CFMS Position Statement on the Social Determinants of Health in Canada

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Introduction

What are the Social Determinants of Health

The Social Determinants of Health include the circumstances into which people are born and the factors shaping how they live, grow, and develop. These circumstances are shaped by the distribution of power, resources and money at global, national and local levels. Health equity implies that all individuals have the ability to acquire and maintain their best level of health given equal opportunity, accessibility, and service (WHO, 2008).

Health inequities are the unfair and avoidable differences in health status between and within countries due to social, economic and cultural limitations. In contrast to health inequities, which are modifiable, health inequalities cannot always be changed. Individuals born with a chromosomal disorder (e.g., Down Syndrome) have a shorter lifespan than the unaffected population. These disparate health outcomes are due to genetic differences outside society's control. The lower life expectancy of Canada's First Nations, Inuit and Metis population is an example of a health inequity because it cannot be attributed solely to a biological source but stems from modifiable barriers in the social determinants of health.

The social and economic environment determines 50 percent of population health, 25 percent is determined by the health care system and only 25 percent of health results from biological factors and the physical environment (Keon and Pépin, 2008). Socio-economic status plays a larger role in improving or damaging health than the health care system or biological factors. We must form health policy for the 21st century to address the social determinants of health in a concrete and measurable way.

Social Determinants of Health: The Canadian Context

Health and socio-economic status are tightly correlated in Canada. Higher social status and educational attainment correlate with better health, while the lowest socio-economic groups carry the greatest burden of illness. Food insecurity, social isolation, and chronic diseases which occur at higher rates in those from lower socio-economic groups are associated with poor health outcomes (Canadian Medical Association, 2012). Rates of hospitalization, emergency department use, and mental health problems are all elevated in Canadians of low socio-economic status. There is evidence from lower-income nations that health can be maintained on minimal resources when resources are appropriately directed at basic public health infrastructure, such as clean air and water, sanitation, education, and stable food supplies (Jameton and Pierce, 2001).

Physicians, whether consciously or not, may select their patient populations with a preference for high socio-economic status individuals who tend to be healthier and more compliant to care. Reduced access

to primary care for low socio-economic status individuals causes high expenses in a health care system which remains reactive rather than proactive. Access to care and the urban-rural divide are challenges reinforced by Canada's sparse population and dense concentration of tertiary care resources in Academic medical centres. Access to primary care is just a small part of improving the health of many of the most underserved Canadians.

First Nations, Inuit and Metis Populations

The largest health disparities within Canada are seen in the First Nations, Inuit and Metis population. As of 2012, Life expectancy at birth in the First Nations, Inuit, and Metis population is significantly lower than that of the general population in Canada (70.8 years versus 80.6 years, respectively (Statistics Canada, 2012). In a study completed from 2007-2010, First Nations, Inuit, and Metis populations reported poorer health and higher rates of chronic conditions as compared to with the non-Aboriginal population (Statistics Canada, 2010). In addition, potential years of life lost in this population due to accidents, injury, or suicide is greater than all other causes of death combined and 3.5 times higher than the national rate (Health Canada, 2002).

Discrimination, cultural loss and geographic isolation threaten the social determinants of health in Canada's First Nations, Inuit and Metis population. Improving access to health care, employment opportunities and post-secondary educational attainment will have a positive impact on the health status of First Nations, Inuit and Metis living on- or off-reserve, whether in cities or remote areas. Incorporating cultural practices and traditional medicine into the delivery of physician care can help combat addiction and suicide and could be used to address broader health inequities (Kirmayer, 2003).

Immigrant and Refugee Populations

Canada's cultural mosaic poses challenges of acculturation, assimilation, and adaptation. Immigrants and refugees often enter Canadian society with limited social or community support. Difficulty navigating new cultural norms and health practices in a new language is common, as is difficulty finding full employment. New Canadians are vulnerable to poor health status based on many different social determinants (World Health Organization, 2010).

Mental Illness

Poor treatment and stigmatization of mental illness is prevalent in Canada and around the world. In fact, one in five Canadians will experience a mental illness in their lifetime. Despite public education efforts, mental illness is still less tangible, less understood, and less widely accepted than physical ailments. Canadians in the lowest socio-economic group were four times more likely than those in the highest socio-economic group to report their mental health as "fair" or "poor". Poverty is a significant risk factor

for mental illness and people with mental illnesses often live in poverty or poor social conditions (Canadian Mental Health Association, 2008).

Recommendations

Every person, through all cultures and social situations, has the right to reach their highest attainable standard of health. Canada must place the social and economic determinants of health at the core of its 21st century public health agenda.

Policy recommendations

Any actions to improve health and tackle health inequity must address its social determinants including education, nutrition, exercise, social support and quality employment. Countries with the lowest income inequality and highest social supports generally have the best health outcomes (Bradley, 2011). Population health is impacted through the social determinants of health by all policies, regardless of which ministry, level of government or private sector actor makes the decision.

The CFMS calls upon Canadian medical students and medical professionals to:

- practice of social justice as the foundation of our profession;
- recognize that all medical practitioners have a responsibility to prevent disease;
- be agents of social change by advocating for health in all policies to decision makers, and providing equitable care and awareness by educating patients about relevant community services and eligible social programs;
- when treating difficult patients, recognize the social situation of poor health;
- develop tools to address the social challenges of patients in routine clinical encounters.

The CFMS calls upon Canadian medical schools and educators to:

- teach future physicians that public health and disease prevention are an inextricable part of medical practice in Canada, regardless of specialization or practice setting
- adapt medical curricula to local contexts, while teaching students the skills to work through current globally-relevant challenges
- train students to participate in local, remote, national, or global initiatives that target health inequity in underserved populations
- provide leadership and research in the areas of health promotion, disease prevention and the social determinants of health

The CFMS calls upon the federal and provincial governments to:

- focus on evidence-based prevention strategies that target the improvement of daily living
- improve access to health care, including pharmaceuticals and medical technologies, for low socio-economic populations
- fund research into comparative effectiveness studies between different treatments of the same condition to guide appropriate and cost-effective treatment decisions
- subject all cabinet decisions and national policies to a Health Impact Assessment that would include health equity principles

The CFMS calls upon the international community, including United Nations agencies, intergovernmental bodies, civil society, and the private sector to:

- recognize that all policies impact health and adopt the Health in all Policies decision-making framework
- deeply embed health metrics in sustainable development policy
- build resilient health systems that can adapt in response to an evolving climate, social or environmental changes

Conclusion

Equitable health for all Canadians is within our reach. Childhood and community interventions coupled with social support programs are an effective way to target the social determinants of health. Patients seek, or fail to seek, different medical treatment based on their social conditions. The sustainability of our healthcare system depends on our ability to re-orient it towards health promotion and equity rather than the treatment of acute illness. The CFMS calls upon physicians and policy makers at home and globally to place strong action on the social determinants of health at the centre of their policy agendas.

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