

# **S/A 4071: Social/Cultural Aspects of Health and Illness**

## **Class 8: Social Inequality, Disease and Death 1:**

### **The Social Determinants of Health**

\* Today we begin looking at social structure, particularly its hierarchical aspects, and health

\* Social structure relates to hierarchy or social inequality in relation to one or more of the following factors:

- geography (e.g. region, rural vs. urban)
- economic wealth/income
- education
- social status
- age
- ethnicity
- gender
- religion

\* Research is clear that there is a consistent relationship between good health & location high in the social structure (& vice versa)

\* Societies that are more equal tend to have better overall health (& vice versa)

\*In the work of Raphael are found different explanations for this:

(1) *Materialist approach*: health related to differential access to minimum level of good food, water, housing, employment, education & transportation. Key are income

sufficiency and income stability. Without these health is threatened directly and indirectly (e.g. poor coping practices)

(2) *Neo-materialist approach*: as above, but notes once a certain level of material adequacy has been reached, issues of equity in distribution become more significant (e.g. having social programs or not).

(3) *Social-Psychological*: Emphasis on the impacts of inequity:

- social capital (i.e. effects of inclusion/exclusion)
- natural capital (access to parks/environmental conditions)
- human capital (education type, amount & quantity)
- material capital (occupation, income & employment)
- social and cultural capital (social support, discrimination & stereotyping)
- psychological capital (sense of well-being & self-esteem)
- corporal capital (genetic background, body shape, size & functioning)

(4) *The Life - Course Approach*: All of the above, but emphasize cumulative effects traced from childhood into adult lives (e.g. when relative lack of redistributive policies foster ill health). Snowball effects such as in teenage pregnancies.

\* Political Explanations for Inequality/Poor Health:

- Navarro & Shi (2003) compared, between 1945-80, health outcomes in social democratic, christian democratic, liberal and ex-fascist countries. Social democratic countries, with broad redistributive policies, generally successful in improving population health. This was much less so in liberal countries, with the others in between.

- Inequality & inequity have grown since the above study, rooted in the growth and spread of neo-liberal ideologies focused on market efficiency, individualism, and competition as innovation. State programs are frowned upon, redistribution increasingly dismantled, social inequality fostered, with negative impacts on health.

\* An operating model for the social determinants of health will include attention to:

- Degree of globalization of capital
- Cultural differences (e.g. degree of medicalization)
- Differing political-economic systems (e.g. capitalism vs. socialism; presence/absence of social policies)
- Ecological (i.e. environmental quality)
- Social structural positions (e.g. relative inequality on gender, age, ethnicity, education, religion, employment/unemployment)
- Social psychology (i.e. stress, social support, coherence)
- Micro-meaning (i.e. definition of situation re: health & illness)

\* Canadian Evidence:

- until 1974, health limited to that managed by medical care system
- 1974 (Lalonde) 4 causes: biology, environment, lifestyle, & health-care organization
- 1986 (Epp) focus on reducing inequalities through promotion of self-care, mutual aid & healthy environments
- 1986: Ottawa Charter for Health promotion stressed peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as health prerequisites.
- Regional/geographic differences in health: residents of large cities (often higher status/healthier behaviors) healthiest/remote communities least so.
- Inequality: Japan with relative equality/ distributive social programs/ community focus healthier/has longer life expectancy than Canada/US, where income inequality growing
- Food insecurity: hunger a problem in Canada (e.g. food bank use related to both hunger/obesity due to poor diets.
- Related to low wages/cost of living/poor social programs). 2.3 million Canadians affected in 2004.
- Poverty: defined as difficulty meeting basic needs/low-income cut-off point. In 2001 child-

poverty rate 18.4% (higher for kids with disabilities, Aboriginals, visible minorities and new immigrants). Those in poverty more likely to suffer developmental diseases, learning disabilities and mental health issues

- Employment: hard to live on minimum wage.

Higher

incomes/greater autonomy associated with better health

- Unemployment: this, along with underemployment, associated

with worse health. Unevenly distributed.

- Education/Literacy: Higher education/literacy associated with better health

- Housing: Good housing associated with better health/

homelessness, inadequate housing and poor neighborhood is not

\* Social Theory, Economics and Health:

- Marxism points to contradiction between interests of capital and

workers, owners and employees, as explanation for health

variations: maximizing profit and minimizing costs harmful as

reflected in distribution of fundamental resources

- Commodification of labour through supply/demand.

Health also

commodified: can be bought/sold by those with the money (e.g.

“healthy enough” workers, organs, profits from  
cigarettes/alcohol,  
etc.)

- Growth of inequality across the globe paralleled in  
Canada,

fostered ultimately by the globalization of neo-liberal  
policies.

Societies with greater inequality have worse health  
outcomes. This, coupled with decline in government  
involvement in health  
care provision, facilitates growth in morbidity and  
mortality.