

WHAT REALLY MAKES US SICK

BY TAMMY HORNE

Despite evidence that social factors impact our health, the Alberta government promotes personal responsibility over enlightened public policy

THE KLEIN GOVERNMENT WANTS ALBERTANS TO TAKE MORE personal responsibility for our health, to prevent disease and save health care costs. Health education messages extol the virtues of physical activity and healthy eating, and warn us of the perils of smoking. Acknowledging personal responsibility recognizes people's desire and capacity for positive change. But lifestyles are strongly influenced by life circumstances. Over emphasizing individual behaviour downplays broader influences on health, such as income, employment, education, housing, food security and the environments where we live, work and play.

Federal, provincial and territorial governments in Canada agree on 12 key determinants of health:

- income and social status
- social support networks
- education
- employment and working conditions
- social and physical environments
- biology and genetic endowment
- personal health practices
- coping skills
- healthy child development
- health services
- gender
- culture

These factors interact. For example, smoking is a personal choice, but is most common among the poor, the unemployed and those with less formal education. Philip O'Hara, acting executive director of the Edmonton Social Planning Council says, "If we want to change the behaviour we need to help change the social condition. For a single parent in a low income situation with several kids, a 10-minute smoke break is her time. We all need time to ourselves. Until she has an alternate [coping] strategy, she's going to continue to smoke, and that's understandable." Similarly, people who see health messages on TV about the importance of eating more fruits and vegetables cannot act on that knowledge unless they can afford to buy more fruits and vegetables and are near stores that sell them.

Dennis Raphael, a social determinants of health expert at York University, writes that the focus politicians and the media place on lifestyle has constrained public awareness of the social factors that influence health. A recent national survey confirms his belief. The Canadian Institute for Health Information found Canadians are most likely to recognize health impacts of personal behaviours such as nutrition, exercise, smoking and drinking, as well as the physical environment. They are less likely to know that social factors such as income, education and social support influence health.

Many population health experts believe income is the most important determinant of health. Raphael, for instance, concludes from Canadian and international research that socioeconomic factors influence health even more than behaviour does, particularly for people with low incomes. Raphael has documented research from Statistics Canada and other sources showing a link between low income and both poor health and early death in Canada. Statistics Canada also reports that while 73 per cent of those in the highest income range rate their health as "excellent" or "very good," only 47 per cent of those in the lowest income range do so.

British researcher Richard Wilkinson points out that health improves with each level of income: the wealthy are healthier than middle income earners, whose health is better than lower-middle income earners, who in turn are healthier than the poor. People with lower income are more likely to experience high stress and low feelings of control over their lives. This can lead to chronic anxiety and damage to physical health through high stress-hormone levels and unhealthy coping behaviours such as substance abuse and overeating. In his book *Mind the Gap*, Wilkinson says the average income of a population is less important than how that income is distributed. What matters is the gap between high and low income earners. The more income equality in a society, the healthier its population. The social environment—trust, friendship networks, community involvement—is weaker when there are large inequalities. By contrast, Wilkinson says that income equality fosters higher social cohesion—there is more trust, social support and community participation, less hostility and violence, and better mental and physical health.

Income inequality has increased over the past decade in both Alberta and Canada, according to Statistics Canada. Furthermore, the National Council of Welfare, a citizens' advisory body to the federal government, reports that compared to other provinces Alberta's 2004 welfare payment rates for individuals and families rank at or near the bottom using three different measures: rates as a percentage of average personal income, rates as a percentage of median personal income, and the gap between welfare payment rates and Statistics Canada's low income cut-off.

"There is so much evidence linking poverty and social inequity to poor health outcomes," says Kim Raine, director of the Centre for Health Promotion Studies at the University of Alberta. "Alberta is well positioned to raise the standard of living for those at the bottom of the social gradient. That would have a positive impact on kids, women and the Aboriginal population, as single mothers and Aboriginal people are among the largest groups affected by poverty."

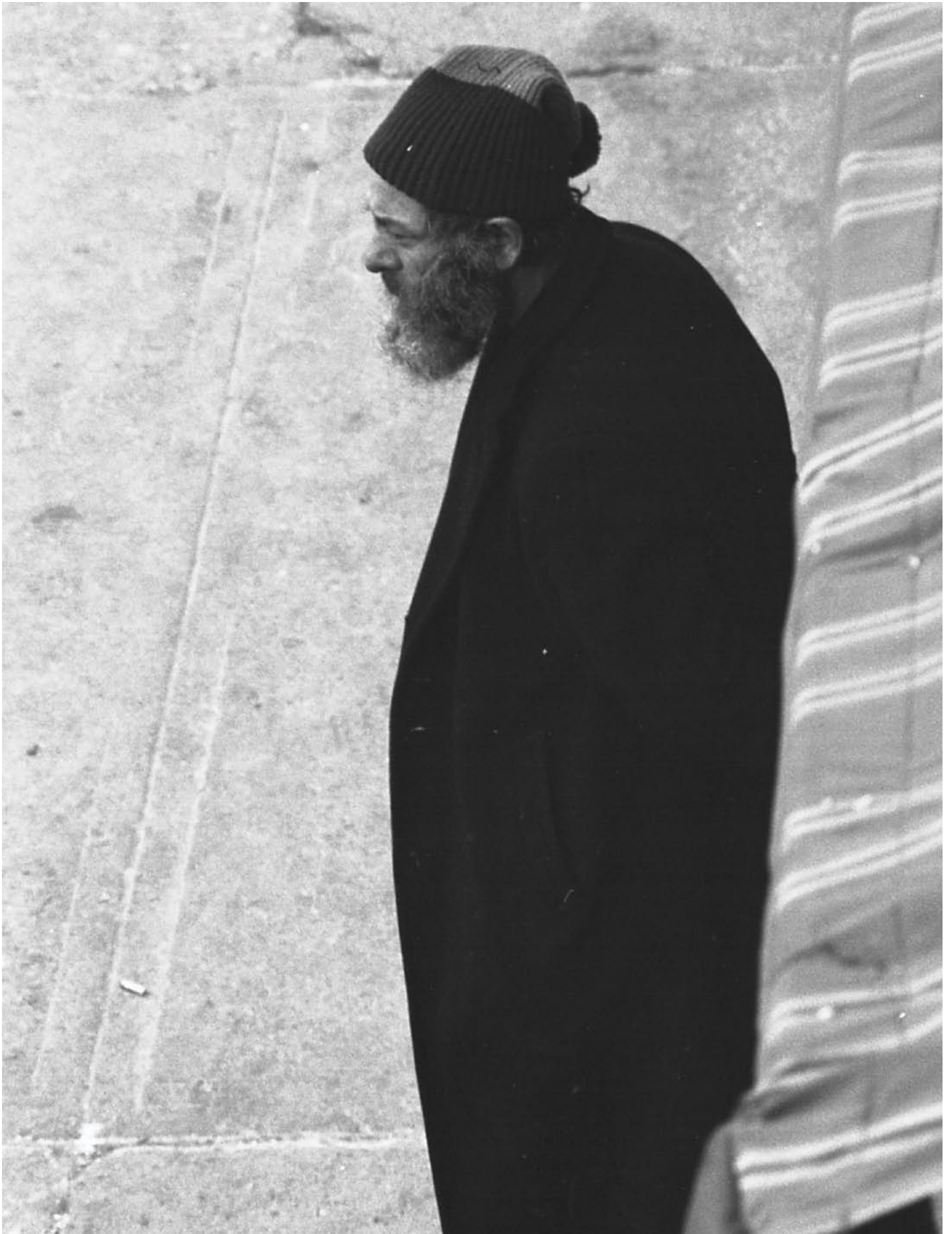


Photo by Kristen Wagner

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However, the government continues to focus on individual responsibility rather than broader social policies to improve health. For example, the most recent health reform blueprint, *Getting on with Better Health Care*, asks Albertans, "What do you think the government's priorities should be in encouraging Albertans to take responsibility for their health?"

The promotion of personal responsibility for health is neither new nor unique to Alberta. Governments of all stripes have done this to some degree since the 1970s, believing it would control health care costs. But Alberta has exceeded other jurisdictions in giving personal responsibility and "self-reliance" high profile across government initiatives, beyond Alberta Health and Wellness. For instance, the 2005 Government of Alberta Strategic Business Plan states "the core value of Albertans is self-reliance." Our government has taken personal responsibility beyond its typical connection with healthy lifestyles. The 2001 Report of the Premiers Advisory Council on Health (Mazankowski report) talks not only of healthy choices, but also about "incentives to stay healthy"—including rewards and penalties for health care use. The follow-up Report of the Task Force on Health Care Sustainability (Graydon report) proposes a deductible that would treat health care as a taxable benefit. These proposed incentives—which the government continues to study but has not yet implemented—build on past media statements by the premier and successive health ministers about rewards for staying healthy and penalties for "self-inflicted" illnesses related to unhealthy "choices" such as smoking, eating poorly or not exercising.

Like many governments, Alberta has focused on deficit and debt reduction over the last 15 years. These actions have been based on a neo-liberal political view that defines societies in terms of producers and consumers motivated by economic considerations above all else. David Coburn, a public health scientist at the University of Toronto, writes that this view sees the effects of markets, including inequalities, as inevitable and even desirable. Strong social programs are seen as interfering with the "normal" functioning of the market. The Klein government claims social programs are no longer affordable, and prioritizes debt reduction and tax cuts. Raphael suggests that right-of-centre governments present health as an individual responsibility so they can appear concerned about it while cutting the very social programs that promote health, and making tax cuts that mostly benefit the wealthy. As Australian sociologist Rose Galvin writes, "Individual responsibility is a fundamental element of neo-liberalism... the healthy person symbolizes the ideal neo-liberal citizen."

Steve Patten, a University of Alberta political scientist, suggests the roots of Alberta's personal responsibility focus go back even further than neo-liberalism to a political belief system that says people should rely on themselves, their families, neighbours, churches and communities first, and only seek support from governments as a last resort. Patten contrasts this "residualist paradigm" to an institutional paradigm, which says governments have both the ability and responsibility to protect

our well-being through strong public social institutions such as health care, education and social services.

The focus on personal initiative is also embedded in Alberta's cultural myths. In his book *Alberta Politics Uncovered*, journalist Mark Lisac points to Alberta's stereotypes of the "maverick" and the "self-sufficient entrepreneur." He suggests such myths are false, given Albertans' political conformity (outside Edmonton) and government aid to agriculture and resource industries. However, these myths continue to be reinforced by media and politicians. For example, the government's latest business plan refers to the pioneering, entrepreneurial spirit of Albertans in promoting self-reliance over active public policy.

A recent example of this clash between the focus on individual responsibility and the need for health-promoting public policy was the tussle over Bill 201 to ban smoking in all Alberta workplaces, including bars, casinos and bingo halls. The original bill, proposed by Conservative MLA Dave Rodney, was supported by present and past health ministers, opposition parties, health groups, unions and most Albertans—a February 2005 Ipsos poll indicated 68 per cent of Albertans supported the ban. Government-sponsored research also seemed to support the proposal. The Alberta Alcohol and Drug Abuse Commission (AADAC) reports higher smoking rates among 20- to 24-year-olds than for the general population (31 per cent versus 20 per cent). The authors of a consultants' report for AADAC point out that young adults' social activities often take place in bars and nightclubs and are linked to alcohol use. Young women, who are more likely to work in venues that allow smoking, are also more likely to smoke than young men. AADAC's Young Adult Tobacco Reduction Initiative supports strategies to prevent tobacco use and to help young adults quit. However, the government refuses to mandate smoke-free environments in places frequented by young adults. The final, watered-down version of Bill 201 passed by the Tory majority exempted bars, casinos and bingo halls.

The premier illustrated his government's tendency to isolate individual behaviour from the context of social environments last January when he said, "If you smoke, you're stupid," and suggested that smoking bans do not help people quit and would be bad for business—despite evidence to the contrary on both counts.

All this government support for personal responsibility does not seem to apply, however, when responsible individuals take collective health-improving actions that threaten market interests. After vocal groups of Albertans in Picture Butte and Hardisty mounted high-profile campaigns to keep large pig and cattle feedlots out of their communities because of concerns about air and water quality, the province removed local governments' right to restrict confined feedlot operations. Those powers have since been transferred to the provincial Natural Resources Conservation Board. So the government drags its feet protecting workers and the public from tobacco smoke, but quickly passes a law to protect the feedlot industry from citizens.

The Alberta government is well aware of the social determinants of health. The Mazankowski report states, "The health of all

Albertans should be promoted and improved by taking a global view of all of the factors that determine and affect people's health. This includes basic public health measures, economic well-being, early childhood development, education, housing, nutrition, employment status, quality of the environment, lifestyle choices and healthy behaviours." And the 2004 10-year Framework for a Healthy Alberta includes the 12 determinants of health agreed upon by the federal, provincial and territorial governments. The Framework is a cross-ministry initiative to improve healthy behaviours and prevent chronic diseases. It builds on Alberta Health and Wellness initiatives—such as the Healthy U website and strategies to address tobacco use, diabetes and fetal alcohol spectrum disorder—as well as major projects outside of the health ministry that could address social determinants of health. Examples of these initiatives are the Low Income Review, Alberta Child and Youth Initiative, Youth Employment Strategy, Aboriginal Policy Framework and the Parent Child Literacy Strategy.

However, most of the Framework strategies are limited to awareness, encouragement and support for healthy personal behaviours. A truly integrated cross-ministry framework would also address the potential impact of other ministries' programs and policies on health—and would include performance measures from those ministries regarding income security, employment, literacy and other economic and social indicators known to influence health status or health behaviours.



Despite business plan statements about integration and collaboration, ministries have a long history of working in “silos.” This, coupled with the governing party’s ideological preference for self-reliance and personal responsibility, restricts the “policy space” for addressing social determinants of health in a collaborative, concerted way. These limitations have in turn created a need for provincial networks outside of government—such as the Alberta Healthy Living Network and the Alberta Social and Health Equities Network—to take leadership in raising awareness and encouraging action (including government action) on the determinants of health.

The Alberta Healthy Living Network (AHLN), which has

received funding from both the provincial and federal health ministries, brings together government and non-government organizations covering a variety of sectors, including health, education, recreation, social services, agriculture, transportation and Aboriginal and multicultural groups. The AHLN works with governments, researchers, practitioners and the public to address multiple factors that influence both health behaviours and population health. It fosters collaboration in more flexible ways than is currently possible within government-led initiatives. While it focuses on healthy behaviours as major influences on prevention of chronic disease, the AHLN also focuses on social determinants through strategies addressing health disparities and healthy public policies.

The new Alberta Social and Health Equities Network (ASHEN) complements the AHLN by specializing in social determinants of health, such as income, employment, and access to healthy, affordable food and housing. ASHEN connects people who have experienced poverty with practitioners, researchers and regional and provincial government bodies to share experiences and propose actions to reduce social and economic inequities. This dialogue also helps raise public awareness.

The Edmonton Social Planning Council’s O’Hara, who recently drafted a Social Determinants of Health Framework for Alberta, believes that government needs to adopt an objective way of measuring income in order to deal effectively with the social determinants of health. “The market basket measure, for all its limitations, is an objective means for agreeing on a basic amount of income that people need to live on. The government could use that to set welfare and minimum wage rates... Right now income support levels are set arbitrarily.” O’Hara says that while the Low Income Review supported adopting the market basket measure, it has never been adopted by the government. Another Edmonton Social Planning Council report suggests the government may be reluctant to use the market basket measure because of the substantial increases to welfare and the minimum wage that would be needed for low-income Albertans to meet the market basket standard.

O’Hara also suggests Alberta provide rent supplements for organizations providing affordable housing. “The cost of housing is going up because of utility costs, but people’s welfare rates are not going up to meet those costs,” says O’Hara. “Organizations that provide housing are seeing a larger and larger gap. The Edmonton Inner City Housing Society doesn’t charge more than 25 to 30 per cent of whatever income people have. [Rent supplements] are a relatively cheap way for the government to help ensure that people are housed in good, safe, affordable housing.”

AHLN manager Cynthia Smith suggests that comprehensive school health would address some of the social determinants of health and would gain immediate political and community support. As the name suggests, comprehensive school health is a broad set of programs—it addresses mental and emotional health, bullying, healthy food and feeding programs for all students, daily

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physical education, self-esteem and respect for cultural diversity. Comprehensive school health is already in place in the Calgary and Chinook health regions through partnerships among health authorities, school boards and recreation departments.

“School-based programs bring communities together to support each other,” says Smith. “We’re all living in isolation. We need to look at the welfare of each student and see what they need in terms of mentorship and support.” Smith also says that in the longer term, income-related issues will need to be addressed. “A family of four needs to spend \$650 per month on food in order to eat according to Canada’s Food Guide,” says Smith. And ASHEN co-chair Stasha Donohue questions whether the government’s recently announced increase in the minimum wage is enough to cover rising costs of housing, utilities, food and transportation. If not, low income Albertans will need to trade off the necessities of life. For instance, if they have to pay a disproportionate percentage of their income on housing, they

will not be able to eat well, and their health will suffer.

Given our government’s penchant for market-oriented solutions, it may be easier to sell social investments by making a “business case” for the potential cost savings of initiatives oriented toward the social determinants of health. For example, a five-year McMaster University study of Ontario single parents on social assistance found that comprehensive services—health promotion, employment retraining, recreation, child care and skills development for children—resulted in 15 per cent more families leaving social assistance within a year, compared to basic social assistance. The study also states comprehensive care recipients used fewer health and other social services. The researchers estimate that providing comprehensive services to all Ontario single-parent families could save the government up to \$24-million a year in social assistance costs alone. The University of Alberta’s Community/University Partnership for the Study of Children, Youth and Families will soon evaluate Families First Edmonton, modelled on the Ontario project, to see how well this approach transfers to Alberta.

Similarly, the 2004 External Costs of Poverty report by University of Calgary economists Alan Shiell and Jenny Zhang concludes that an effective, sustained poverty reduction strategy could save Calgary taxpayers about \$8.25-million a year in health and education costs. They argue that poverty reduction benefits all of society. “A society with any appreciable level of poverty will need to use more of its resources to support the less well off, to provide health care for the additional low birth weight babies, to provide remedial education for children whose development is stunted by low income,” they write.

However, Shiell cautions against over-emphasizing financial arguments. “The case that has to be made is one of social cost and social benefit—where the benefits span beyond reduction in health costs,” he says. He mentions community development, where benefits are long-term but cost savings are not readily apparent. He also says decisions about social program investments should be based on evidence of effectiveness, not untested assumptions.

Alberta needs to find a better balance between the current emphasis on personal responsibility and the social responsibility for health. While it is both intuitive and true that we each have some role to play in our own health, it is increasingly clear that the social determinants play an even more important role. Politicians who oppose strong social investments that do not fit ideological beliefs about self-reliance must realize governments have a responsibility to address social conditions that not only directly influence our health, but also affect our ability to adopt the very health-enhancing behaviours the government promotes.

Social Determinants of Health Online Resources

Alberta Healthy Living Network: Background information on the Alberta Healthy Living Framework and current initiatives. www.health-in-action.org/content.asp?catid=37&rootid=7

Alberta Social and Health Equities Network (ASHEN): Background information on ASHEN, as well as the proceedings from the recent social determinants of health conference. The site is hosted by Growing Food Security in Alberta, a coalition devoted to ensuring “secure access to adequate amounts of safe, nutritious, culturally appropriate food for everyone, produced in an environmentally sustainable way and provided in a manner that promotes human dignity.” www.foodsecurityalberta.ca/content.asp?catid=34&rootid=3

Centre for Health Promotion Studies (University of Alberta): The publication *Cross Links* includes numerous articles on the social determinants of health. Also provides Eric Hemphill’s recent report on access to fast food in poor versus affluent neighbourhoods. www.chps.ualberta.ca/whats_new/whats_new.htm

Edmonton Social Planning Council: See the report *Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework*, by Philip O’Hara. www.edmspc.com/factsheets.aspx

Public Health Agency of Canada: Introduces the determinants of health most commonly recognized in Canada. www.phac-aspc.gc.ca/ph-sp/phdd/index.html

External Costs of Poverty
report by Allan Shiell and Jenny Zhang.
www.calgaryunitedway.org/files/Costs_of_poverty_report04.pdf

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