **SDoH** (antenatal care visits, skilled birth attendance, measles and DPT3 immunization coverage, lag distributed income, and educational attainment)

- **Health indicators** (life expectancy, disability-adjusted life years by cause, years lived with disability by cause, and causes of death)

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# Example – Indigenous health

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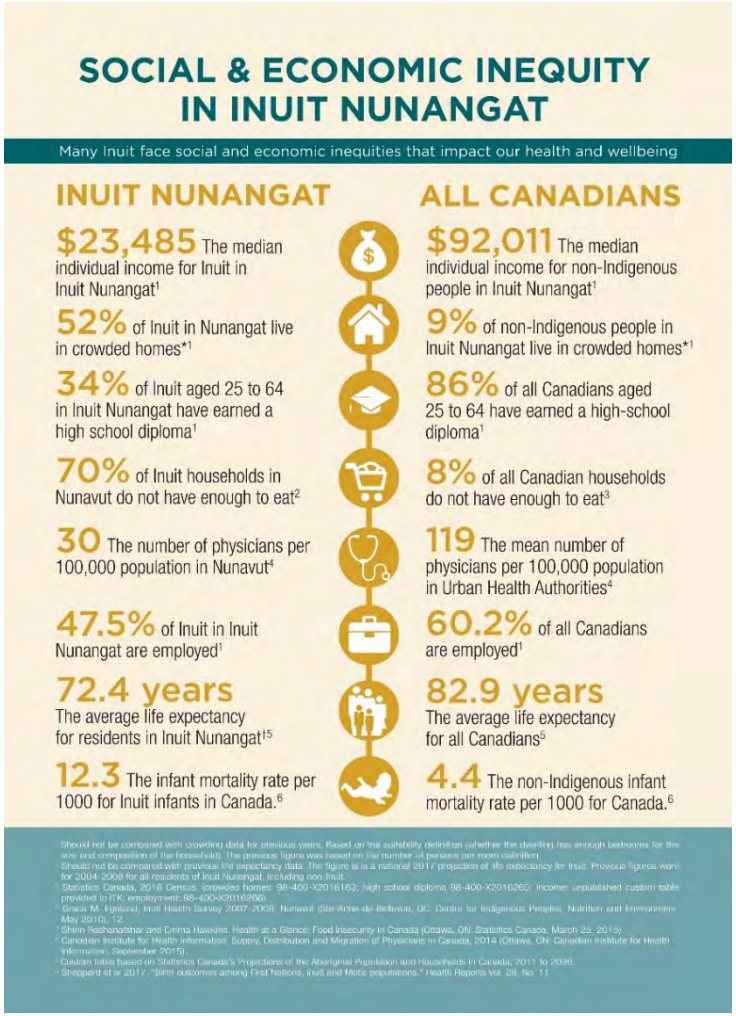


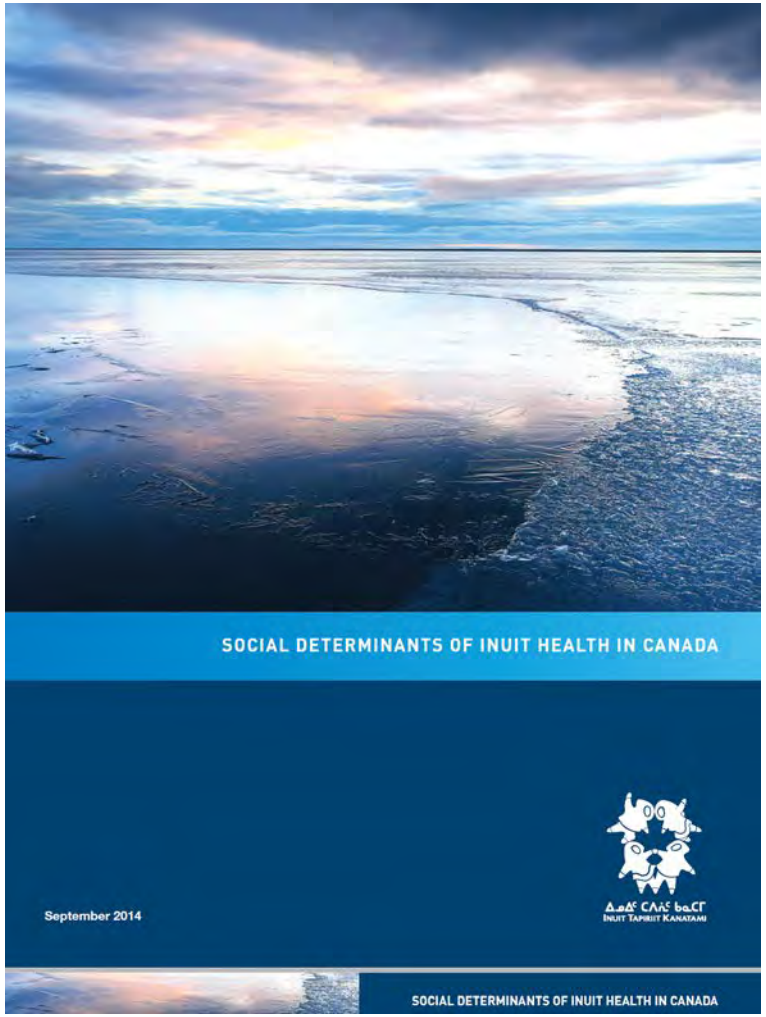


https://healthydebate.ca/2019/01/topic/tuberculosis-inuit-canada

https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf

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Social Determinants of Inuit Health


https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf

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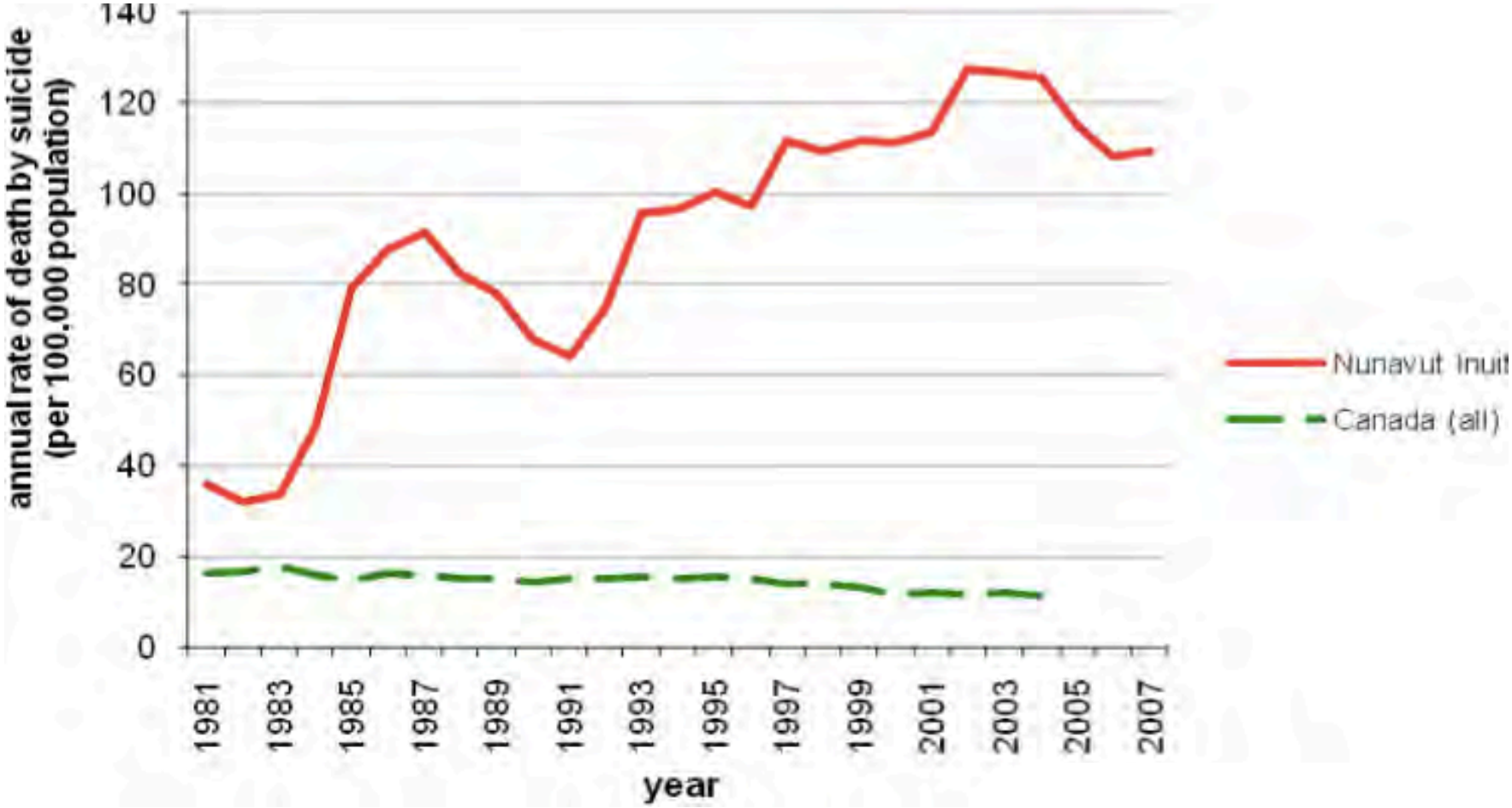
# Unequal suicide rates among Nunavut Inuit Vs. Canadians as a whole, 1982-2008




*Courtesy of Hicks J, Romain S UTSC 2016*

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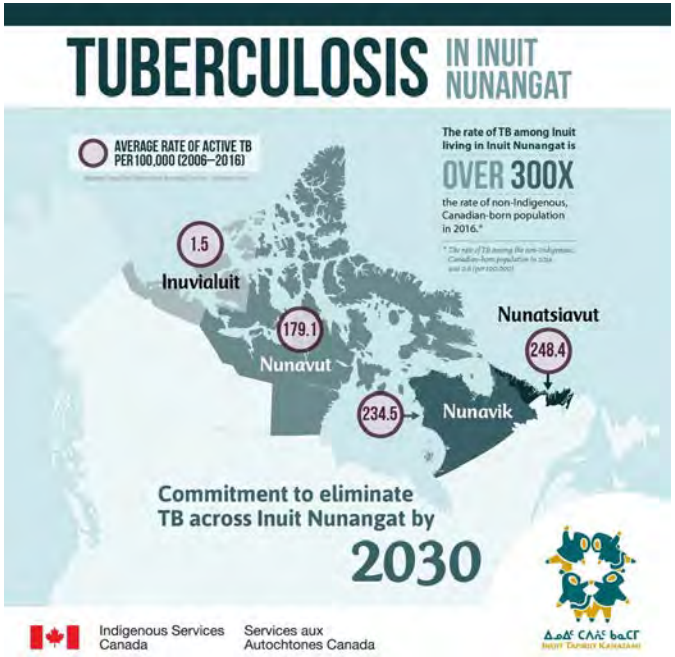
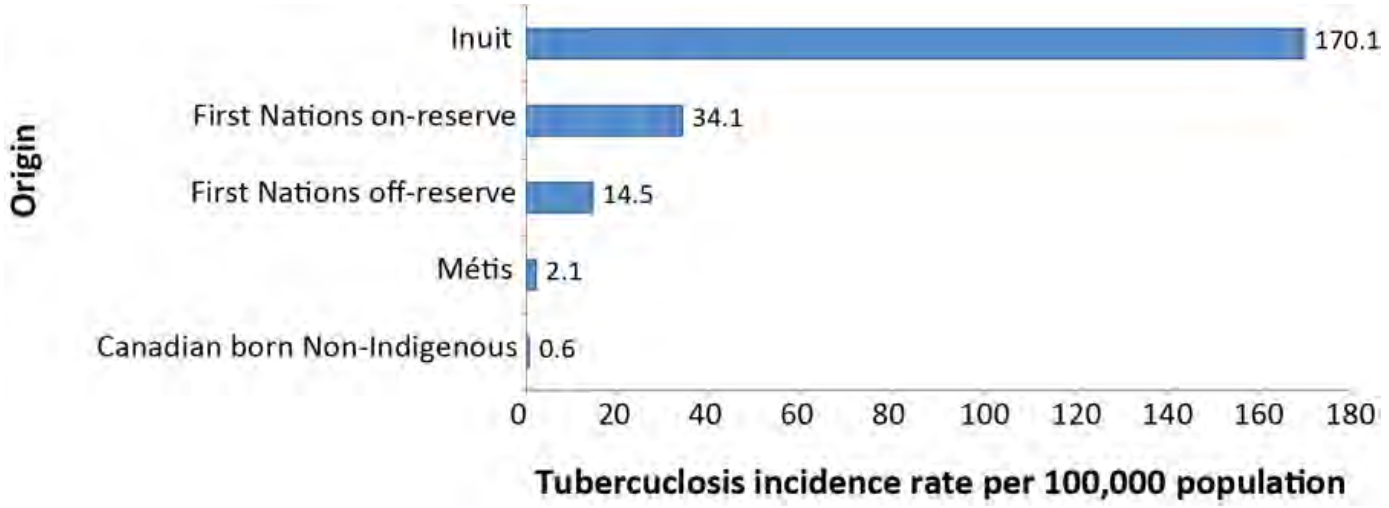



TB incidence rates in Canada




https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2018-44/issue-3-4-march-1-2018/article-1-tuberculosis-2016.html

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Journal of Epidemiology and Global Health
**In Press, Corrected Proof**
DOI: https://doi.org/10.2991/jegh.k.190314.002; ISSN 2210-6006
https://www.atlantis-press.com/journals/jegh

# The Enduring Plague: How Tuberculosis in Canadian Indigenous Communities is Emblematic of a Greater Failure in Healthcare Equality

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tuberculosis

**ABSTRACT**

Despite global strides made in prevention and treatment, tuberculosis (TB) remains an acute problem for Indigenous people in Canada. TB affects Indigenous communities at significantly higher rates than the general Canadian population, for whom it is a disease of the past. This paper suggests how colonialism and its history of violence have shaped the face of TB in Canada, and thus how TB is a telling point of analysis for considering the lack of equity and equality in healthcare delivery in Canada.



https://www.atlantis-press.com/journals/jegh/125906210

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OPINION

# Ending TB among Canada's Indigenous peoples: treat the fundamental causes, not just the disease

By DICK MENZIES AND MARCEL BEHR APR. 29, 2019

To wipe out TB in Canada's Indigenous populations, we need a big boost in their general health and social conditions.


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https://www.hilltimes.com/2019/04/29/ending-tb-among-canadas-indigenous-peoples-treat-the-fundamental-causes-not-just-the-disease/197630

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# A narrow, biomedical approach will simply not work

Historically, programs and research on Inuit health have focused on narrow indicators of health status without investigating a holistic view of social determinants of health as they relate to Inuit specifically. Therefore, future health initiatives must focus on issues such as food security, acculturation, and livelihoods as well as specific health outcomes. This change in focus would facilitate a more realistic perspective of Inuit health for Inuit organizations and governments.

+

Inuit-specific policies, Inuit-designed programs, and Inuit employment

https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf

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Truth and Reconciliation
Commission of Canada


http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

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## Health

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

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20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

    i. Increase the number of Aboriginal professionals working in the health-care field.

    ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

    iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

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# Example – maternal deaths among African Americans

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Serena Williams

# Serena Williams: I almost died after giving birth to my daughter

**Grand slam champion says she was lucky to receive excellent care, but that others are not so fortunate after giving birth**

Guardian sport
Tue 20 Feb 2018 20.15 GMT

151



# Beyoncé, Serena Williams bring attention to risks of childbirth for black women

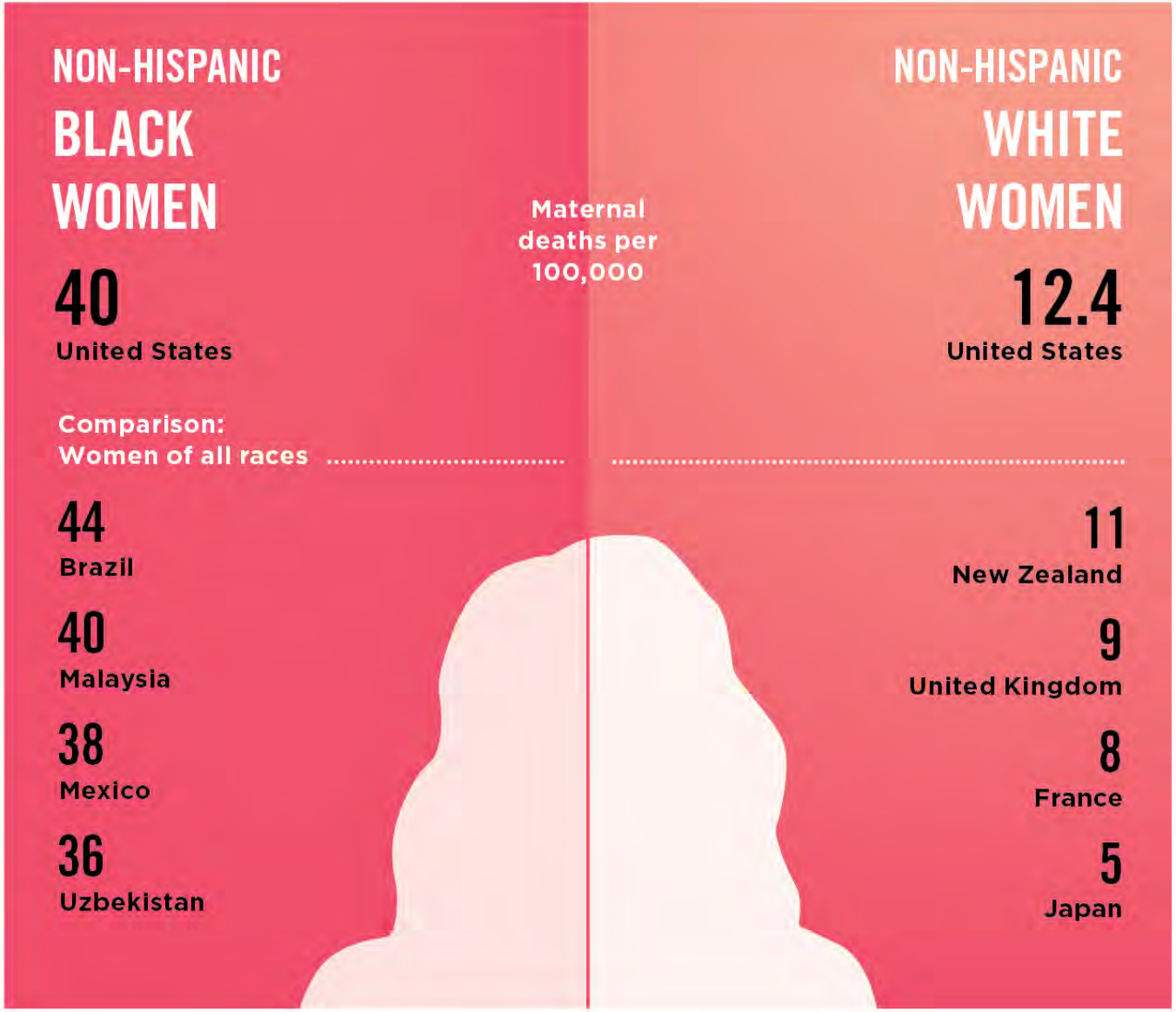
By Jacqueline Howard, CNN
Updated 4:52 PM ET, Mon August 6, 2018

Photos: American Vogue reveals September cover starring Beyoncé

September's Vogue cover was shot by photographer Tyler Mitchell

# MORTALITY GAP FOR U.S. MOMS

**In the U.S., black women who are expecting or who are new mothers die at rates similar to those of the same women in lower-income countries, while the maternal mortality rate for white U.S. mothers more closely resembles rates in more affluent nations.**




Sources: U.S. ratios (2011-2013): CDC Pregnancy Mortality Surveillance System; Global ratios (2015): UNICEF

https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/

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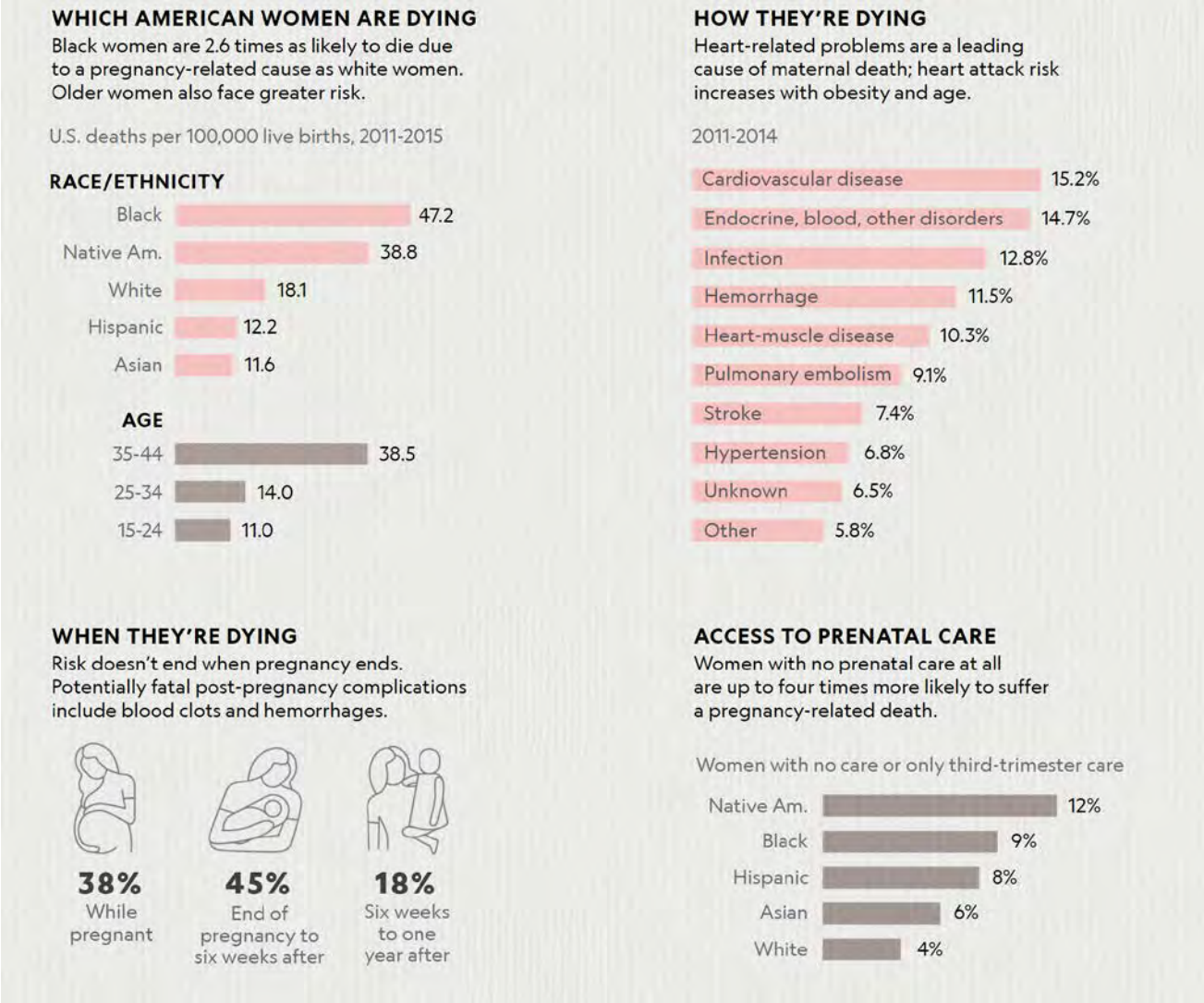


https://www.nationalgeographic.com/culture/2018/12/maternal-mortality-usa-health-motherhood/

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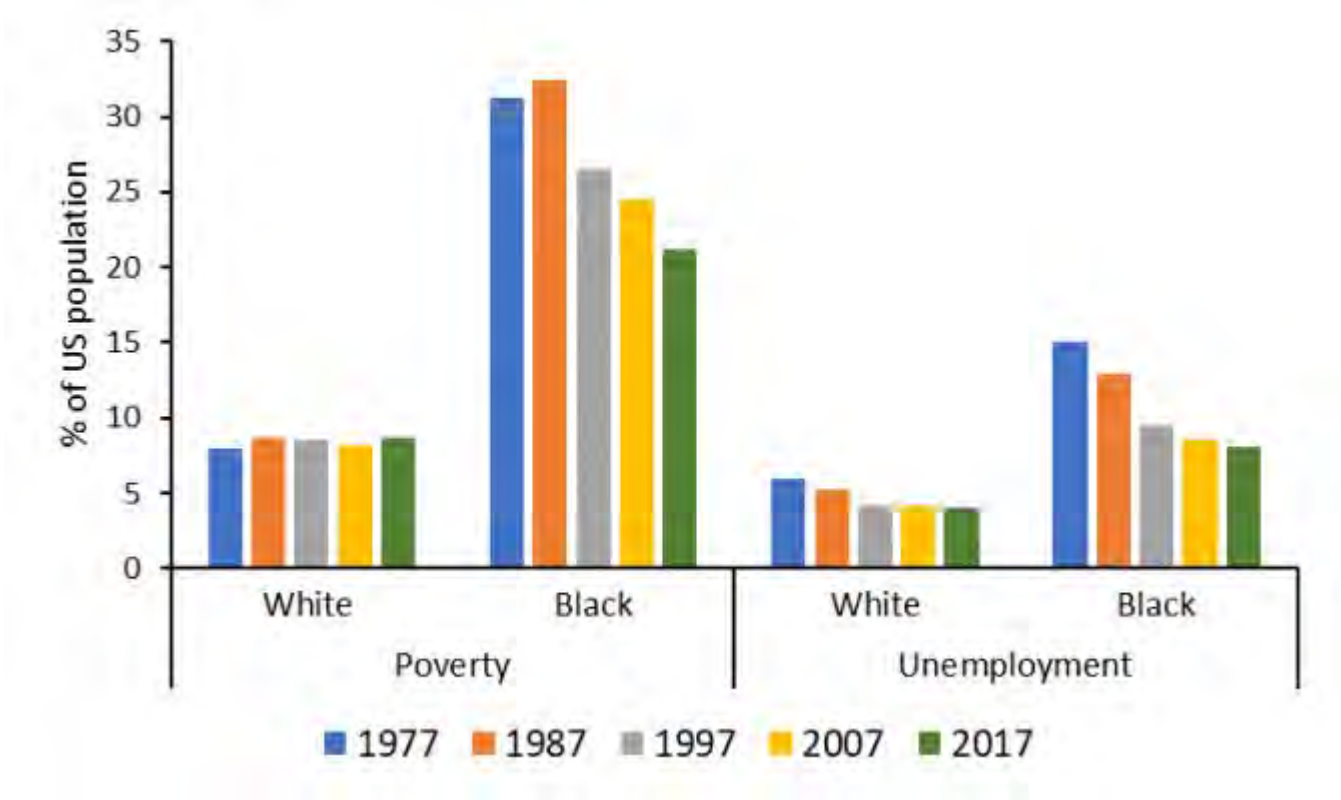
# Percentage of the US population in poverty or unemployed




https://blogs.lse.ac.uk/usappblog/2019/03/08/the-curse-of-slavery-has-left-an-intergenerational-legacy-of-trauma-and-poor-health-for-african-americans/

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"For black women in America, an inescapable atmosphere of societal and systemic racism can create a kind of toxic physiological stress, resulting in conditions — including hypertension and pre-eclampsia — that lead directly to higher rates of infant and maternal death. And that societal racism is further expressed in a pervasive, longstanding racial bias in health care — including the dismissal of legitimate concerns and symptoms — that can help explain poor birth outcomes even in the case of black women with the most advantages."

https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html

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One hundred and fifty years after the freed people of the South first petitioned the government for basic medical care, the United States remains the only high-income country in the world where such care is not guaranteed to every citizen. In the United States, racial health disparities have proved as foundational as democracy itself. "There has never been any period in American history where the health of blacks was equal to that of whites," Evelynn Hammonds, a historian of science at Harvard University, says. "Disparity is built into the system." Medicare, Medicaid and the Affordable Care Act have helped shrink those disparities. But no federal health policy yet has eradicated them.

https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html

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# Developing a global agenda to tackle the SDoH

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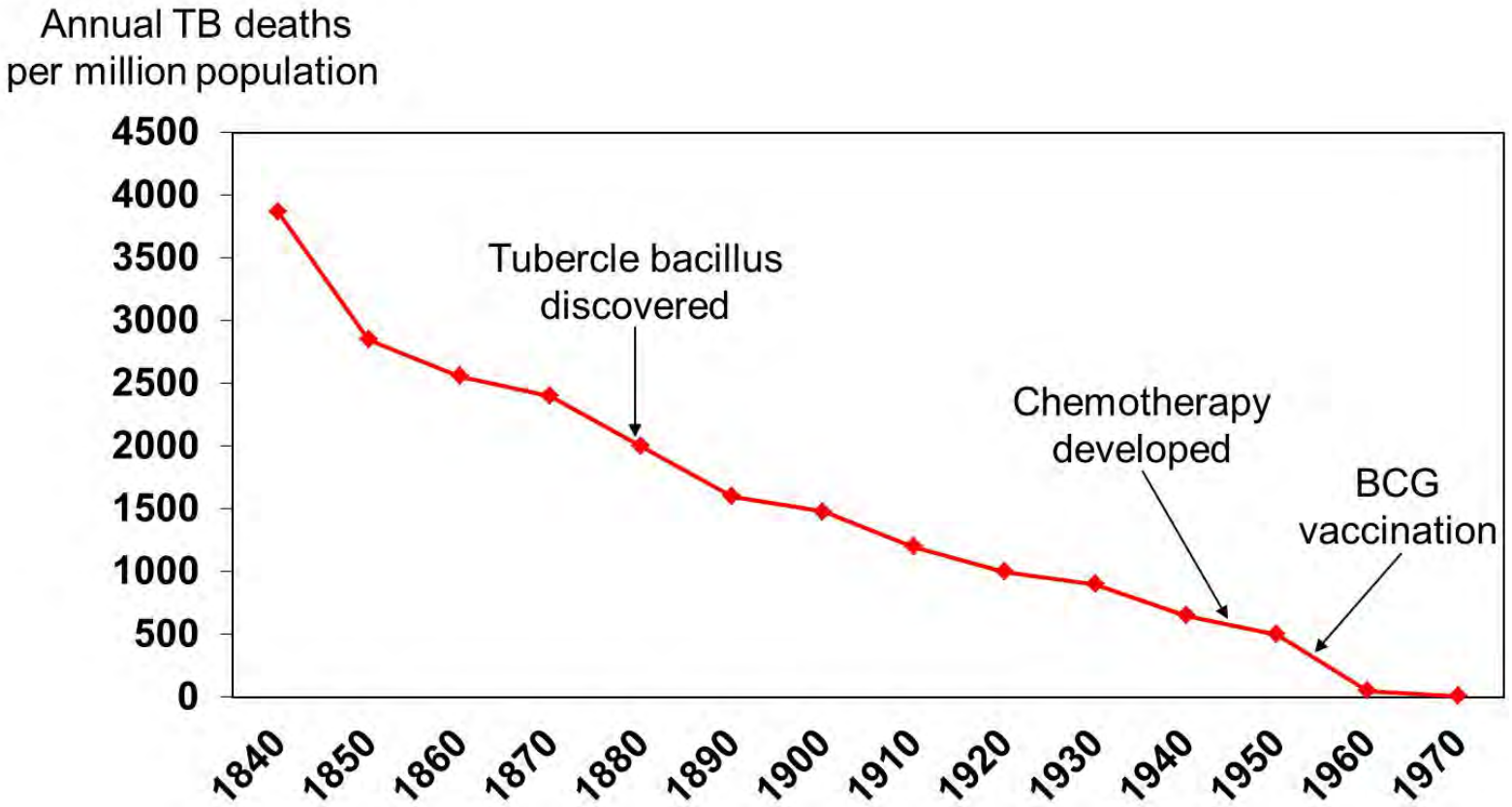
# McKeown Thesis
# Declines in TB: social > medical progress

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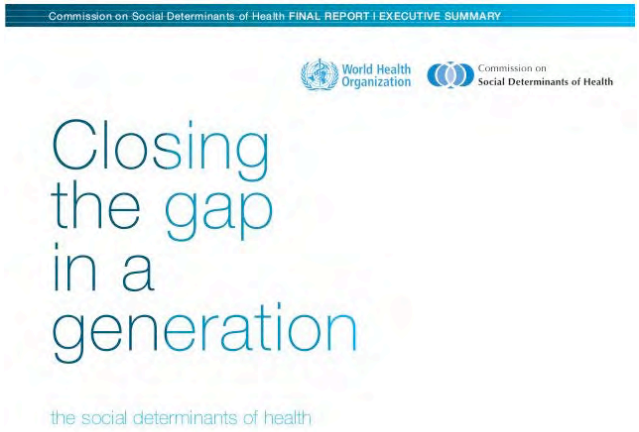
# Early efforts

- Marmot (1987) found rates of mortality from cardiovascular disease in British civil servants working in the 1960s-70s were 3X greater in those employed in lower employment grades (cleaners) vs. higher employment grades (managers), regardless of age and smoking.
- He argued that health is a function of social inequality not just biomedical markers.

# WHO Commission on the SDoH

- Report of the WHO Commission on SDoH
- Led by Michael Marmot (Whitehall study)




Marmot et al. 2008
http://whqlibdoc.who.int/publications/2008/9783703_eng.pdf?ua=1

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# Contributions of the WHO report on SDoH

- Legitimized the SDoH
- Call to measure and monitor indicators of health (in)equity
- Highlighted the global dimensions of health inequality
- Identified *health care systems* as a determinant of health

# Key recommendations

1. Improve the conditions of daily life
2. Mitigate inequitable distribution of power, money and resources
3. Understand the problem, evaluate action
4. Engage stakeholders

Easier said than done!

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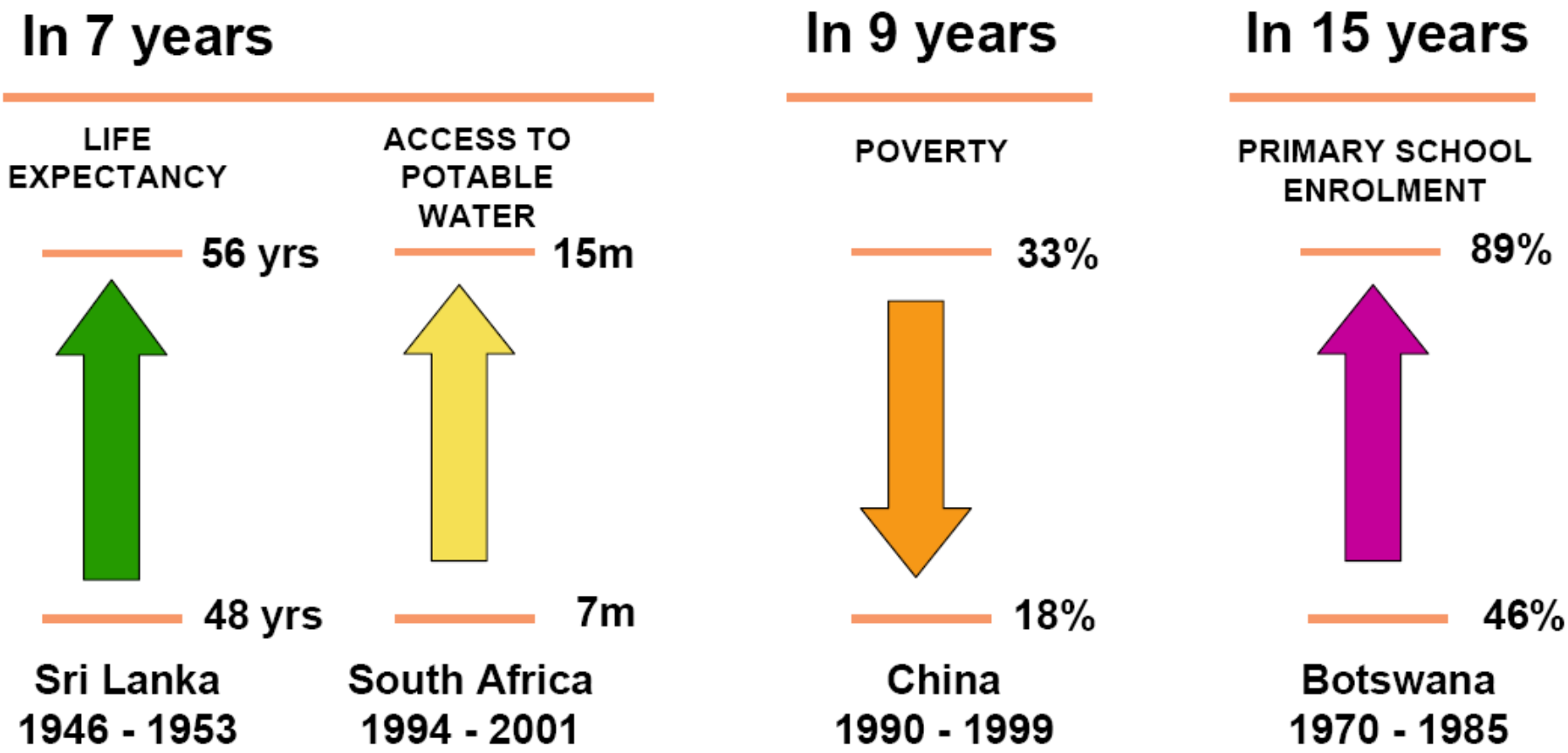
# Can we close the gap?

# Progress can be achieved in short periods




WHO SDoH Report 2008

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# SDGs: equity is key


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# Addressing equity requires some farsightedness

The quick fix
Low hanging fruit
Necessary but insufficient

The slow squeeze
Difficult to achieve
Necessary for sustainability

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# We need to fight against “socialization for scarcity”

*This is something I’ve been struggling with since I was a student: socialization for scarcity. But scarcity for ourselves? No. Scarcity for our mom? No. For our own kids? No. We’re socialized for scarcity for other people, and they’re usually black or brown or poor. So then we start cutting corners. Like saying we can treat drug-susceptible tuberculosis but not drug-resistant tuberculosis. We can give vaccines in Liberia but not chemotherapy. We must focus on prevention of trauma, or AIDS, in such settings, but not treatment. It might sound OK in a classroom, but such logic is lethal on the ground.*

- Paul Farmer, Harvard Gazette 21 May 2018

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# THANK YOU

QUESTIONS?