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A History of the Social Determinants of Health in Canada through the Lens of the Canadian Public Health Association, 1910-2010: Implications for Present and Future Population Health in Canada

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Canada

by

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Abstract

The 2008 final report of the WHO's Commission on Social Determinants of Health (SDOH) marked a watershed in the history of the SDOH for bringing together decades of evidence and theory on the social causes of illness from the diverse health research landscape. Yet, a rich history predates this and other contributions (e.g., 1974 *Lalonde Report*) that are widely credited as the start of the SDOH approach. This history is revealed through casting the contemporary interpretive lens of the SDOH onto the past.

I gained a nuanced understanding of the emergence and evolution of the SDOH in Canada by analyzing the archives of the Canadian Public Health Association (CPHA) from 1910 to 2010. I applied a social history and critical public health perspective while exploring this data using methods of thematic content analysis. To situate my findings with relevance to the contemporary landscape of population and public health (PPH), I complemented my analysis of archival sources with that of published and grey SDOH literature, print news articles, and oral history interviews with PPH leaders.

My findings show that as a way of thinking, the SDOH approach is complex and diffuse. This, coupled with the inherently political nature of the SDOH, presents challenges in terms of communicating key messages of the SDOH to decision-makers and the public. Additionally, the history of the SDOH is non-linear and changes alongside social, economic, and political events. Economic recession and growth, for example, at times brought more and less urgency to act on the SDOH within the Canadian PPH community. However, despite that ebb and flow, the foundations of health equity and social justice have remained firm throughout the history of the SDOH. These foundations, combined with the growth and increasing disciplinary coherence of PPH, suggest that action on the SDOH will remain a core commitment of PPH.

Preface

Explanation of manuscript-based thesis

A manuscript-based thesis is a collection of papers, first-authored by the student, that form a cohesive program of research.(1) The intention of a manuscript-based thesis is to support the career development of students, by encouraging them to publish manuscripts in peer-reviewed journals during the course of their studies.(1) In this way, trainees are provided the opportunity to experience the process and rigor of scientific peer review. Additionally, according to the Department of Community Health Sciences, the completion of manuscripts versus traditional dissertation chapters may potentially lead trainees to produce more practical and useable results (e.g., by publishing findings and recommendations for certain research, practice, or policy audiences).(1) I pursued a manuscript-based thesis to gain experience with the peer-review and publishing processes, and to better position myself for future career options. First-authored publications at this stage of my career indicate research productivity and, ideally, will enhance my competitiveness as a candidate for future training and employment positions (e.g., post-doctoral fellowship, academic or non-academic research position). Six manuscripts comprise my dissertation; as described in this preface, the manuscripts that constitute Chapters 3, 4, and 5 are published. The manuscripts that constitute Chapters 6, 7, and 8 are being prepared for peer-reviewed submission.

Contribution of authors

I (Kelsey Lucyk) am the lead author of all manuscripts in this dissertation. My primary supervisor, Lindsay McLaren, is the senior author of all manuscripts included in this dissertation. I analyzed and interpreted the data and led the writing of each manuscript. Together we conceptualized the manuscripts, critically revised them, and are accountable for this work – except for Chapters 5 and 8, which I completed as single-author studies. My supervisory

committee also contributed to the development of the manuscripts in this dissertation, and are included as co-authors for the manuscripts presented in Chapters 6 and 7. All co-authors meet the recommendations for authorship outlined by the International Committee of Medical Journal Editors (ICMJE), outlined below:

1. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; and,

2. Drafting the work or revising it critically for important intellectual content; and,

3. Final approval of the version to be published; and,

4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.(2)

Specifically, Lindsay McLaren met the criteria 1 through 4 for Chapters 3, 4, 6, and 7. Frank W. Stahnisch, my co-supervisor, and Margaret Russell and Loreen Gilmour, members of my dissertation committee, met the ICJME criteria 2 through 4 for Chapters 6 and 7.

In this dissertation, I used the first person active voice. In Chapters 1, 2, and 9, the chapters which contextualize the manuscripts, I refer to "my" work or what "I" have done in each chapter, even where these include the contributions of co-authors. I do this in reflection of my dissertation as a single-authored piece of work. In Chapters 3 to 8, I use "we" or "I" as appropriate; "I" where it is a single-authored work, and "we" where it is a co-authored work.

Status of manuscripts

The permissions to reprint and include published manuscripts in this dissertation (i.e., Chapters 3 through 5) are in Appendices A through C. Permissions from co-authors to include published and unpublished manuscripts in this dissertation are included in Appendix D. As

indicated in the list below, the following manuscripts have been published, are under review, or are being prepared for submission to peer review journals.

1. **Lucyk K,** McLaren L. Is the future of "population/public health" in Canada united or divided? Reflections from within the field [Commentary]. *Health Promotion and Chronic Disease Prevention in Canada* 2017; 37(4) [In press].

2. **Lucyk K,** McLaren L. Taking stock of the social determinants of health: A scoping review. *PLOS ONE* 2017;12(5): e0177306. Available from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0177306

3. **Lucyk K.** They are not my problem: A content and framing analysis of references to the social determinants of health within Canadian news media, 1993-2014. *Canadian Journal of Communication* 2016; 41: 631-54. Available from: http://www.cjc-online.ca/index.php/journal/article/view/3034

4. **Lucyk K,** Stahnisch FW, Russell ML, Gilmour L, McLaren L. Poverty and public health: The ebb and flow of a social determinant of health, 1900s-2010s. [Unpublished. In the process of preparing for submission to *Critical Public Health*]

5. **Lucyk K,** Stahnisch FW, Russell ML, Gilmour L, McLaren L. "For all those who need them": Efforts to secure equitable access to family planning services within the Canadian public health community, 1960s-80s. [Unpublished. In the process of preparing for submission to *International Journal of Health Equity*]

6. **Lucyk K.** "It's a tradition of naming injustice": An oral history of the social determinants of health – Canadian reflections, 1950s-present. [Unpublished. In the process of preparing for submission to *Social Science & Medicine*]

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1.   Department of Community Health Sciences, Cumming School of Medicine. Guidelines for manuscript-based thesis. Calgary, AB: Cumming School of Medicine; 2014 [cited 2017 April 15]. Available from: https://wcm.ucalgary.ca/gse/files/gse/chs-guidelines-for-thesis-by-manuscript_updated2014.pdf.
2.   International Committee of Medical Journal Editors. Recommendations for the conduct, reporting, editing, and publication of scholarly work in medical journals. Washington, DC: American College of Physicians; 2016 [cited 2017 April 15]. Available from: http://www.icmje.org/icmje-recommendations.pdf.

Acknowledgements

Social support is one among the many determinants that shape our life chances and opportunities for health. In my life, social support has played a key role in my health and has been essential to my completion of this degree. It is with great privilege and profound gratitude that I acknowledge the many colleagues, mentors, friends, and family who have helped me on this journey.

My completion of this degree would not have been possible without the patient support of my supervisor, Dr. Lindsay McLaren. I am extremely grateful for the investment you have made in my learning and in my future through your thoughtful critique and positive attitude. I am proud to leave this program as one of the many trainees in whom you have instilled a love of science and passion for health equity. My co-supervisor, Dr. Frank W. Stahnisch, has also provided invaluable support for this project. Your belief in my project as a significant 'drop in the bucket' of population and public health history is especially humbling, considering your ocean of knowledge. I appreciate the many challenging intellectual debates you have introduced throughout my training. Sincere thanks go as well to my committee members, Drs. Margaret Russell and Loreen Gilmour, particularly for their mentorship and steadfast support of my career goals, as well as their assistance in navigating options.

I also wish to acknowledge the institutions that have provided financial support for this project and my graduate training: Alberta Innovates-Health Solutions Graduate Studentship, Achievers in Medical Sciences scholarship (Cumming School of Medicine, University of Calgary), Canadian Institutes of Health Research, Alberta Medical Foundation, Graduate Students' Association (University of Calgary), Faculty of Graduate Studies (University of Calgary), University Research Grants Committee (University of Calgary), and Population Health

Table of Contents

List of Tables

List of Figures

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAN	Canada
CIAR	Canadian Institute for Advanced Research
CIDA	Canadian International Development Agency
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CJPH	*Canadian Journal of Public Health*
CMA	Canadian Medical Association
COREQ	Consolidated Criteria for Reporting Qualitative Research
CPHA	Canadian Public Health Association
CSDH	Commission on Social Determinants of Health
DSS	Déterminants Sociaux de la Santé
GRIDS	Gay-related immune-defiency syndrome
HIV	Human Immunodeficiency Virus
ICES	Institute for Clinical Evaluative Sciences
Intl	International
ICJME	International Committee of Medical Journal Editors
IPPH	Institute of Population and Public Health

K.L.	Kelsey Lucyk
L.M.	Lindsay McLaren
LAC	Library and Archives Canada
NCC	National Collaborating Centres
NCCDH	National Collaborating Centre on the Determinants of Health
OCR	Optical Character Recognition
PDF	Portable Document File
PHAC	Public Health Agency of Canada
PHJ	*Public Health Journal*
PHO	Public Health Ontario
PPH	Population and Public Health
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
REACH	Research & Educational Attack on Community Health
SARS	Severe Acute Respiratory Syndrome
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SPCL	St. Petersburg College Libraries
TAC	Therapeutic Abortion Committee
UK	United Kingdom
US	United States of America

Epigraph

Let us never reach the stage when we cannot abandon something when shown that it is wrong or that it can be improved upon. We should not hesitate a moment when convinced the time has come for change. [...]

Time passes. Life is short. Men come and go. Possibly it is too much to hope for that the individual contribution of any one of us to the cause will be sufficient to be noticeable; but taken in the aggregates, if we carry on, play the game, give the best that is in us [...it] may cause future generations to adjudge that our labour has not been in vain.

Dr. Alexander James Douglas, Winnipeg Officer of Public Health
"Ways and Means in Public Health," *Canadian Journal of Public Health* 1930;21(6):263-6

Chapter One: Introduction and Literature Review

1.1 Overview

      This dissertation is comprised of six manuscripts that aim to gain a comprehensive

understanding of the history of the social determinants of health (SDOH) in Canada since 1910.

The intent of this work is to gain insight into present issues and challenges facing the SDOH and

the scholarly and applied field in which it is currently nested, namely, population and public

health (PPH). The history of the SDOH spans many academic and professional disciplines, and

shares a past that overlaps with social and medical histories of public health and Canada. I use

this first chapter to situate my manuscripts in this broad history. In Section 1.2, I introduce my

conceptual approach, where I describe concepts key to this dissertation. Next, in Section 1.3 I

review literature pertinent to the history of the SDOH in Canada to identify existing gaps and

provide a rationale for this research, which is further discussed in Section 2.3. Finally, in Section

1.4 I provide an outline for this dissertation and discuss how its manuscripts connect to one

another to form a history of the SDOH in Canada.

1.2 Conceptual approach

1.2.1 Population and public health

      My conceptual approach to this research is principally informed by my graduate training

in the "population and public health" specialization of Community Health Sciences, which aims

"to train transdisciplinary researchers who can work with policy-makers, program administrators

and public health professionals" (1, p2) to identify and study the SDOH and evaluate

interventions to improve population health.

      The field of **population health** is new to public health, as population health has only

formally entered Canadian health research and practice in the past three decades.(2-7) Population

health has been described variously as a perspective (i.e., the general discourse and umbrella term that envelops population health as a research, framework, and approach), research (i.e., investigation into the health of populations, with consideration of social, cultural, and environmental influences), a framework (i.e., ways of explaining research findings and their implications), and an approach (i.e., ways of applying knowledge to public policy).(4, 8-11) The Public Health Agency of Canada (PHAC) defines population health as "an approach that aims to improve the health of the entire population and reduce health inequities among population groups…[by acting] upon the broad range of factors and conditions" that influence our health.(12) On the other hand, PHAC defines **public health** more functionally, as the "science and art of promoting health, preventing disease, prolonging life and improving quality of life through the organized efforts of society."(7, p46) I expound on the differences and similarities between population health and public health further in Chapter 3; however, some preliminary distinction is necessary here for the purpose of contextualizing the content of this chapter. To this end, population health may be considered as an academic field of inquiry, whereas public health may be considered as a professional discipline and set of government functions with the legal authority to protect and promote health, respond to emergencies, assess health and conduct surveillance, and prevent disease and injury.(13)

Through conducting this research, I contended with the combined concept of PPH to consider its meaning and how it fit with my work. I found it necessary to reflect on this meaning because of my transitional role as a trainee and researcher trying to locate my position in this new, interdisciplinary field. Consequently, the first manuscript of this dissertation (Chapter 3) contemplates the nature of PPH and the degree to which it is united or divided as a research field. I disclose that, as a PPH trainee, I support the idea of its existence as a combined research field

and approach that incorporates public health, population health, and the activities of both fields (i.e., health protection, health promotion, health surveillance, disease and injury prevention, disaster response, and population health assessment, as well as population health research that aims to produce knowledge on policy and program interventions within and outside of the health sector to shift the distribution of health risk by addressing the SDOH).(7, 14) Personally, the combined nature of PPH was an important draw for my entrance to this field. Having completed undergraduate training in sociocultural anthropology and Canadian history, PPH offered a space where I could pursue my research interests in social justice, health, public policy, and history, in ways that were relevant to and grounded in public health sciences.

I refer to "population and public health" collectively in my dissertation where I wish to acknowledge the shared historic overlap of both fields, their interdisciplinary communities, and their complementary efforts to protect and promote health.(15) Referring to PPH in this combined way is apt for a history on the SDOH, which incorporates implicit and explicit histories of population health and public health. As shown throughout this dissertation, much of the history of the SDOH in Canada predates the formal emergence of population health, even though efforts to address what are today known as the SDOH have historically maintained key themes within population health, such as concern with reducing health inequities through upstream actions. I use the terms separately (i.e., "population health" and "public health") where historically appropriate, particularly in Chapters 6 and 7, where the timeframe of analysis predates the emergence of PPH.

1.2.2 Social determinants of health

In research, theory, and practice, the SDOH approach is nested within the academic field of PPH as a way of understanding the root causes of health and illness in populations. As defined

in the constitution of the World Health Organization (WHO), health is not merely the absence of disease, but also a state of complete physical, mental and social well-being.(16) The SDOH impact well-being, defined in this holistic way, and refer to the complex set of social, economic, and political conditions (e.g., employment, gender, income) in which people live their daily lives, grow, work, and age.(12, 17-19) Inequities in daily living conditions may result from the unfair distribution of money, power, and resources in society and the policies, practices, and social norms of society that tolerate or promote this distribution.(20) For example, an urban planning policy that allows for neighbourhood sprawl without ensuring affordable housing, public transportation, or local amenities for residents may affect individuals' ability to secure housing, work, food, and access to other services.(20) Such inequities shape the health of individuals, communities, and jurisdictions.(17, 18)

On the one hand, the SDOH may be considered a theory for its explanatory power in describing the mechanisms through which social, economic, and political factors influence health. Theories organize "sets of concepts to define and explain phenomena."(21, p286) Theories underpin the entire research process by informing study design, methodology, data analysis, and the interpretation of findings.(21) Importantly, theories justify courses of action, thus have implications for policies and practices aimed at improving population health. On the other hand, the SDOH may also be considered more broadly as an approach. Used in this context, an approach refers to a way of dealing with some topic or issue, such as when discussing the qualitative research approach. Both the SDOH approach and qualitative research approach aim to understand the 'what' and 'how' of complex phenomena in society.(22) Specifically, the SDOH approach seeks to understand the systematic conditions that create health inequities, which – as mentioned above – refers to the unequal distribution of money, power, and resources

in society. Throughout this dissertation, I refer to the SDOH as an approach to represent its diverse conceptualizations as a concept, theory, approach, research field, and perspective (see Chapter 8). In this section, I use to the terms 'theory' and 'approach' interchangeably to avoid repetition when discussing theories on the explanatory pathways of the SDOH.

As shown in Chapter 4, the literature on the SDOH is diverse and its theories are abundant. To provide readers with some theoretical understanding, below I describe seven widely-regarded theories of the SDOH, selected from the WHO Commission on Social Determinants of Health (CSDH) report (20) and the PPH literature more generally. My review is purposive in its attempt to place theories of the SDOH on a continuum from explanations that are more biological in nature to those that point more to the unequal nature of society's structures and systems. The different foci of SDOH theories have implications for interventions that act on the SDOH. For instance, where a psychosocial approach (described below) is adopted, interventions may focus on reducing individuals' exposures to life stresses by providing subsidized housing or counselling to improve coping skills to vulnerable groups. An intervention influenced by a broader SDOH approach, such as the fundamental social causes of disease, may instead seek to implement policies that guarantee access to basic neighbourhood services, create healthy and safe working environments, or design safer physical neighbourhoods.(20) More comprehensive reviews of the SDOH, SDOH models, and theories can be found elsewhere in the literature (17, 23-26) and in this dissertation (see Chapters 4 and 8).

At one end of the continuum, the **psychosocial approach** of the SDOH asserts that an individual's vulnerability to disease may be increased by the potential weakening effect of psychological stress on their neuroendocrine function, influenced by stresses experienced in their social environment.(27) Social epidemiologists Michael Marmot and Richard Wilkinson further

5

theorize the mechanism through which psychosocial stressors influences health.(28) They

suggest that psychosocial stressors, referring to the external demands that individuals experience

in their social environments (e.g., life events, chronic stressors, daily hassles), combine with

resistance factors and vulnerability factors to elicit **psychobiological** stress responses in one's

hormonal, metabolic, or immune system.(28) Resistance factors (e.g., adequate coping

responses, control over one's environment, social supports) protect individuals from stress-

related responses and disorders, whereas vulnerability factors (e.g., inadequate coping responses,

control over one's environment, social supports) make individuals more susceptible to them.(28)

At the population level, clusters of ill health may be observed in groups facing psychosocial

disadvantage (e.g., anxiety, insecurity, low self-esteem, etc.).(28)

In unequal societies, the psychobiological stress response may result where individuals

are conscious of their position in the socioeconomic hierarchy. Ichiro Kawachi and Bruce

Kennedy (Harvard University) suggest in the **social comparison model** that inequality may

result in lower levels of trust, social cohesion, or social capital (i.e., "the features of social

organization, such as civic participation, norms of reciprocity, and trust in others, that facilitate

cooperation for mutual benefit" (29, p1491)), which can influence health at the individual and

communal level.(30) Individuals may compare their role and life circumstances to those

positioned elsewhere in the social hierarchy, which can lead to negative feelings that manifest as

psychobiological health effects (e.g., depression) or the adoption of risky health behaviours or

coping mechanisms (e.g., smoking, alcohol consumption).(30, 31) At the communal level, an

unequal society may lead to distrust among its members and weaken support for public

infrastructure, such as education or social programs, that could positively influence health.(30,

31) The social comparison and psychosocial models have been critiqued for their emphasis on

status and prestige (i.e., perceived differences), and their disregard of absolute material resources (or lack thereof), social class, discrimination, and power.(17, 30)

The **life course approach**, which was refined by the work of Clyde Hertzman (University of British Columbia), moves further along the continuum of SDOH theories to consider how psychosocial and material stressors and other experiences unfold over the life course, or the trajectory of one's life. Hertzman identified three ways that health could be influenced throughout the life course: latently, via a pathway, or cumulatively.(17) Latent effects refer to the early life experiences and exposures that can influence the health of individuals later in life.(17, 32) Pathway effects refer to the early life experiences or exposures of individuals that set them onto trajectories that influence their health, wellbeing, and competence over the life course.(33) Cumulative effects, which refer to a combination and accumulation of latent and pathway effects, are the advantages and disadvantages that follow individuals from childhood into adulthood.(17, 33) Today, this model is embodied in a legacy of life course epidemiology, particularly in the United Kingdom, due to the unique data available there (i.e., birth cohort studies spanning over 60 years).(34)

Somewhere in the middle of the continuum of SDOH theories, between biological and social structural explanations, lies the **material approach**. To some extent, psychosocial stress may be elicited in response to the material conditions (e.g., income, housing, food insecurity), that individuals have and of which they are deprived. Working across the life course, material advantage and disadvantage "determine health by influencing the quality of individual development, family life and interaction, and community environments."(35, p657) Individuals may adopt supporting or threatening health behaviours in response to their material advantage or disadvantage and the psychosocial stresses they experience.(17, 35-37) However, some have

7

argued that the SDOH operate beyond the material resources individuals possess and rely more on social, economic, and political resources, as well as the position these resources afford them, in the socioeconomic hierarchy.(38)

In their theory on the **fundamental social causes of disease**, Bruce Link and Jo Phelan (Columbia University) suggest that health disparities result from the ability of individuals who possess resources to benefit from knowledge and treatments that exist for disease, to minimize its consequences.(38) They argue that resources such as money, power, and knowledge serve as determinants of risk factors for disease because they determine the extent to which people can avoid risks for morbidity and mortality (e.g., adopting a healthy diet or exercise regimen, or benefit from a health intervention).(38) In their words, "no matter what the current profile of diseases and known risks happens to be, those who are best positioned with regard to important social and economic resources will be less afflicted by disease."(38, p87) As Link and Phelan argue, this relationship remains persistent over time and across multiple disease profiles. Further, fundamental causes influence health at the individual level (e.g., the health behaviours individuals can access) and also the broader, contextual level (e.g., the neighbourhood individuals live in, the extent of an individual's social network, or the occupation an individual holds).(39) Fundamental causes thus have protective or harmful effects on health individually (e.g., alcohol consumption) and contextually (e.g., air pollution).(38)

Moving further along the continuum of SDOH theories, the **neomaterial approach** considers how society distributes its social, economic, and political resources to influence health through shaping access to material and other resources. At the level of nations, more equal societies invest in the economic and social resources that improve health (e.g., education, health services, transportation, a generous and universal social safety net).(40) The neomaterial

approach considers how material conditions affect the quality of SDOH to influence health,(17, 40) while also directing attention to the societal forces that shape material conditions and the distribution of money, power, and resources.

Another SDOH theory occupying space on the continuum near the neomaterial approach is the **ecosocial theory** of the SDOH, put forth by social epidemiologist Nancy Krieger (Harvard University). In some ways, the ecosocial theory may be considered as a constituent theory of the neomaterial approach, for it relates to how societies distribute and invest in its environmental resources. Though, unlike the neomaterial approach, the ecosocial theory extends beyond the level of individuals, communities, and nations, for as Krieger argues, the SDOH and patterns of disease occur at biological, social, and ecological levels (e.g., cell, individual, population, ecosystem) as they evolve and interact in ways that influence health.(41, 42) Importantly, the ecosocial theory situates humans as just one species among all others that inhabit our planet and share its ever-evolving, dynamic ecosystem.(41) Presently, the ecosocial theory is experiencing renewed interest in PPH as the field contemplates the **ecological determinants of health** in light of the potential health impacts of global ecological changes (e.g., climate change, resource depletion, species extinction).(43)

1.2.2.1 The WHO Commission on Social Determinants of Health conceptual framework

A common understanding of the SDOH is necessary to anchor this dissertation, its research approach, and findings. Rather than adopting a single theory, I use the WHO CSDH's action-based conceptual framework for its inclusivity in considering competing SDOH theories. In line with the neomaterial approach, the WHO CSDH maintains that the SDOH are fundamentally about the distribution of money, power, and resources – a process that is inherently political and occurs through the multiple levels at which the SDOH interact and shape

9

health.(25) The WHO CSDH framework also explicitly adopts a health equity focus and recognizes the role of the health care system in mitigating the health effects of the SDOH.(25) The WHO CSDH framework is particularly valuable to my dissertation, which ties the history of the SDOH to the trends that have occurred at multiple levels of Canadian society (e.g., government, non-government organizations, grassroots) through changes in public policy, science, health, values, economics, and other areas.

As the framework describes, the SDOH operate at two levels. The **structural level** consists of the social, economic, and political context of a society (e.g., public policy, societal values, governance) and how this context stratifies individuals within a population through the ways that power, prestige, and resources are distributed.(25) Some examples of axes of stratification include income, education, gender, occupation, and race/ethnicity.(25) All persons occupy a position on the stratified socioeconomic hierarchy and it has repeatedly been empirically demonstrated that the higher your position, the better your health.(25) For this reason, the structural determinants of health are also known as the "social determinants of health inequities." **Health inequities** refer to the unfair and socially unjust differences in health that result "from the systematically unequal distribution of power, prestige, and resources among groups in society."(25, p20) As discussed in later chapters, health inequities is a concept central to the SDOH that appears to have gained increased prominence in PPH following the publication of the WHO CSDH's final report.

At the **intermediary level**, structural factors shape health and health outcomes through a set of material, psychosocial, and behavioral, biological circumstances.(25) Here, the opportunities that individuals have for health are influenced by what material resources are available to them (e.g., money, clothing, physical work environment), the degree to which they

experience stress and are able to cope with it in their lives, the genetic or biological factors they were born with and which may increase vulnerability or resilience, and their ability or inclination to engage in healthy behaviours (e.g., diet, exercise, alcohol consumption).(25) Finally, the health care system plays a role "in mediating the differential consequences of illness" (25, p6) that persons experience across the socioeconomic hierarchy. This WHO CSDH conceptual framework is illustrated in Figure 1.1.

The WHO CSDH Conceptual Framework is also an appropriate choice for this research because it is adopted by the CPHA, the organization through which I am examining the history of the SDOH approach. In 2008, the CPHA responded and committed to the WHO CSDH's findings from their final report, which tied health inequalities and the social gradient of health to the unfair distribution of money, power, and resources at the structural level of public policy.(20, 106) In their response, CPHA acknowledged the relevance of the WHO CSDH's findings and action statement for Canadian populations.(106) Specifically, CPHA reported that, "The evidence indicates significant health inequity across the social gradient in Canada. […] What we need is the political commitment, a national will and the resources to turn talk and numerous pilot projects into results."(106, p7)

Figure 1.1 WHO CSDH conceptual framework
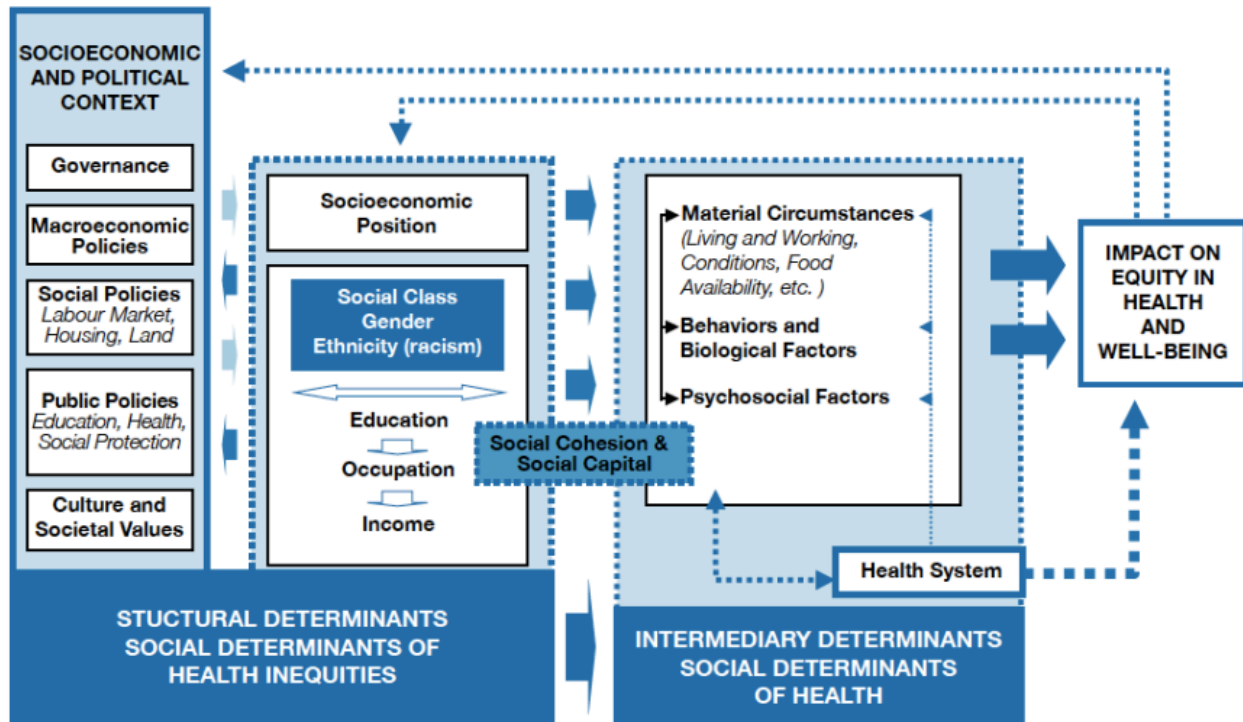
Reprinted from: A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2 (Policy and Practice), O. Solar and A. Irwin, p6, Geneva: WHO, Copyright 2010.(25) Reprinted with permission from the WHO (Appendix E).

1.3 Literature review

1.3.1 Purpose and process of literature review

This literature review is historiographical; that is, it was conducted with the aim of reviewing the historical scholarly work that has been written to date on the SDOH in Canada. The breadth of the SDOH make historiographical synthesis a difficult task; theoretically, all histories of medicine or PPH related to income, gender, housing, or other SDOH could be considered an implicit history of the SDOH. Rather than focus on discrete aspects of the SDOH, in this review I focused on PPH histories where the primary topic of interest concerned social influences on health. I intentionally sought breadth and inclusivity when conducting my review, meaning that I sought to incorporate histories on a number of topics related to the history of the SDOH, though inevitably it does not represent a complete historiography of the SDOH, due to the above-mentioned parameters.

I searched the keywords, title and abstract, and full-text of major health and social sciences databases (i.e., PubMed, Medline, Academic Search Complete) and the archives of the *Canadian Bulletin of Medical History* and the *Canadian Journal of Public Health* to ensure that older, non-indexed articles were not missed. Additionally, I searched the University of Calgary's library database to identify relevant books. Search terms included "history" AND "Canada," which I then refined by subject (e.g., "health," "medicine," "public health"). I employed more a precise search from combinations of keywords to identify sources more specifically related to the SDOH (e.g., "social adj3 health" [meaning 'social' within the range of 3 words from 'health' in a text] AND "history"). I also reviewed the reference lists of articles to further identify relevant literature. Finally, I incorporated literature that I became aware of throughout my dissertation research, such as when interview participants provided me with resources that were previously

unknown to me or unindexed in the academic literature, or when I discovered new resources in the CPHA archives. This review was not intended to be exhaustive or systematic; a more systematized literature review is presented in Chapter 4, a scoping review of the SDOH literature.

1.3.2 Historiography on the social determinants of health

In setting the stage for this dissertation, I review literature from various disciplines related to the history of the SDOH. First, I review the historiography of PPH in Canada as pertains to the SDOH by considering histories that explore the social, economic, and political factors that influence health and illness, described further below. Next, I examine literature on the history of the SDOH, generally, followed by a review of Canadian-specific literature on this topic. I then review existing historiography on the Canadian Public Health Association (CPHA), the lens through which I examine the history of the SDOH.

1.3.2.1 Histories of population and public in Canada that emphasize social factors

The history of the SDOH in Canada is intimately tied with the development of public health as a set of centralized government functions. Many histories exist that document the measures that public health and government actors took to improve sanitation by reforming living conditions and imposing controls (e.g., milk pasteurization, food handling regulations, waste disposal bylaws). John Heagerty, former Director of Public Health Services in Canada, provided an historical overview of public health in Canada in 1940. Heagerty considered how public health developed in relation to shifting sociodemographic changes, such as urbanization, since the 1600s.(44) Historian Jay Cassel's monograph on the development of public health in Canada from the 1800s to 1990s, paid some attention to how economic and social factors impacted public health services and administration, such as the development of public health

boards.(45) In writing on the Spanish Influenza epidemic of 1918-19, military historian Mark Humphries considered the influence that this outbreak had on the organization of public health in Canada.(107) Humphries argued that the epidemic was important in mobilizing social reformers to call on the federal government to centralize public health services.(107) Labour historian Esyllt Jones (University of Manitoba), also wrote on the Spanish Influenza epidemic of 1918-19 in Winnipeg, Manitoba.(109) Jones recounted this history by acknowledging the agency of the immigrant and working-class communities who suffered from the epidemic and the tension that existed between them and the voluntary sector health workers who sought to control it.(109)

Canadian medical historians James Moran (University of Prince Edward Island) and David Wright (McGill University) more explicitly considered the role of social, economic, and cultural values in their edited collection of histories on public mental health in Canada.(46) Related to the history of the SDOH, chapters in Moran and Wright's history address the interplay of factors such as Aboriginal status, geography, poverty, gender and others in state attempts to control mental health.(46)

Some social histories of organized public health in Canada have explored this topic by considering the social, economic, and political aspects of disease. As well, these histories offer critical perspectives on the aims of public health organizations and reformers at the time, particularly related to their class, racial, and gender biases. Throughout the history of Canada in the twentieth century, eugenic, nativist, and racist motivations accompanied some public health campaigns and responses to disease and illness in the population.

On the topic of venereal disease, Mariana Valverde (University of Toronto) wrote of how the clergy, social workers, politicians, and bureaucrats approached illness in English Canada during 1885-1925.(47) In what she terms the "Age of Light, Soap, and Water," Valverde

15

explored how public health was approached through moral reforms that cut across issues of poverty, gender, and ethnicity.(47) Valverde critically connected the campaigns of social reformers, which included active CPHA members such as Toronto Medical Officer of Health, Dr. Charles Hastings (1858-1931), with the underlying motivations and attitudes of white, middle-class Protestants.(47, 92)

Heather MacDougall (University of Waterloo) considered the social response to the cholera outbreak of 1832 in the Upper and Lower Canadas, which she framed as both a social and political event.(48) She described how the voluntary and professional sectors attempted to control the outbreak by acting within the social and cultural values at the time (e.g., fear of premature burials, contagion beliefs about disease).(48) An important observation made by MacDougall was the ethnic stereotypes that health workers carried about the poor and immigrant populations they served, which sometimes overrode their humanitarian intentions.(48)

As a final example, Jane Jenkins' (St. Thomas University) history of the 1918 influenza epidemic in New Brunswick examined the outbreak from a sociopolitical point of view.(49) At the time, New Brunswick was the only province with a Minister of Health or Department of Health, and its citizens were critical of the restrictive public health measures taken by the Department (e.g., closure of businesses and churches).(49) Jenkins' work presents an historical case of the political and social tensions that underlie public health interventions, and the necessity of co-operation between sectors in tackling public health issues. Other works by Jenkins similarly explore the tensions that existed in the organization and delivery of public health services during particular social and economic circumstances.(108)

Marry Anne Poutanen (McGill University) further explored intersectoral action in her history on Montréal's Protestant School Board from 1900-47, which worked with hospitals,

charities, educators, social reformers, and the public to prevent the spread of tuberculosis.(50) In some ways, Poutanen's paper may be considered an early history of what are today known as the SDOH and health promotion, for its focus on the role of culture, education, housing, and other social factors related to tuberculosis.(50) Some Canadian scholars have considered overlapping histories of public health, medicine, social institutions (e.g., schools), and culture by focusing on Indigenous populations, such as the works published by Canadian researchers Mary Ellen Kelm (Simon Fraser University), Maureen Lux (Brock University), or Renisa Mawani.(51, 52, 111)

Other histories have been written that document the social and economic benefits of population health interventions. Cynthia Comacchio (Wilfred Laurier University) interrogated the history of "scientific motherhood" in Ontario during 1900 to 1940, a time when medical experts attempted to reduce child and infant mortality by educating mothers about "modern" methods of child-rearing on topics such as feeding or toilet training.(53) The educational campaigns were received with limited success, however, in large part due to the impoverished conditions in which parents with sick children lived.(53) Thus, to some extent, Commacchio's social history represents an account of poverty as a primary determinant of health and of the barriers to health associated with social and economic disadvantage. On the other hand, Commacchio's history also provides an important critique of the public health community during the first half of the twentieth century, particularly in how the views and class of educated health workers complicated the delivery of maternal health services to ethnic communities as a form of social control.(53) Other historians who have written critically about family and maternal health campaigns in the twentieth century include Katherine Arnup (Carleton University),(112) Mona Gleason (University of British Columbia),(113, 114) and Denyse Baillargeon (McGill University).(115)

Canadian historian Paul Bator's 1979 paper documents another perspective on public health reform in Ontario, through his examination of how the City of Toronto worked to raise the lower classes from 1910 to 1921.(54) Social reformers such as Dr. Charles Hastings, the city's medical officer of health, intervened in the health of the poor to prevent disease by implementing measures at the population level, such as milk pasteurization.(54)

Other histories have focused on social and moral reform in Canada from the perspective of eugenics,(55-58, 110) the practices and beliefs aimed at improving the genetic or racial quality of the human population.(59) One such example is Angus McLaren's (University of Victoria) well-known history of eugenics in Canada from 1885 to 1945.(60) Similarly, a 1972 paper by Neil Sutherland (University of British Columbia) examined sanitary and public health reforms implemented for school children across Canada from 1880 to 1914 (e.g., excluding sick children from school), to build up the strength and racial quality of the next generation.(61) Eugenic histories relate to the SDOH for their contemplation of how factors such as race, ethnicity, gender, education, and class justified intrusive public health action (e.g., sterilization of the 'feeble-minded'); however, eugenic history is not the focus of this review.

Two articles on the history of public health in Canada relate more explicitly to the SDOH, by focusing on the concepts of health equity and social justice. One article, by Nancy Edwards (University of Ottawa), explored the "social justice roots" of population health intervention research and highlighted the advocacy efforts of this research in Canada since the early twentieth century.(62) The second article was published in 2010, by Rachel Douglas (Fraser Health Authority) and Allan Best (University of British Columbia).(63) These authors provided a concise overview of the vision of public health that they argued has existed in Canada since 1907.(63) Furthermore, they suggested that "the principles of equity, action on the

determinants of health, and the use of evidence" (63, p274) have remained throughout the evolution of PPH to its present form.

1.3.2.2 International histories of the social determinants of health

Of the existing histories on the SDOH, some explore the evolution of this approach from an international perspective. Predominantly, these contributions are tied to the work of the WHO CSDH and its Chair, social epidemiologist Sir Michael Marmot. Perhaps the largest volume on the history of the SDOH is that edited by Harold Cook, Sanjoy Bhattacharya, and Anne Hardy. The 364-page collection, which was compiled to inform the WHO CSDH Commission, reviews global histories and contemporary debates on the SDOH, with a particular focus on low and middle-income countries.(64) Alec Irwin and Elisabetta Scali (Harvard University) took an action-based perspective in their background paper for the WHO CSDH, which is available as a long-form white paper (65) and short-form academic article.(66) The authors focus on the contributions to the SDOH provided by the work of the WHO, since the organization's foundation in 1948. Two other historical contributions to the history of the SDOH are those written by Michael Marmot and his mentor, S. Leonard Syme. These first-person narratives recount Marmot and Syme's careers, their introduction to the SDOH, and some of the influential people they worked with on this topic.(67, 68)

Another contribution to the international history of the SDOH is the work published in 1994 by professor and epidemiologist, John Frank, and founder of the Canadian Institute for Advanced Research, J. Fraser Mustard (1927-2011).(69) Frank and Mustard begin their history of the determinants of health in Europe, during the period just prior to the Industrial Revolution. The authors highlight the contemporary concepts of health gradients and health inequalities that were observed during Industrial Revolution for issues such as life expectancy and height.(69)

They continue their history into the twentieth century, where they consider more contemporary contributions to the development of the determinants of health (e.g., those of Michael Marmot, Margaret Whitehead, and Richard Wilkinson), as discussed elsewhere in this dissertation.

1.3.2.3 Histories of the social determinants of health in Canada

In Canada, many health researchers,(17, 66, 70-77) organizations,(78, 79) and historians (80-82) have identified former Minister of Health and Welfare Marc Lalonde's 1974 report, *A New Perspective on the Health of Canadians* (83), as the turning point where ideas related to the SDOH first gained national recognition. For example, Trevor Hancock, a Canadian professor in public health and social policy, has described the *Lalonde Report* as:

> the first modern government document in the Western world to acknowledge that our emphasis upon a biomedical health care system is too narrow, and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public.(72, p10)

Importantly, the *Lalonde Report* drew attention to the determinants of health outside of the health care system.(83) In particular, the report's "health field" concept included human biology, lifestyle, health care organization, and also environment which was defined as "all those matters related to health which are external to the human body and over which the individual has little or no control,"(83, p32) such as the social environment. Thus, the *Lalonde Report* does represent a jumping off point in the history of the SDOH and a paradigm shift in public health through the development of health promotion that followed its release. This history is discussed in further detail in Chapters 4, 5, and 8.

In the literature, a brief history of the *Lalonde Report* is frequently included by authors who use it to contextualize other events,(17, 66, 71) issues,(70, 72, 84-86) or individuals in PPH.(67, 69, 70, 87) For example, epidemiologist Lawrence Green (Johns Hopkins) and

behavioural scientist John Allegrante (Columbia University) used this recent history to situate the 10-year vision for health, *Healthy People 2020,* put forth by the United States Government in 2010.(71) Dennis Raphael (York University) referenced the *Lalonde Report* as the starting point of the history of the SDOH in Canadian health promotion, public health, and population health.(17, 81, 82) Raphael also used the *Lalonde Report* to contextualize a series of policy documents that brought attention to the SDOH, such as the 1986 *Epp Report* (88) or the 1998 Health Canada position paper, "Taking Action on Population Health."(89) Other authors, such as Hilary Graham (York University in the UK) (70) and Trevor Hancock (University of Victoria),(72) present this recent history of public health by exploring trends in UK public policy and the development of healthy public policy in Canada. Graham also used the *Lalonde Report* as the backdrop to discuss other individuals important in the contemporary history of the SDOH approach, such as medical historian Thomas McKeown (1912-1988) and his recognition that improved economic conditions, rather than medicine, improved public health,(90-92) or that of epidemiologist Geoffrey Rose (1926-1993) in his population strategy for prevention in determining the "causes of incidence" of disease.(93)

One example of an SDOH-related history tied to health promotion includes the historical lessons drawn by sociologists Jacqueline Low and Luc Thériault (University of New Brunswick).(77) The authors cast a contemporary lens onto the past by interpreting history vis-à-vis health promotion, defined by the WHO as "the process of enabling people to increase control over, and to improve, their health."(94) Low and Thériault's work serves as an example of how contemporary understanding can be used to discern lessons from history with relevance for contemporary PPH practice. One of their lessons is "that promoting the health of Canadians requires […] of particular importance, addressing the social determinants of health."(95, p201)

Sholom Glouberman (University of Toronto) and John Millar (University of British Columbia) noted that the *Lalonde Report* was "ahead of its time" for having identified the need for intersectoral collaboration to address the SDOH.(85, p388) These authors review the history of the determinants of health and health information systems in Canada, which they situate in the evolution of health promotion.(85)

Suzanne Jackson (University of Toronto) and Barbara Riley (University of Waterloo) provided a recent history of health promotion in Canada since the Ottawa Charter, from 1986 to 2006, in which they document shifts in health promotion towards and away from addressing the SDOH.(96) Similarly, Ann Robertson (University of Toronto) focused on how discourses in health promotion, public health, and population health evolved to recognize health as the product of social, environmental, and political context, since the Second World War in Canada.(86)

As a final example, Michael Hayes (University of Victoria) and James Dunn (University of Toronto) traced the academic history of population health from 1983 to 1998 in their review of the field in Canada.(4) They begin with the founding of the Canadian Institute for Advanced Research, the institution credited for developing early understandings of the determinants of health (see Chapter 8 for further details). This work represents an important contribution in the history of the SDOH for its comprehensive review of population health, the academic field in which the SDOH approach is nested.

1.3.2.4 Histories of the Canadian Public Health Association

This dissertation considers the history of the SDOH through the lens of the CPHA; therefore, some attention to existing CPHA histories is necessary. Background on the CPHA is provided in Chapter 2.

The electronic book entitled *This is Public Health: A Canadian History*,(97) represents the most comprehensive history to date on the CPHA in Canada. Christopher Rutty (University of Toronto) and Sue Sullivan, in collaboration with the CPHA, highlighted key public health accomplishments (e.g., sanitation reforms) in Canada from 1600 to 2009, and integrated discussion of some of the social factors (e.g., crowded living conditions urbanization) that drove these reforms.(97)

Former honors student Azalyn Manzano (York University) and professor Dennis Raphael (York University) conducted a review of CPHA policy statements related to the SDOH, from 1970 to 2009.(98) In some ways, that work is historical due to the time period analyzed and the new insight provided on the evolution of the SDOH. Manzano and Raphael argued that the CPHA has been "well ahead of its time" (98, p399) regarding its relatively early recognition of the SDOH (compared to other public health organizations) and their distribution as the result of social, economic, and political factors.

Another history of the CPHA was produced by former Master of Health Administration student Joan Costello (University of Ottawa) in 1979, as a practicum component of her studies. Costello produced seven short articles, one for each decade from 1909 to 1979, that were published in the CPHA's newsletter *Health Digest* through 1980 to 1981.(99-105) These articles focus on the institutional history of the CPHA, similar to Rutty and Sullivan's, but do not examine the broader social context of public health, health promotion, or public health at the time.

1.3.3 Summary of literature review and identified gap

Considered together, the above sources constitute an informative body of literature on this history of PPH and the SDOH, internationally and in Canada. As shown in my review,

however, much of the literature does not focus explicitly on the SDOH approach and does not

examine the history of PPH using the SDOH as an interpretive lens. Accordingly, my

dissertation occupies a novel place in the historiography of the SDOH; I am a member of the first

generation to be trained in the PPH and SDOH (see Chapter 2 for further explanation), thus one

of the first historians to apply this as an interpretive lens and consider the history of the SDOH in

a nuanced way.

Additionally, this research fills a gap in the literature by extending the history of the

SDOH beyond the introduction of the 1974 *Lalonde Report*,(83) from 1910 to 2010. Existing

histories of PPH in Canada prior to 1974 are typically descriptive in nature and do not

specifically focus on the SDOH. This dissertation attempts to fill this gap by providing an in-

depth history of the SDOH specific to the Canadian context using archival materials from the

CPHA. This builds on the work of Rutty and Sullivan's history, which was compiled using the

archives of the *Canadian Journal of Public Health* and the Connaught Laboratory Archives (i.e.,

the Sanofi Pasteur Limited's Connaught Campus Library) in Toronto.(97) The Connaught

Laboratory, today known as Sanofi Pasteur, has an historic connection with the CPHA. Both

organizations initially operated out of the same institution, the University of Toronto, and both

comprised many of the same members. For example, the CPHA initially had a Laboratory

Section, where Connaught Laboratory members discussed developments in areas such as

antitoxins. Thus, while Rutty and Sullivan's extensively resourced history is certainly

representative of the CPHA, it did not use the CPHA archives used for this dissertation.

According to the literature and staff at the CPHA, this dissertation represents the first attempt to

conduct an historical study using the CPHA archives in their entirety. The rationale of this study

is further discussed in Chapter 2.

1.4 Thesis structure

The Preface of this dissertation explained the structure of this dissertation as a manuscript-based thesis and reviewed the contributions of authors as well as the publication status of each manuscript. Chapter 1 (this chapter) provided background information for this research. This included a review of my conceptual approach, concepts key to this dissertation, and a review of pertinent literature on the history of the SDOH and PPH in Canada. Chapter 2 reviews the methodology used for this research and describes my research objectives, methods of data collection and analysis, CPHA archival materials, ethics, and my research perspective. Chapter 2 also restates the rationale for this study.

Chapters 3 through 8 consist of stand-alone manuscripts prepared for publication in peer-reviewed, scientific journals (see Preface). The first manuscript (Chapter 3), is entitled "Is the future of 'population/public health' in Canada united or divided? Reflections from within the field." Here, I debate and discuss the field of PPH as a united or divided discipline, for as described earlier, I wrestled with demarcating a clear definition of PPH. The SDOH approach, which is nested in PPH, is a similarly difficult concept to pin down. In my second manuscript (Chapter 4), entitled "Taking stock of the social determinants of health: A scoping review," I set out to synthesize and map SDOH grey and academic literature from the fields of health promotion, population health, and public health to demarcate an understanding of the key concepts that underpin the SDOH approach. As I learned through my scoping review of the literature, action on the SDOH often requires political pressure through public mobilization, organization, and involvement in social change to influence policy changes by the elected officials involved in decision-making. As well, I found that the SDOH were presented in the literature in several different ways (i.e., as a list, story, or narrative). To bridge these findings, I

explored the different ways that the SDOH were presented to the public through a media analysis of print news articles in Chapter 5, entitled "They are not my problem: A content and framing analysis of references to the social determinants of health within Canadian news media, 1993-2014."

To hone in on the broad and interdisciplinary history of the SDOH, in Chapter 6, entitled "Poverty and public health: The ebb and flow of a social determinant of health, 1900s-2010s," I explore the history of a single SDOH: poverty. This manuscript also sought to identify how the SDOH related to changing social, economic, and political contexts in Canada. I further interrogated how these changing contexts influenced the history of the SDOH in Chapter 7, entitled "'For all those who need them': Efforts to secure equitable access to family planning services from within the Canadian public health community, 1960s-80s." Here, I focused on a period in PPH that was radically altered by a national event, the 1969 amendments to the *Criminal Code of Canada*, as well as shifting social and PPH contexts.

In Chapter 8, I focus on the more recent history of the SDOH by weaving together oral histories with Canadian PPH leaders. This manuscript, entitled "'It's a tradition of naming injustice': An oral history of the social determinants of health – Canadian reflections, 1960s-present," traces the concept of the SDOH as it developed through the firsthand experiences of those who lived this history. Finally, in Chapter 9, I conclude my dissertation by highlighting its key findings, considering its strengths and weaknesses, situating it within the existing literature, and discussing its contributions to PPH policy in Canada.

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Chapter Two: Objectives and Methods

2.1 Overview

In this chapter, I introduce the objectives, research question, and rationale of my dissertation (Section 2.2). Next, in Section 2.3 I describe my methodological approach, which is qualitative and is informed by social historical and critical public health perspectives. In Section 2.4, I provide a description of the Canadian Public Health Association (CPHA), the organization through which I examine the history of the SDOH, and an overview of its activities since 1910. Then, in Sections 2.5 and 2.6, I discuss my methods of data collection and analysis for my study materials, which include archival materials, oral history interviews, academic and grey literature, and news media articles. Overall, my methods use thematic analysis and content analysis. Finally, in Section 2.7 I describe the strategies I implemented to ensure rigor in this dissertation. I conclude by commenting on the ethics approval of this study and reflecting on my role as the researcher for this study in Section 2.8.

2.2 Research question, objectives, and rationale

The overall aim of my dissertation was to gain a nuanced understanding of the emergence and evolution of the social determinants of health (SDOH) approach in the history of Canada since 1910, to gain insight into the contemporary issues and challenges facing SDOH, in the context of the academic field(s) in which it is nested, population and public health (PPH). I use the term "nuance" throughout this dissertation to refer to the subtle differences in meaning and expression that have historically existed for the SDOH; the contemporary scholarly SDOH approach allows for this nuance to be inferred historically.

In the qualitative research paradigm, research questions are used as a positioning devices or compasses for the research and are expected to evolve throughout the course of a study.(1)

This is illustrated in the manuscripts that comprise this study; each manuscript has specific

research question(s) that address different components of the objectives below, in depth. Joan

Eakin and Eric Mykhalovskiy, two Canadian qualitative health researchers who contributed to

the development of the *Canadian Journal of Public Health*'s (CJPH) guide for the critical

appraisal of qualitative work, have suggested that research questions are even "sometimes not

really known until the end of the research."(1, p190) In reflection, having completed this study, I

recognize that the guiding research question for my dissertation has been:

> What is the history of the SDOH approach in Canada and how has it been influenced by
> the social, economic, and political factors that have shaped Canadian society since 1910?

 I pursued this question via specific objectives that aligned with the papers:

(1) To reflect on the future of "population/public health" in Canada as a united or divided field

by exploring the challenges and opportunities that exist to achieving greater coherence.

(2) To discern core concepts from the SDOH through a scoping review of academic and grey

literature from health promotion, population health, and public health.

(3) To explore how the SDOH have been represented to a general audience, by analyzing their

representation in Canadian news media; specifically, by identifying: when the SDOH were first

reported; which SDOH were reported most frequently; how coverage of the SDOH has

changed over time; how messages about the SDOH were communicated to the public; and, how

reports of the SDOH were framed.

(4) To explore the history of poverty, a long-recognized SDOH, in twentieth-century Canadian

public health; this entailed: (a) tracing how poverty has been conceptualized over time; (b)

identifying who, or which societal sector, was viewed as primarily responsible for poverty and

what were deemed viable solutions; (c) considering the extent to which poverty was regarded

as intersecting with other determinants; (d) identifying the prominence of poverty in relation to other public health issues.

(5) To consider, historically, the intersection of the SDOH with law, public health, and social movements by exploring the efforts of the Canadian public health community related to the family planning movement during the 1960s-1980s.

(6) To synthesize the history of the SDOH by constructing a social history narrative of the SDOH from oral history interviews conducted with past and present PPH leaders.

The rationale for this study is threefold. First, this dissertation seeks to fill the knowledge gap identified in Chapter 1, particularly to contribute to the historiography on the SDOH prior to the 1974 *Lalonde Report* by using the SDOH as an historical and interpretive lens. Second, as mentioned in Chapter 1, this study uses archives from the CPHA. These archives have not been examined historically in depth prior to this dissertation, which allows for the exploration of the history of the SDOH with a richness previously unknown. Third, this study will clarify present understandings of the SDOH approach with relevance to PPH by contemplating the nature and history of the SDOH approach and the PPH field. Fourth, the lessons learned from the history reviewed in this study may be used to inform present efforts to take action on the SDOH in PPH and in policy settings.

2.3 Methodological approach

My dissertation generally follows the qualitative health research paradigm, which Judith Green and Nicki Thorogood describe as research that "aims to answer the 'what,' 'how' or 'why' questions about social aspects of health, illness and health care" by focusing on gaining meaning and understanding.(2) This differs from the quantitative research paradigm that seeks to answer questions of 'how much' or 'how many.'(2) Throughout my research, I have adopted an

interpretivist epistemology, which maintains that truth exists relative and subjective to individuals, the realities they construct and experience, and how they interpret the world.(2)

Despite my adoption of an interpretivist epistemology, it is important to note the potential appropriateness of other post-positivist theories of knowledge to underlie and inform my research. The constructionist approach, for example, holds reality as something that is constructed according to the historical, social, and political processes that determine how society is divided (e.g., labour, gender, or disease categories).(2) This approach would undoubtedly be valuable in interpreting some of my findings (e.g., understandings of poverty in relation to political factors); however, I wanted to ensure flexibility in my chosen epistemology because my research question is equally situated in history and PPH. My research findings are drawn from textual archival materials and oral history interviews, both which rely on individual interpretations of knowledge on the SDOH and the contribution of this approach to PPH. I sought to contextualize and explain the history of the SDOH socially, economically, and politically; I did not aim to deconstruct the meaning of the SDOH according to constructed social, economic, or political institutions. I therefore adopted an interpretivist lens to account for the ways that, historically, the authors of my sources have understood the "SDOH" approach. Further, interpretivism recognizes that my understanding and knowledge about the SDOH past and present is influenced by my own reality, which in this case is as an interdisciplinary PPH graduate trainee with contemporary knowledge of the SDOH. As such, I have sought to understand the history of the SDOH from the point of view of those who lived and recorded it in archival sources and through oral history interviews.

In this section, I first outline my methodology, which refers to the philosophical assumptions that underlie this study and my research approach.(2) I then describe the methods I

used to collect and analyze my data. As an interdisciplinary researcher in PPH (see Sections 1.2 and 2.9), my methodology is informed by social historical and critical public health perspectives. I review each of these below.

2.3.1 Social history methodology

Social history is defined by the International Encyclopedia of the Social & Behavioral Sciences as "a general approach to history that focuses on society at large."(3) This approach is appropriate for my dissertation, because of the interplay between the history of the SDOH and social change movements, living conditions, social and cultural values, demographic transitions, and other structures of society.(3) In the 1960s-1970s, social history emerged as a discipline that challenged the conventions of mainstream history alongside social movements that shifted social and cultural values to become more philosophically liberal (e.g., New Left, feminism).(4) Social history aimed to document and recover the voices of individuals and groups that had historically been marginalized, ignored, or dismissed by society (e.g., farmers, workers, poor, women).(4) As a methodology, social history is concerned with power relations and explores how these are negotiated through the social attributes of class, gender, race, culture, and others.(4)

Social history methodology is ideally suited to a history on the SDOH, a topic that is fundamentally about the unequal distribution of power, money, and resources in society.(5) This distribution influences the health of individuals by shaping the conditions that they grow, live, work, and age in.(5) Typically, those who experience poorer health in a society are those who occupy its margins; the 'worst off' tend to face multiple disadvantages related to income, housing, gender, race, education, and other SDOH.(5, 6)

My dissertation also represents a history of medicine and PPH. At times, medical histories have been critiqued for their tradition of producing "'top-down' [accounts] celebrating

professional, institutional, and therapeutic developments…".(4, p11) As a function of government, public health necessarily operates as a top-down enterprise (see Section 1.2.1).(7) Certain legal powers and duties are afforded to public health professionals to protect and promote health, which from a public health perspective is considered a common good.(7) However, public health has also "traditionally been at the margins of both health policy and the academy" as a practice and academic endeavour.(8) In suppressing epidemics, for example, the public health community has historically adopted radical positions, at times going against the assumptions and interests of medicine, business, government, and the public.(9) This radical position lends well to social historical study, in the broad sense defined above. My research does not explicitly focus on power relations between the public health community and the public as a conventional social history might. However, power relations are implicitly explored in the manuscripts that comprise this dissertation and through my use of a critical public health perspective, described in Section 2.3.2.

I selected historical methodology as the best fit for my research question, which aimed to trace the history of the SDOH approach in Canada. As with epistemology, however, it is important to recognize that other methodologies may also have been suitable for this work. Case study methodology, for instance, offers one alternate way of approaching my work because it allows researchers to explore an individual, group, organization, or related phenomena in depth.(54) Further, case study methodology allows for researchers to understand the complexity of a phenomenon while also retaining its meaningful and distinctive characteristics (e.g., small group behaviour).(54) As Yin (2009) identifies, both histories and case studies overlap in their use of methods and sources (e.g., archival analysis) and their shared aim of determining the "how" and "why" of exploratory research questions.(54) I selected history as my methodology

38

over case studies because for the scope of my thesis, I aimed to understand the SDOH approach as it existed and evolved in the past, in addition to its contemporary role in PPH.(54) Future research on contemporary SDOH events (e.g., since the WHO CSDH) may consider employing case study methodology.

2.3.1.1 Social history of medicine

Finally, because of the overlap between health and medicine, the focus of this study on the SDOH, and the critical perspective I adopt, this dissertation may also be considered a social history of medicine. Defined by journal editors Linda Bryder and Richard Smith in the inaugural issue of *Social History of Medicine,* the social history of medicine refers to an interdisciplinary field that considers medical history in its social and economic context.(10) In contrast to conventional medical history, which has traditionally approached the history of medicine uncritically and retold it through narratives of scientific and technological advancement,(10-12) the social history of medicine is a critical discipline that rejects monocausal explanations of medical history or the use of narratives that adopt a progressive view of this history.(10) The critical perspective is described further in Section 2.3.2.

Another feature of the social history of medicine that differentiates it from conventional medical history, is its interdisciplinary nature. In what historian Samuel Shortt describes as "an historiographic cliché,"(11, p5) conventional medical history was traditionally written by physicians and other medical professionals. Since its emergence in the 1960s, the social history of medicine has evolved to become an interdisciplinary field comprised of general historians, medical scientists, social scientists, and members of other professions and disciplinary backgrounds.(10) As Bryder and Smith suggest, multidisciplinary perspectives are invaluable to the history of medicine, which unfolds across the disciplines of sociology, administration,

economics, biological sciences, and many others.(10) The interdisciplinarity of the social history of medicine was exemplified in the literature review of this dissertation (Section 1.3) and the manuscripts that comprise it; the historiography of the SDOH includes contributions and collaborations from epidemiologists, physicians, economists, public health and health promotion practitioners, social scientists, social workers, and many others (e.g., 13, 14-25).

2.3.2 Critical public health perspective

My methodological approach also incorporates elements of a critical public health perspective, which is defined by Judith Green and Ronald Labonté as "offering a critical voice *for* public health, but also, less comfortably, at times offering a critique of public health."(2) Critical public health seeks to understand the ways that social, economic, and political structures construct conditions for health, and challenge these structures where they create health inequities.(8, 26)

Critical public health is a contemporary derivation of Critical Theory. In the history of the social sciences, Critical Theory can be traced to the Frankfurt School of German philosophers and social theorists that formed in the late 1920s.(27) Max Horkheimer (1895-1973), a founding member of the Frankfurt School, asserted that Critical Theory sought the goal of "man's emancipation from slavery,"(28, p246) implying that philosophy radically analyze social and economic conditions beyond the "rational constitution of society,"(28, p246) to critique society, its powers, values, and freedoms, and its political and economic institutions. Since Horkheimer, critical theory has evolved from that associated with the Frankfurt School (i.e., "Critical Theory"). Today, critical theory is considered broadly as any approach to social science that seeks to understand domination and oppression and their manifestations. Some examples include post-colonial criticism,(29) feminism,(30) and critical race theory.(31) The

40

social history of medicine and critical public health, as described above, may also be considered forms of critical theory.

I adopt a critical public health perspective in part because of my training in population health, which epidemiologist John Frank has suggested "reaffirms the need for public health professionals to examine critically social inequities, and policies that maintain them."(32, p163) Yet, I also adopt a critical perspective because of its implications. Critical public health not only seeks to understand how social structures construct the conditions that shape health, but also seeks to challenge these structures and their sources of social, economic, and political power, especially where they marginalize certain population groups.(8, 26) A critical public health perspective is particularly well-suited to research on the SDOH, which explicitly interrogates how these powers are distributed in society.

Further, a critical public health perspective *takes sides* in the interest of public health,(8) the common good, and health equity by advocating for the just distribution of power, money, and resources in society. In this aim, it is an explicitly moral endeavour. Personally, I adopt a critical public health perspective comfortably, for it reflects my own world view, which is rooted in social justice (i.e., "the concept of a society that gives individuals and groups fair treatment and an equitable share of the benefits of society" (33)), equity (i.e., fairness (33)), and feminism (i.e., a perspective and political theory centred on the human dignity and equality for all sexes (34)).

Social scientists who are more familiar with conventional social histories or medical sociologies may challenge my use of a critical public health perspective in this dissertation for not further questioning the values, motivations, and paternalistic tendencies of the PPH workforce. A Marxist view on this dissertation's findings, for instance, may have illustrated class differences between the public health workforce, government decision-makers, and the public

whom they served and specifically, and how economic conditions drove changes in public health.(55) Alternatively, a Foucauldian perspective (56) may have positioned this history as one that considered the power relationships that existed within the public health profession (e.g., voluntary sector health workers, medical officers of health), between public health and other medical and non-medical professionals (e.g., physicians from other medical specialties, Ministers of Health, educators), or between the PPH workforce and the public. While these and other critical perspectives may offer interesting interpretations of this dissertation's findings, it was not the intent of this work to provide insight into class and power relations of the public health workforce. Rather, this dissertation sought to trace the history of the SDOH approach in Canada.

As explained elsewhere in this dissertation (see Chapter 4), the SDOH are fundamentally about health equity. Given this understanding of the SDOH, I sought to illustrate past instances where the public health community was *inclusive* and sought to create fairer conditions for health, rather than where the public health community was *exclusive* and marginalized certain population groups. Because of this approach, my dissertation may read less critically compared to other works on similar topics. As an interdisciplinary researcher situated in PPH and history, however, I believe that my approach is warranted in presenting the findings from my work to my intended audience: the PPH community and those interested in its history.

Through the many times I have presented this work to PPH audiences, I have found it more constructive to opening dialogue on past and present strengths and shortcomings in PPH when the material is conveyed in a neutral and relatable way (e.g., 'attempts to achieve health equity' versus 'attempts to achieve social control'). To reflect on our history and to learn from it, it is important that we are able to connect with it and, to some extent, see ourselves in it. For this reason, I present my history of PPH as one where the PPH workforce consistently attempted to

improve the health of Canadians, even though these attempts were limited by the time, place, and social context in which they operated in. My neutral (and sometimes positive) presentation of the PPH workforce is therefore not intended to be uncritical, but to present PPH history in a way that is constructive to the workforce's present-day efforts to achieve health equity and act on the SDOH.

2.4 About the Canadian Public Health Association

As discussed in Section 2.5, the CPHA archives comprise the major source of data for this thesis. As well, this dissertation considers the history of the SDOH through the lens of the CPHA. Therefore, some background information on the CPHA and its history is necessary. In this section, I provide a brief overview of the history of the CPHA and its activities related to the SDOH in Canada, which I gained through my analysis of this organization's archival documents. This overview serves to orient readers with the CPHA, to better understand my reasoning for using the CPHA as the interpretive and historical lens for this paper.

The CPHA is the oldest non-governmental organization devoted to public health in Canada.(35) It has provided an independent voice for public health since it was established in 1910.(36) Since its existence, the CPHA has represented individuals from diverse areas related to PPH (e.g., public health nursing, environmental health) with an interest in establishing professional standards, providing networking opportunities, and advocating for policy change to improve the health of all Canadians.(35, 36) Today, the CPHA is a national, not-for-profit, voluntary association comprised of members from over 30 professions related to PPH across Canada, who work to advise decision-makers and guide initiatives on matters related to PPH.(37) The breadth and history of the CPHA present an ideal perspective for examining the history of the SDOH in Canada.

2.4.1 The history of the SDOH through the lens of the Canadian Public Health Association

From the 1900s to 1920s, the CPHA and its members advocated for initiatives that may today be considered as action on the SDOH. This included town planning bylaws, shorter workdays, and improved sanitary measures to lower child and maternal death rates, lower communicable disease rates, and improve housing conditions for Canadians. Later, from the 1920s through until the 1940s, the CPHA and its members continued the trend to improve child and family living and working conditions, through initiatives such as medical examinations at schools or in the work place, the establishment of well-baby clinics, or the provision of workmen's compensation. Following the Second World War, from the 1950s through the 1990s, the CPHA and its members became influenced by the social movements ongoing in Canadian society, which brought a greater recognition of rights and equity into public health. Since the 2000s, the CPHA has continued to maintain its support of the SDOH and has evolved its direction as the evidence-base on the SDOH has developed. The CPHA now advocates in support of initiatives that aim to create equal opportunities for health by redistributing power, money, and resources in broad areas such as government taxation and transfer policies, the environment, and poverty reduction.

2.5 Data collection and access

To achieve the objectives of this dissertation, I used several different sources of data: archival sources, interviews, media, and other literature. Specifically, I used published academic and grey literature to achieve objectives 1 and 2, print news media for objective 3, and archival materials and oral history interviews for objectives 4 through 6. Below I review each data source in detail, ordered by their contribution to the findings of this dissertation.

2.5.1 Archival sources

2.5.1.1 The Canadian Public Health Association archives

To gain a nuanced understanding of the emergence and evolution of the SDOH approach in the history of Canada since 1910, I analyzed primary source materials from the Canadian Public Health Association (CPHA) archives, located in Ottawa, Ontario. The CPHA archives represent a body of past and present institutional records that have not been accessioned or indexed (e.g., no fonds numbers or collection signatures) and for which there is no historical finding aid available. As a researcher, I was granted access to the CPHA "general" archives and past program archives (i.e., not financial, membership, or activity records [e.g., materials related to specific research projects]).

The general archives predominantly consisted of 76 boxes (15 3/4 x 12 3/8 x 10") of hard-copy paper documents, which in many cases were not filed by date, document type, or size. Many of the boxes did contain files organized by topic and year. The boxes themselves were labelled generally according to their topic or the activity they reported on; specifically, global health (n=9), HIV archive (n=14), Strengthening Public Health Associations project (n=3), National Specialty Society for Community Medicine – Public Health Physicians of Canada project (n=2), Canadian International Immunization (n=7), policy (development) (n=4), and general (n=37). The 37 boxes categorized as "general" were most relevant to my research question, for they contained documents older than 1990, including: meeting minutes of the executive council, annual general meetings, Board of Directors, and committees; CPHA reports, position papers, policy statements, newsletters, motions, and resolutions; conference programs, CPHA awardee brochures, speeches and speaking notes; newsletters; correspondence; newspaper clippings; pamphlets; photographs, and many others sources. The archives also contained some

relevant documents that were outside of the CPHA's immediate operations but that CPHA participated in, such as records of the meetings of the Dominion Council of Health from 1919 to 1960. During my data collection period at the CPHA archives, from October to December 2015, I created content lists of the boxes, which I taped to the outside of the boxes after numbering and labelling them.

In small part, the general archives consisted of electronic documents (e.g., Microsoft Word documents or portable document files [PDF]) that the CPHA's Director of Policy and Office Manager provided to me as potentially relevant sources. The electronic documents recorded some of the CPHA's more recent (e.g., 1990-) activities related to the SDOH; for this reason, they constituted only a small portion of the records collected.

Access to the CPHA archives was granted through a research agreement approved by the CPHA Board of Directors in 2011, which is included in Appendix F. The archives were accessible to me during the association's operating hours, via swipe card access to CPHA's main office and its locked storage room, where the archives are held. The electronic materials provided by the CPHA were made accessible to me only through permission of the Director of Policy and the Office Manager, who directed me to their location on the CPHA intranet. I accessed the intranet through a CPHA institutional login I was assigned at the time of my arrival. Some CJPH articles were publicly accessible online (e.g., older than the 1960s), while more recent articles were not. I used my library membership with the University of Calgary's library services to access CJPH articles with restrictions, through its subscription to this journal.

2.5.1.1.1 Sampling of archival materials

Informed by my scoping review (Chapter 4), which was underway at the time of my field work, I had a working definition of the SDOH which I applied when sampling materials for

further consideration. Specifically, I retained any materials that concerned: health equity or the social gradient of health; factors having to do with the social, economic, or political influences on health; or the SDOH as represented by existing lists of determinants (e.g., housing, income, education, Aboriginal status). This scope was intentionally broad and inclusive; I had a large number of boxes to work through in a limited time frame, thus I wanted to ensure I collected as much material as possible during my time in Ottawa.

My sampling process was as follows. I opened a box and removed its contents, document by document. I quickly reviewed each document to determine its relevance. If relevant (or potentially so), I created a copy of the source by taking a photograph of each relevant page with a tablet computer. I accumulated approximately 700 photographs per day. Once I went through the entire box and copied relevant documents, I reassembled the documents (e.g., staples, fasteners, envelopes, elastics, folders) and re-boxed them in their original order. It was during this latter process that I recorded content lists for each box. Following each work day, I transferred the photographs of documents onto my computer and deleted them from the tablet computer. I then assembled them into PDFs, which I renamed by date and title. I processed all PDFs for optical character recognition (OCR), to make them text searchable; however, because of the poor quality of some images, and/or the presence of highlights or other marks on some documents, this was not possible for the entire dataset. Following OCR processing, I filed the PDFs on my computer into meaningful folders (e.g., CPHA Pamphlets, Board of Directors). These folders comprised what I refer to as my "electronic dataset" of CPHA archives. In total, my electronic dataset of CPHA archives consists of nearly 3000 records, which I imported into an NVivo database to assist in managing and analyzing these resources.(38)

2.5.1.2 The *Canadian Journal of Public Health*

I also used the archives of CJPH, which has functioned as the official organ of CPHA since 1910. The CJPH archives are available in their entirety online through Early Canadiana Online (1911-1912), JStor (1910; 1912-2014), and the CPHA (1997-present). The journal has undergone three name changes in its 107-year history from *The Public Health Journal* (1910-1928), to the *Canadian Public Health Journal* (1929-1928), to its current title of CJPH (1943-present)*. I reviewed the table of contents of every journal issue from 1910-2010 to identify potentially relevant titles. In the earlier (ca. 1910-1960) issues of the CJPH*, titles were often uninformative and so I quickly reviewed these articles to determine relevance, using the criteria identified described in Section 2.5.1.1.1. I took notes on relevant articles using a Microsoft Word document, creating a separate document for each decade. I then added these notes to my electronic dataset in Nvivo for analysis.

2.5.1.3 The Library and Archives of Canada

I also considered archival records that were related to the CPHA from the Library and Archives of Canada (LAC), which is also located in Ottawa, Ontario. The LAC is a national and extensively accessioned collection that preserves "the documentary heritage of Canada for the benefit of present and future generations."(39) Using the LAC's online library management system, I requested all documents returned from a keyword search of "Canadian Public Health Association." I then determined the relevance of these documents, and photographed and organized them using the same process outlined in Section 2.5.1.1.1. CPHA records held by the LAC archives mainly included documentation from decision-makers who were involved in CPHA activities. For example, if a federal Deputy Minister of Health was invited to speak at a CPHA conference, there may be a file folder that contained: correspondence concerning the

invitation; travel and accommodation arrangements, receipts, and reimbursement claims; speaking notes; general notes; a conference and banquet program; or other documents. In total, approximately 400 records were collected from the LAC. I did not add the LAC archives to the CPHA archives in the NVivo database. Rather, I consulted them only as needed to provide added context to findings from the CPHA archives.

The LAC are accessible to all members of the public who possess a LAC user card, which is free and can be obtained onsite. Materials must be requested in advance, through the LAC's online library management service. The LAC allows photography of documents, with some exceptions.

2.5.1.4 Oral history interviews

I conducted qualitative interviews with individuals who held leadership roles in Canadian public health, past and present. My interviews were informed by the methods of oral history, which emphasize participants' perspectives, via open-ended questions, and seek to gain their experiential knowledge in the field.(40) Oral history is a method of social science research that collects narratives from individuals for the purposes of research, as an effective method of gaining in-depth knowledge of a topic.(40)

2.5.1.4.1 Participant recruitment

I identified potential participants for interviews during the data collection phase described for CPHA archival materials in Section 2.5.1.1. I maintained a list of potential interviewees who seemed to have made a substantial contribution to the history of the SDOH in Canada, which I considered as persons whose names were repeatedly (i.e., more than twice) associated with SDOH-related research, issues, discussions, or activities. I also used snowball sampling, a strategy where other potential participants are nominated by the interviewees,(41) to broaden my

potential interviewee pool. I approached 19 people as potential participants in my recruitment; two did not participate, for personal reasons, but did refer me to other potential participants and documents that could inform my project.

Interviews were conducted face-to-face, by telephone, or by videoconference. Apart from two interviewees, I provided participants with the question guide (see Appendix G) in advance of their interview. Initially, I had not intended to circulate the question guide in advance of the interviews for my study, to allow for a more natural conversation and interview compared to pre-prepared responses. After my second interview, however, the participant expressed that they would have preferred to receive the question guide in advance. For every interview thereafter (i.e., for participants 3 through 17), I circulated the question guide in advance to participants. I interviewed a total of seventeen participants, which included 8 males and 9 females, with the oldest participant aged 88 years. Participants were provided with a copy of their transcript for content verification following transcription (see Section 2.7.4). Further details on the recruitment and sampling strategy are provided in the methodological appendix of Chapter 8. A summary of participant and interview characteristics is provided in Appendix H.

2.5.1.4.2 Interview process

I audio-recorded interviews and transcribed them using intelligent verbatim (i.e., capturing the content but omitting non-verbal or repetitive components of the conversation, such as utterances of 'um' or 'ah').(2, 42) Once transcribed, I added the transcripts to my electronic dataset for analysis in NVivo. Further details on my interview and transcription process are provided in Chapter 9. Appendix H summarizes the interviews and interviewees.

Oral history interview participants underwent an informed consent process. All but one participant agreed to link their name with their interviews, due to the nature of their position in

the public service, so that quotes could be attributed to participants in an identifiable form. This is consistent with oral history, which aims to give authenticity to the interview as an historical source and to credit participants as "bearers of tradition" who represent "living links in the historical chain, eye witnesses to history, and shapers of a vital […] way of life."(43, p13) The form used to consent participants into this study can be found in Appendix I.

2.5.2 Academic and grey literature

To achieve objective 2, I conducted a scoping review of PPH academic and grey literature to discern its key components. I searched the title, abstract, and keyword fields of 5 academic (CINAHL, Embase, Medline, PsycInfo, PubMed, SocIndex) and 3 grey (Google [general], Canadian Health Research Collection, Canadian Research Index) literature databases for the terms "social determinants of health" and "public health" or "population health" or "health promotion," limited to English language abstracts published between 2004 and 2014. I also included a secondary literature search of Canadian-specific literature, as my understanding of the SDOH literature evolved. I added the terms "inequity" or "inequality" or "disparity" or "social gradient" and "Canad*" to my search to meet this end. My search strategy and methods of inclusion and exclusion criteria for this review are discussed in further detail in Chapter 4. My final sample of SDOH literature synthesized consisted of 108 full-text articles.

I accessed academic and grey literature databases through the University of Calgary's institutional subscriptions to CINAHL, Embase, Medline, PsycInfo, PubMed, SocIndex, Canadian Health Research Collection, and Canadian Research Index. Google is publicly accessible and did not require access permissions.

2.5.3 News media articles

To address objective 3 and to provide an alternate perspective of how the SDOH are represented outside of the academic and grey literature, I conducted a media analysis of Canadian news media articles. I searched the Canadian Newsstand Complete database (now known as Canadian Newsstream) for "social determinants of health" or "social factors of health" or "social elements of health" or "social determinants" or "social aspect* of health" or "social NEAR/2 health" (meaning: the word "social" was within a 2-word distance from the word "health"). I did not restrict my search by date, though I did limit my search to the English language and the 25 most widely circulated newspapers in Canada, which I identified using Wikipedia's 2011 "List of newspapers in Canada by circulation."(44) My final sample, after removing duplicates and applying my inclusion and exclusion criteria, consisted of 183 news media articles. Further details of methods used to obtain this sample are provided in Chapter 5.

I accessed the Canadian Newsstand Complete database through the University of Calgary's institutional subscription.

2.6 Data analysis

2.6.1 Thematic content analysis

I used thematic content analysis as the primary method of analysis for this research, across all textual materials (i.e., archival materials, oral history interview transcripts, academic and grey literature, and news media articles). Green and Thorogood describe this method as appropriate in qualitative research studies that aim to find and categorize common themes across data sources.(2) Thematic content analysis consists of closely reading (and rereading) sources, coding information meaningful to the research question, grouping codes together, and then comparing these groupings to look at the relationships and patterns that exist in the data.(2)

I coded documents according to the methods described by grounded theorists Barney Glaser and Anselm Strauss. Of note, while I borrowed the method of coding from grounded theory, I did not adopt grounded theory methodology in my study. I first performed open-coding of the documents in my electronic dataset by identifying concepts and information related to the SDOH.(45, 46) Open coding is an intense and early phase of data analysis intended to open the researcher to "all potential avenues of enquiry" by generating as many codes as possible.(2) I did this through a close reading of documents, line by line, and decade by decade. I then revisited my codes and considered which ones seemed core to my research question.(45, 46) At this re-coding stage I developed a codebook to document how I grouped codes into meaningful categories. Throughout this process, I used constant comparison to consider how my codings and groupings of codes related to one another and generated common themes meaningful to my research questions.(2, 45, 46) I provided thick description of my findings in the manuscripts by describing the social, historical, political, and economic context of themes.(2) My methods of thematic content analysis differed slightly between objectives and are explained in detail within each manuscript.

2.6.2 Content analysis

In addition to grounded theory, my coding process was also informed by the methods for general content analysis described by communications professor Klaus Krippendorff, which I felt appropriate, as my analysis relied so heavily on textual material. According to Krippendorff, texts are considered as artifacts of a given social and cultural context that influences how they are written and interpreted, with multiple valid interpretations.(47) The Krippendorff process for collecting and analyzing texts for content analysis firsts consists of compiling texts of interest into a manageable and representable set.(47) Then, pertinent information from texts is recorded

through the coding process and later reduced by tabulating and organizing data.(47) Finally, researchers infer meaning on their findings and make interpretations comprehensible to others through narrative explanation.(47) I adopted Krippendorff's process early on in my research process, as it provided a logical and sequential way to work through my study and electronic dataset from data collection to writing an historical narrative.

2.7 Rigor

In qualitative research, rigor refers to the "trustworthiness of data collection, analysis, and interpretation."(48, p107) I applied several strategies to enhance the rigor of this study. I briefly review each of these, below.

2.7.1 Triangulation

I applied the method of triangulation to my data, which means that I drew my findings from multiple sources to provide different perspectives on an issue.(49) To some degree, triangulation helped to verify content claims in documents and increase the reliability of my findings; however, this was not the primary aim of its utilization. More importantly, triangulation overcame the potential weaknesses that may have existed in sources (e.g., incomplete records) and mitigated some of the potential bias of relying on a single perspective or source.(2)

2.7.2 Reflexivity

Reflexivity is an important component of qualitative research, for as Green and Thorogood describe, "researchers should subject their own research practice to the same critical analysis that they apply when studying their topic."(2) I employed reflexivity throughout the research process by memoing and documenting my thoughts and presuppositions as I collected and analyzed data. I also interrogated my own potential biases, through the reflexive passage in Section 2.9, where I examine the journey of my research orientation.

54

2.7.3 Purposive sampling

I used purposive sampling in my interviews to ensure that I obtained data useful and meaningful to my research questions.(2) Purposive sampling allowed for the collection of rich information on the history of the SDOH from those whom I identified as having known this history well, among a population of PPH leaders (described further in Appendix H). This sampling method helps ensure the credibility of my findings to the PPH community with whom I wish to share the results of this research.(2)

2.7.4 Respondent validation

Following the transcription of interviews, I used respondent validation to ensure that participants agreed with the content and representation of their interview.(2) At this stage, participants had the opportunity to expand on certain topics raised in the interview, remove potentially sensitive information, or correct the information recorded. This step also helped to enhance the credibility of findings.

2.7.5 Iterative research process

I conducted this research iteratively and adapted my methods of data collection and analysis as I learned new information that could enhance my approach. I conducted data collection and data analysis concurrently; this was particularly helpful for qualitative interviews, as I modified my question guide for participants as I refined my vocabulary and understanding related to issues in the history of the SDOH.

2.8 Ethics approval

This research was approved by the University of Calgary's Conjoint Health Research Ethics Board, with the ethics ID of REB14-1287. Ethics approval for this dissertation is appended in Appendix J.

2.9 Reflexivity: About the researcher

Reflexivity is an important component of qualitative research.(2) By being transparent and explicit about my values and background, I hope to make it easier for readers to consider my potential and inherent biases and how these may have affected my interpretation of findings.(50) Below, I briefly discuss some of the main influences on my world-view and orientation.

As a fourth-generation Canadian, I was raised with the privileges and values that generally accompany a white, middle-class upbringing. I was happy and wanted for nothing. Without diminishing the efforts of my hard-working parents or the challenges they faced in providing my sister and I with the quality of life they did, I do recognize that we were on the lucky side of the socioeconomic distribution and benefitted from the opportunities it afforded us. We lived comfortably and securely, which not everyone in our community did.

I grew up in the rural, northern community of Kitimat, British Columbia. Kitimat exists as the result of large-scale industrial operations (e.g., aluminum smelter, logging, natural gas) and is largely comprised of the first-, second-, and third- generation immigrants who settled in the town after the Second World War to work its new industries.(51) The town site serves the needs of Kitimat's residents, as well as those of the neighbouring Haisla First Nation that lives in Kitamaat Village and has occupied the area for hundreds of years.

I began to recognize some of the economic, social, and racial inequities that existed in Kitimat as I grew older and began to function in the community independent from my parents. Some of the town's residents have been fortunate in securing well-paying unionized jobs in Kitimat's industrial or public service sector jobs. Yet many others work low-paying jobs in the retail and hospitality sectors, which has introduced difficulty in sustaining the high cost of living that accompanies life in a rural community (e.g., high cost of food and transportation). I worked

in all four of these sectors during high school and through holding summer jobs to finance my post-secondary education. In each job, I gained new insight into my community and the residents I shared it with, and came to understand some of the challenges my neighbours faced that were unfamiliar to my experience. Throughout my teenage and early adulthood years, I developed the sense that the status quo unfairly operated in my favour. Somewhat angrily, I began to connect the social injustice that I witnessed with wider-scale political structures, such as class struggle, corporatism, and war — though admittedly this realization was accelerated by a heavy listening period of anti-establishment punk rock. In sum, I became unsettled with my position in the world and sought to learn more about it, which set me on my path of developing a critical perspective.

When I entered my Bachelor of Arts training, I began to look to the margins of Canadian society to learn more about myself in relation to my society. I studied Canadian social history and sociocultural anthropology at the University of Alberta, where I began to connect my feelings with feminist theory and thought. I vividly recall first reading Peggy McIntosh's 1988 working paper, "White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies,"(52) after which I began unpacking my own 'knapsack of privilege.' I became interested in health in my senior undergraduate years, and began to question how my own health and the health of my community had been shaped by wider social, economic, and political structures. I pursued a Master of Science (MSc) degree at the University of Calgary, and for my thesis in that program I explored the historical construction of mental health in Kitimat.

I was afforded interactions with exemplary critical scholars in the Department of Community Health Sciences through the completion of my MSc thesis. Here also, I was exposed to critical ideas and concepts with strong theoretical and empirical (qualitative and quantitative)

bases, such as the social gradient in health (i.e., a phenomenon whereby people with fewer

advantages and lower socioeconomic positions have worse health compared to those with more

advantages and higher socioeconomic positions) (53) and health equity (i.e., the absence of

remediable or avoidable health differences among population groups),(5) and formalized my

research orientation as one that privileged a critical public health perspective. It is from this

background that I approached my dissertation research, on the history of the SDOH.

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Chapter Three: Is the Future of "Population/Public Health" in Canada United or Divided? Reflections from within the Field

3.1 Highlights

Despite the supposed integration of "population and public health" (PPH), issues in the areas of research funding, the public health workforce and ethics continue to present challenges to the field's unity. The authors argue that overcoming these challenges is a worthwhile goal for the future of population well-being in Canada.

3.2 Introduction

"Are population and public health truly a unified field, or is population health simply attaching itself to public health as a means of gaining credibility?"

This commentary was prompted by the above question, which was asked during K. L.'s PhD candidacy exam. In response, K. L. cited recent developments in the field to support her conviction that population and public health (PPH) existed positively as a unified discipline. However, through conversations that ensued over the subsequent weeks and months, the authors concluded that this issue goes deeper than the existence of departments and organizations labelled "population and public health," and may benefit from debate and discussion, particularly for the incoming generation of PPH scholars. In this commentary, we argue that (1) the PPH label at times implies a coherence of ideas, values and priorities that may not be present; (2) it is important and timely to work towards a more unified PPH; and (3) both challenges and opportunities for a more unified PPH exist, which we illustrate using the broad areas of research funding, the public health workforce and PPH ethics.

3.2.1 Argument 1. The PPH label implies a coherence that may not be present

In our experience, the PPH label at times conveys the impression of a coherence of ideas, values and priorities that may not exist. The impression of coherence is conveyed in many ways; for example, by PPH graduate training programs that exist in universities at Calgary,(1)

Vancouver,(2) Ottawa,(3) and Waterloo;(4) by the existence of PPH departments within health systems;(5, 6) and by various historical developments (see Table 3.1). Yet, the coherence is not always present in practice. K. L., for example, recalls meeting a fellow graduate student at a national public health meeting who remarked that they were used to "no one knowing what [population health] is" and that they "usually just say public health," thus implying that they are – at least to some extent or to some audiences – the same. A contrasting example is L. M.'s experience, as an academic who would describe herself as a "population/public health researcher," of being regarded by colleagues within public health as "not really a public health person" because she does not have a health professional degree. Therefore, the need to clarify the boundaries and future of PPH remains, particularly due to the increasing number of trainees in this field.

3.2.2 Argument 2. It is important and timely to work towards a more unified PPH

A key question at the heart of our commentary is whether PPH *should* be a unified discipline. Some have asserted that the answer is "no."(7) Arguments against a unified PPH include important points such as the concern that PPH is too broad in scope to be useful or that it carries the potential of diluting the urgency of public health.(7)

We disagree, and feel that efforts towards a more unified PPH are both important and timely. These efforts are important because embracing the social determinants of health (SDOH) and thinking critically about health inequities, which PPH aims to do,(8) is necessary to accept a holistic conceptualization of health and to overcome professional and organizational silos that prevent intersectoral action on health and health equity. In some cases, overcoming silos includes offsetting historical changes to the public health system. For example, in many Canadian jurisdictions, "health" presently constitutes its own ministry (e.g. Alberta Health or Health Canada), implying a separation from other determinants of well-being, whereas formerly it was

broader in scope (e.g. the federal Department of Pensions and National Health [1928] and Department of National Health and Welfare [1944]).(9, 10)

It is timely to work towards a more unified PPH. Unlike even 20 years ago, there are now many programs of study in Canadian universities for students who do not necessarily intend to go into public health in its conventional sense (e.g. public health nursing or a Public Health and Preventive Medicine specialty) but rather who wish to pursue an academic career, or to apply principles of PPH in a range of sectors. The Bachelor of Health Sciences Program at the University of Calgary, and in particular, the Health and Society specialization within that program, is an excellent example. We disclose that this relatively recent trend describes us: we were both drawn to the idea of a unified PPH because it represented a way to bring together health and social sciences/humanities in a way that was connected to, but importantly steps outside of, the formal health sector and professions.

3.2.3 Argument 3. Important challenges and opportunities for an integrated field exist

To permit reflection on PPH, we identify three (of potentially many) areas that appear to create cleavage in the field: research funding, the public health workforce and PPH ethics. For each area, with the intention of opening a dialogue, we identify what we see as key challenges and opportunities.

3.3 Research funding

Challenge: The 2009 announcement by the Social Sciences and Humanities Research Council of Canada that they would no longer fund health research created a challenge for PPH as an interdisciplinary field, as it left many social scientists working within PPH to navigate the different funding landscape and procedures of the Canadian Institutes of Health Research (CIHR).(11) This change highlighted the different norms and expectations for social sciences versus traditional health research (e.g. structure of research grant applications, authorship, length

63

and pace of publications, emphasis on theory),(12) as well as the areas of research considered viable and worthwhile. These differences, arguably, may particularly disadvantage those who are most poised to contribute rich theoretical and critical scholarship to PPH.

Opportunity: The integration of social and health sciences is essential to PPH. As a national funding agency and guiding body for health research in Canada, CIHR provides a forum where challenges to integration can be overcome. One example, is the significant efforts that have been made by CIHR's Institute of Population and Public Health (IPPH) to shift the peer review landscape to facilitate fair and transparent evaluation of interdisciplinary applicants by reviewers with appropriate expertise through specific, priority-driven competitions.(13) Though the challenges noted above have not disappeared, it seems that important progress is being made.

3.4 Public health workforce

Challenge: To a large extent, the public health workforce (e.g. physicians, public health inspectors, laboratory workers, nurses) remains situated within the health sector (i.e. in health services organizations or ministries of health). This arrangement presents a challenge for action on the SDOH and health equity, which is at the forefront of PPH and by definition goes beyond the regulatory and legal frameworks of public health. Action on the SDOH may fall outside the scope of day-to-day public health work providing services and programs to the public.(14) Additionally, the legislative framework that mandates public health in jurisdictions may not support an integrative PPH. For example, Alberta's *Public Health Act: Revised Statues of Alberta 2000* (15) makes no mention of the SDOH, or even of chronic disease. These issues may present a source of cleavage between the large number of experts working within public health's core functions (e.g. disease prevention, and communicable disease prevention in particular) and the stated aim of PPH to broadly influence population health (i.e. via social policy interventions, outside of the health system).

Opportunity: Despite these sources of cleavage, significant opportunities do exist and in some cases progress has been made within the professional and regulatory arms of public health towards a more unified field. Brassolotto, Raphael and Baldeo,(14) for instance, have documented that in Ontario some health units actively pursue advocacy and action on the SDOH in addition to their delivery of more traditional public health services. Public Health Ontario, for example, has incorporated addressing determinants of health and reducing health inequities throughout the *Ontario Public Health Standards*.(16)

Legislative progress has also been made in some jurisdictions. In British Columbia, the *Public Health Act (SBC 2008)* includes chronic disease as a health impediment, which at least in theory allows for the minister to incorporate the social determinants of health or equity concerns when developing a plan "to identify, prevent and mitigate" its adverse effects.(17) Québec's *Public Health Act (S-2.2)* goes further, by allowing the Minister of Health, public health director and institutions to intervene not only to prevent disease and trauma, but also to consider "social problems that have an impact on the health of the population" through acting on the SDOH.(18, p4) An example of this is Québec's promotion and implementation of healthy public policies through health impact assessment.(19) Finally, in recent years, the Public Health Agency of Canada has attempted to define the ever-expanding PPH workforce, through core competencies for public health work and the harmonization of information on the diverse postsecondary and postgraduate training opportunities that exist in PPH.(20, 21) Such attempts present the opportunity to better understand some of the features of PPH that permit intersectoral action and build on them, toward a more integrative PPH workforce and field of practice.

3.5 Efforts to advance the ethical foundations of PPH

Challenge: As public health practice is predominantly situated within the health care system, its ethical guidelines have traditionally been sanctioned by bioethical principles (i.e.

autonomy, beneficence, nonmaleficence, respect for human rights) and guided by the moral theory of utilitarianism (i.e. the public good).(22) However, as noted elsewhere,(23) these bioethics principles have proven inadequate to fully meet the challenges of PPH, where intervention activities include structural interventions that apply to whole populations and may therefore conflict with the will of the public to the benefit of the population (e.g. community water fluoridation). This tension has led to the creation of critical subdisciplines (e.g. public health ethics) to encourage advancements to ethical thinking in ways that respond to this need (e.g. the Nuffield Council on Bioethics' stewardship model).(24)

Opportunity: There is an exciting trend in evolving critical scholarship on some of the unique challenges that exist for population health interventions sanctioned under public health ethical frameworks. For instance, there is scholarly debate around the merits and drawbacks of population-wide, or universal, interventions in PPH which, on the one hand, identifies potential negative consequences of the population-level approach,(25, 26) and, on the other, argues for the leverage and potential equity of that approach.(27) This work will contribute to an increasingly robust intellectual foundation for PPH. Relatedly, some ethical frameworks that better incorporate aspects of population health have emerged that respond to the field's need for transparency and minimal restriction, social justice and equity.(23, 28-30) Such work may facilitate greater unification of PPH, as it begins to tackle the issue of how to balance the utilitarian aspect of public health, which many view as its key asset, alongside thoughtful consideration of the possible unintended consequences of this approach towards improving health for all.

3.6 Conclusion

As PPH continues to evolve throughout the twenty-first century and enrollment in "population and public health" interdisciplinary graduate programs continues to grow, we

believe that the question of whether and how to better integrate PPH will remain relevant and important. We recognize that the areas we have considered above (i.e. research, the public health workforce and PPH ethics) are not mutually exclusive and represent only a few examples among many others that likely exist.

We encourage future research and discussion on the topic and we hope that this paper prompts further debate and discussion among PPH leaders, workers, and trainees.

3.7 Acknowledgments

Table 3.1 Historical timeline of key events in the development of "population and public health," 1974-2004

Year	Event	Contribution to field of PPH
1974	*Lalonde Report* (31) published	Influences a number of developments in health promotion
1975	National Health Research and Development Program is established	Stimulates and supports research into national health issues
1978 (UK)	Marmot, Rose, Shipley and Hamilton (32) publish findings from Whitehall I	Introduces the notion of the social gradient into epidemiological research
1982 (CAN)	Canadian Institute for Advanced Research is established	Serves as a "think tank" for developing new conceptual frameworks
1985 (UK)	Rose publishes *Sick Individuals and Sick Populations* (33)	Introduces the population strategy of prevention
1986 (Intl.)	The *Ottawa Charter for Health Promotion* (34) published	Facilitates developments in health promotion and introduced the prerequisites for health
(CAN)	*Epp Report* (35) published	Canadian government departments begin to adopt health promotion in their programs
1987 (CAN)	Canadian Institute for Advanced Research establishes a population health program	Reflects changes in government and PPH where public health shifted away from health promotion towards population health
1989 (CAN)	Canadian Institute for Advanced Research introduces population health concept	Considers complex interaction of determinants of health
1991 (CAN)	Mustard and Frank (36) publish *The Determinants of Health*	Concludes that major determinants of health lay beyond the reach of the medical care system, at the individual and population levels
(UK)	Marmot, Davey Smith, Stansfeld et al. (37) publish findings from Whitehall II	Brings language of health inequality to the forefront of population-level research
1994 (CAN)	Evans, Barer and Marmor (38) publish *Why are Some People Healthy and Others Not?*	Provides epidemiological support to explain the influence of social and economic factors on health
(CAN)	Federal, provincial, and territorial ministers of health publish *Strategies for Population Health: Investing in the Health of Canadians* (40)	Population health approach is officially endorsed by governments
1996 (CAN)	Hamilton and Bhatti (39) produce Population Health Promotion: An Integrated Framework for Population Health Promotion	Combines ideas of population health and health promotion
1997 (CAN)	Federal, Provincial, and Territorial Advisory Committee on Population Health is formed	Provides government definition of population health
1998 (CAN)	Hayes and Dunn (40) publish systematic review on population health in Canada	Identifies multiple ways that population health can be conceived as a perspective, research, framework, or approach.
(CAN)	Poland, Coburn, Robertson, and Eakin (41) publish *Wealth, Equity and Health Care: A Critique of a "Population Health" Perspective on the Determinants of Health*	Critiques the population health model for being atheoretical and reductionist

Table 3.1 Historical timeline of key events in the development of "population and public health," 1974-2004 (continued)

Year	Event	Contribution to field of PPH
2000 (USA)	National Committee on Vital Health and Statistics at the Centers for Disease Control considers Canadian Institute for Advanced Research concept of population health in their vision for health statistics	Exemplifies international spread of the population health concept
(CAN)	Canadian Institutes for Health Research established through an Act of Parliament, replacing the National Health Research and Development Program	Includes the Institute for Population Health in 2000
2001 (CAN)	Health Canada's Health Promotion and Programs Branch produces a position paper for health promotion staff	Population health approach is adopted as a unifying force by Health Canada for its spectrum of health system interventions
2003 (CAN)	Coburn (42) publishes "Population Health in Canada: A Brief Critique"	Acknowledges that health promotion had been "squeezed out" by population health as a credible health policy discourse
2004 (CAN)	Public Health Agency of Canada formed	Adopts a population health approach and establishes regional offices of the Population and Public Health Branch to mobilize it

Abbreviations: CAN, Canada; Intl, international; PPH, population and public health; UK, United Kingdom.

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Chapter Four: Taking Stock of the Social Determinants of Health: A Scoping Review

4.1 Abstract

4.1.1 Background

In recent decades, the social determinants of health (SDOH) has gained increasing prominence as a foundational concept for population and public health in academic literature and policy documents, internationally. However, alongside its widespread dissemination, and in light of multiple conceptual models, lists, and frameworks, some dilution and confusion is apparent. This scoping review represents an attempt to take stock of SDOH literature in the context of contemporary population and public health.

4.1.2 Methods

We conducted a scoping review to synthesize and map SDOH literature, informed by the methods of Arksey and O'Malley (2005). We searched 5 academic and 3 grey literature databases for "social determinants of health" and "population health" or "public health" or "health promotion," published 2004–2014. We also conducted a search on "inequity" or "inequality" or "disparity" or "social gradient" and "Canad*" to ensure that we captured articles where this language was used to discuss the SDOH. We included articles that discussed SDOH in depth, either explicitly or in implicit but nuanced ways. We hand-searched reference lists to further identify relevant articles.

4.1.3 Findings

Our synthesis of 108 articles showed wide variation by study setting, target audience, and geographic scope, with most articles published in an academic setting, by Canadian authors, for policy-maker audiences. SDOH were communicated by authors as a list, model, or story; each with strengths and weaknesses. Thematic analysis identified one theme: health equity as an

overarching and binding concept to the SDOH. Health equity was understood in different ways with implications for action on the SDOH.

4.1.4 Conclusions

Among the vast SDOH literature, there is a need to identify and clearly articulate the essence and implications of the SDOH concept. We recommend that authors be intentional in their efforts to present and discuss SDOH to ensure that they speak to its foundational concept of health equity.

4.2 Introduction

4.2.1 Overview

In recent decades, the social determinants of health (SDOH), that is the social, economic, and political conditions that influence the health of individuals and populations, has gained increasing prominence as a foundational concept to the field of population and public health (PPH). During the past 15 years, the SDOH concept has evolved to the point of being a formal component of many undergraduate and graduate training programs in PPH and related fields, and thus it is timely to take stock of the SDOH literature and identify its major themes in this context.

4.2.2 Background

In this paper, we use the term "population and public health" to refer to the shared goals, combined efforts, and overlapping histories of population health and public health. Public health refers to the organized and collective efforts of society (e.g., health promotion, disease prevention, emergency preparedness, health protection) (1) to assure conditions for people to be healthy. Population health is an approach that studies disease burdens, risks, determinants, vulnerabilities, and conditions (e.g., of living and working) among population groups with the aim of reducing health inequities through action on the structural influences (e.g., SDOH).(2-4)

The combined field of PPH research and practice therefore includes multiple actors and agencies in governmental and academic spheres of influence, as well as the voluntary and private sectors.

In Canadian and United Kingdom (UK) policy circles, the SDOH concept has been increasingly incorporated into PPH literature and policies since it first gained recognition in the 1970s and 1980s alongside health promotion (i.e., the process of enabling people to increase control over and improve their health).(5) When considered together, the uptake of SDOH and health promotion by the PPH community represents a shift away from a focus on the individual-level factors that influence health, towards factors at the community and societal levels. Some prominent early examples of the SDOH concept, before it was named as such, appear in health policy documents such as the Canadian *Lalonde Report* (6) in 1974 and the UK *Black Report* (7) in 1980. The 1974 *Lalonde Report*, known formally as *A New Perspective on the Health of Canadians,*(6) represents the first government document in the Western world to acknowledge factors external to the health care system in achieving health (e.g., environment, lifestyle).(8) In the UK, the 1980 Black Report – *Report of the Working Group on Inequalities in Health* – found that inequities in health between upper and lower classes persisted despite universal access to health care.(9) Aside from policy documents, the SDOH has also gained prominence in the academic literature through studies that elucidated findings on concepts such as the social gradient in health. The Whitehall Studies conducted by Marmot and colleagues throughout the late 1970s and 1980s illustrated this stepwise relationship regarding mortality rates among different employment grades of British civil servants, which were used as a measure of social class.(10, 11)

Because the SDOH concept is multifaceted, different models and theories have emerged in the literature to try and explain what the SDOH are, how they operate, and how they can be

addressed via policy. Examples of these models include: the life course model, the allostatic load model, theories of materialism and neomaterialism, and population health promotion theory.(9, 12-22) As described in detail later in this paper, some of these models privilege more 'downstream' efforts to increase access to health and social services or resources at the individual or family level, while others represent more 'upstream' efforts to reform the distribution of power, wealth, opportunities, and decision-making at the societal level.(23) The many theoretical models and ways the SDOH are operationalized have created "conceptual ambiguity."(24, p896) When faced with this ambiguity, students, researchers, policy-makers, or members of the general public who are new to the SDOH concept may find it difficult to extract the key messages.(25) Considering the ongoing efforts to approach SDOH from an intersectoral and multidisciplinary perspective,(26) a clear understanding of the SDOH concept is especially important. Thus, there remains the need to discern key components from the SDOH concept, which is the purpose of this paper.

Recent attempts have been made to synthesize literature on the SDOH. Some examples include the body of work by Raphael and colleagues,(27-35) and contributions from the World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH).(16, 17) These documents are important to the SDOH literature, as they have helped strengthen the theoretical basis of the field, yet they do have some limitations. First, previous syntheses have not been explicitly systematic. Second, the time period for many of these contributions predate the 2008 WHO CSDH, which brought significant public attention to the SDOH, as reported by a recent media analysis on the coverage of SDOH in print news media. The significance of the WHO CSDH to the SDOH field, warrants revisiting the literature contemporarily. Finally, prior literature reviews of the SDOH have focused on specific health conditions,(36-39) health

services,(40-42) populations,(42-46) or theories (e.g., policy analysis theory, systems change),(47, 48) and not the concept as a whole.

This paper reports on findings from a scoping review of SDOH-related academic and grey literature from the fields of population health, public health, and health promotion. Our purpose is to discern key concepts and themes about the SDOH as evidenced in the PPH literature. The novelty of this review lies in our comprehensive and multidisciplinary perspective and inclusion of grey literature. We explicitly focus on the concept of SDOH as a whole, rather than its contributive role to narrower topics (i.e., specific health conditions). Additionally, by situating our work within the broad, overlapping scholarly and applied fields of population health, public health, and health promotion, we cast a wide net in our search strategy which (to the best of our knowledge) has not been done. Our approach allows for reflection on the current state of the SDOH with recognition of health promotion's historic influences on this concept's development. Finally, the time frame of our review allows for the consideration of articles that represent more recent contributions to the SDOH literature (e.g., since the WHO CSDH 2008 report).

This review will be of interest to those working and studying in population health, public health, and health promotion. Specifically, it may serve as a resource for students looking to navigate this vast and complex field, as well as scholars from various disciplines who wish to situate themselves within the foundations of PPH.

4.3 Methods

We conducted a scoping review to synthesize and map literature about the SDOH within the scope of PPH. We followed the framework outlined by Arksey and O'Malley (2005) (49) in their methodological paper on scoping studies and by drawing on the methods of two recent

76

publications.(50, 51) Scoping review studies differ from systematic reviews in their breadth and aims.(49) Systematic reviews tend to ask more narrowly-defined questions and answer these questions from a narrower range of studies that have been formally appraised for quality.(49) Scoping reviews ask broader questions and do not assess the quality of studies reviewed.(49) Scoping reviews may be undertaken to examine the range and extent of research on a topic, summarize and disseminate findings, identify gaps in the literature, or to determine the value of a conducting a systematic review.(49) Our aim was to summarize and disseminate findings. Specifically, we sought to answer the research question: what are the key terms, concepts, and ideas associated with the social determinants of health within PPH? We adopted a comprehensive approach because our findings are intended to inform another study (in progress), which aims to trace the evolution of the SDOH concept (as identified through this review) in contemporary Canadian history.

4.3.1 Analysis

We extracted information related to each study's location (i.e., based on the first author's institutional affiliation), audience (i.e., implied based on the paper's purpose and recommendations), date of publication, and setting (i.e., based on the geographic location of the first author's affiliation) to understand the landscape of the literature. Next, using NVivo QSR software,(52) we coded and organized the documents and generated themes. We first coded all studies for ideas, terms, and concepts that emerged repeatedly in the literature.(53) Then, we developed themes iteratively by rereading our sources, reviewing our codes, and identifying patterns in the data.(54)

We also conducted a quantitative content analysis of the key concepts identified from thematic analysis by calculating the proportion of articles that included key terms. Both our

qualitative and quantitative analyses were informed by the methodology for content analysis described by Krippendorff (2004), which regards texts as meaningful representations of human phenomena.(53) Content analysts, through asking questions, interpreting, and closely reading texts, infer meaning from the common components, patterns, or trends they observe.(53) Following Krippendorff's (2004) steps we recorded information from and coded information about our texts, tabulated our findings to determine how frequently these words appeared in the literature, and also interpreted them narratively.(53) Finally, we grouped our codes and key concepts into wider themes that synthesized the literature as a whole, which we explore in-depth below.

4.3.2 Search and inclusion/exclusion strategy

We searched 5 academic (CINAHL, Embase, Medline, PsycInfo, PubMed, SocIndex) and 3 grey literature databases (Google [general], Canadian Health Research Collection, Canadian Research Index) for the terms "social determinants of health" and ("public health" or "population health" or "health promotion") in the article's subject heading, title, abstract, or keyword section. We limited our search to those with English language abstracts published between 2004 and 2014.

Before commencing this review, we understood that the SDOH literature contained a wide variety of document styles, including papers that list or mention the SDOH without any elaboration, as well as papers that provide substantive discussion. Because we were interested in the latter, our approach to identifying those materials was by necessity iterative and flexible. We privileged articles that contained explicit discussion of the SDOH and its related ideas, concepts, or key terms, and excluded articles that did not. To be included, articles had to go beyond description to consider the 'why' and 'how' elements of the SDOH. As we gained familiarity

with the literature, we purposively began to include articles that discussed the SDOH in more nuanced ways (e.g., social gradient, inequities, social factors), regardless of whether they explicitly mentioned 'SDOH.' We privileged papers that were, in our view, clearly about PPH regardless of whether that was explicitly mentioned. We also searched reference lists of articles to further identify articles that were pertinent but not captured by the parameters of our search (i.e., papers that were well-known and widely consulted in the PPH community were always considered for possible inclusion). Overall, as befits the nature of the field, we used a more flexible approach to inclusion/exclusion (see Figure 4.1 Visual representation of approach to inclusion criteria) than one might find in reviews of other subject areas.

Figure 4.1 Visual representation of approach to inclusion criteria

Health Equity

Social gradient of health

Social Determinants of Health (SDOH)

- Population health, public health, health promotion (PPH)
- Substantive
- Explicit discussion of key ideas, concepts, terms

Implicitly PPH

Implicitly SDOH

Other substantive work

Not substantive

- List only
- Too short

Not relevant

- Not PPH
- Not SDOH

Inclusion

Exclusion

Literature of Interest
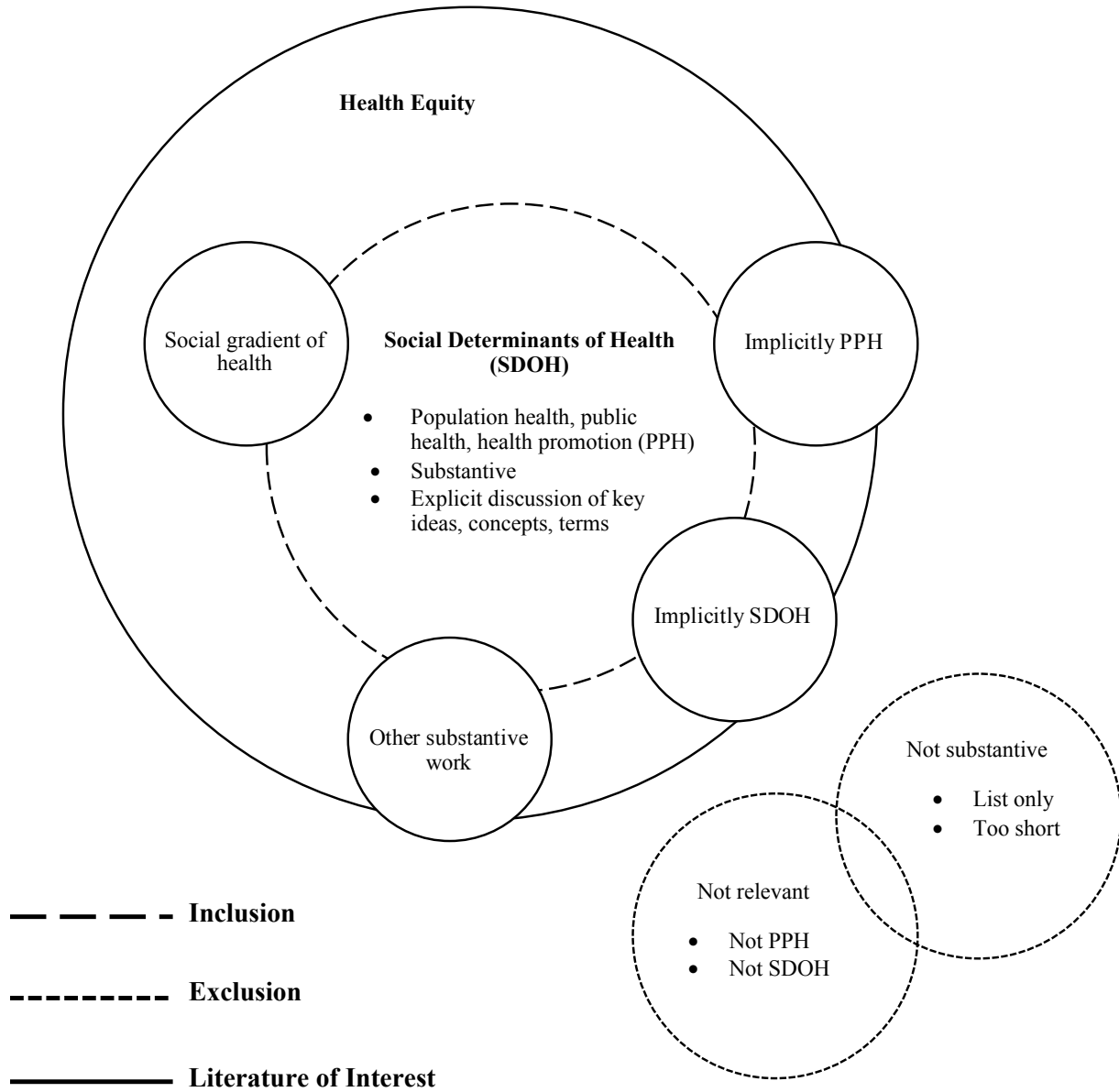
The conceptual search strategy used to capture various bodies of literature.

Authors developed the inclusion and exclusion criteria collaboratively, and revised them as they gained familiarity with the literature. KL applied the inclusion/exclusion criteria to all titles and abstracts, after which LM reviewed the selections. Both authors agreed that the sample of articles selected for full-text review, described below, were relevant to our research question. KL extracted data from relevant articles and met regularly with LM to discuss findings. It was during these meetings that key concepts were discerned and themes were generated.

Early in our title and abstract review, we recognized that the concept of health inequity was used repeatedly in the literature in ways akin to our understandings of the SDOH, even in articles where the SDOH were not explicitly mentioned. Braveman et al. (2011), for example, discussed health disparities and health equity in their abstract, but went on to discuss the SDOH in detail in the full-text of their article.(55) Therefore we felt it necessary to revisit our search strategy to ensure that we were capturing such articles. We first tested the feasibility of a revised search in PubMed, by adding the terms "inequity" or "inequality" or "disparity" or "social gradient" to our search. With no geographic parameters, this returned 28,472 abstracts, which we deemed insufficiently sensitive and not feasible for this review. We then tried restricting the geographic scope by adding the term "Canad*". As described below in detail, this resulted in the identification of 619 abstracts, which were incorporated into our review. The implications of this Canadian-specific, inequity search are discussed in the limitations section of our paper.

4.4 Results

We present our results as follows. First, we introduce our descriptive findings of the literature regarding number of articles published by date, institutional affiliation of the first author, target audience, and geographic setting. Second, we explore the different ways that the literature presented the SDOH as a list, model, or story. We consider the implications of these

different presentations and also show how they may align with different epistemologies. Third, we discuss health equity as a key theme and binding concept of the SDOH and explore how it, and the related concept of the social gradient in health, have been used in the literature. Finally, we demonstrate how action on the SDOH has been conceptualized in the literature, through more 'upstream' or 'downstream' approaches.

4.4.1 Descriptive findings

Our initial search returned 5259 articles from our database search, 3018 articles from grey literature, Google, and reference lists, and 619 articles from our Canadian inequity search, for a total sample of 8896 articles. After duplicates were removed, 7708 articles remained and underwent title and abstract review for relevance. During this stage, we excluded 7690 articles (see Figure 4.2 Flow diagram for search of SDOH literature for exclusion reasons) and retained 115 articles for full-text review. We excluded 7 articles during our full-text review (see Figure 4.2 Flow diagram for search of SDOH literature for exclusion reasons) and retained 108 articles for qualitative synthesis. A summary of our review process is shown in Figure 4.2 Flow diagram for search of SDOH literature (PRISMA).

Figure 4.2 Flow diagram for search of SDOH literature

Records identified through database searching **(n = 5259)**	Additional records identified through other sources **(n = 3018)**

Additional records identified through other sources:
1. Grey Literature: 2943
2. Google: 50
3. Reference searching: 25

Records identified through inequity search, Canadian sample **(n = 619)**

Total records identified from all sources **(n = 8896)**

Duplicates Removed **(n = 1073)**

Records remaining after duplicates removed, that underwent title and abstract screening **(n = 7823)**

Records excluded after title and abstract screening **(n = 7690)**

-No sources cited
-No discussion of SDOH
-SDOH used in analysis only
-No discussion of SDOH
-Not published between 2004-14
-No original information

Articles selected for full-text review **(n = 115)**

Records excluded after full-text review **(n = 7)**

-No in-depth discussion
-No original information

Studies included in qualitative synthesis **(n = 108)**

PRISMA diagram showing search and selection process of literature review.

83

4.4.1.1 Time trends and the impact of the WHO CSDH

Of the full time period considered (1986 to 2014), the most active period in terms of numbers of publications was 2005 to 2009 for grey literature (with 46.9% of included grey literature documents being published during that period) and 2010 to 2014 for academic publications (with 43.4% of included academic publications being published during that period). Time trends are summarized in Table 4.1.

The large numbers of documents appearing in the 2005 to 2009 and 2010 to 2014 periods (relative to the prior periods) likely reflects the momentum of the WHO CSDH, which commenced in 2005 and culminated with its final report in 2008.(17) Many of our included articles used the WHO CSDH to frame their work and/or support its timeliness and relevance.(56-63) Other articles built on the work of the WHO CSDH to contribute to the literature for certain populations, such as articles that discussed SDOH specific to the Métis population, British Columbians, or populations in conflict settings.(64-67) Some articles sought to critique the work or scope of the WHO CSDH,(68, 69) reflect on its process,(70) or respond to its findings.(71) Others simply included the WHO CSDH in their work by adopting its framework and reiterating its goals.(72, 73) Some articles that were published prior to the WHO CSDH report (e.g., in the mid-2000s) highlighted the anticipated contributions of that initiative.(16, 74-76)

Table 4.1 Descriptive characteristics of SDOH literature

Characteristic	All Articles (N=108)		Grey literature* (n= 32)		Academic literature * (n= 76)		Canadian Sample Only (n= 5)	
	No.	%	No	%	No.	%	No.	%
Publication date								
Before 2000	6	5.6	2	6.3	4	5.3	0	0
2000-2004	9	8.3	2	6.3	7	9.2	0	0
2005-2009	45	41.7	15	46.9	30	39.5	2	40.0
2010-2014	43	39.8	10	31.3	33	43.4	3	60.0
No date (webpages)	5	4.6	3	9.4	2	2.6	0	0
First Author Institutional Affiliation								
Academic	76	70.4	0	0	76	100.0	5	100.0
Non-academic	32	29.6	32	100	0	0	0	0
Study Location (derived from first author's location if none specified)								
Canada	57	52.8	23	71.9	33	43.4	5	100.0
United States	20	18.5	2	6.3	18	23.7	0	0
Australia	5	4.6	0	0	5	6.7	0	0
UK	15	13.9	1	3.1	14	18.4	0	0
Germany	2	1.9	0	0	2	2.6	0	0
Spain	2	1.9	0	0	2	2.6	0	0
Sweden	1	0.9	0	0	1	1.3	0	0
Switzerland (WHO)	6	5.6	6	18.8	1	1.3	0	0
Target Audience/End Users								
Academia	14	13.0	0	0	14	18.4	0	0
Public Health Workforce	37	34.3	12	37.5	25	32.9	2	40.0
Policy	45	41.7	18	56.3	27	35.5	1	20.0
Academia and Policy	3	2.8	0	0	3	3.9	1	20.0
Academia and Public Health Workforce	2	1.9	0	0	2	2.6	0	0
Academic, Public Health Workforce, and Policy	1	0.9	0	0	1	1.3	0	0
Public Health Workforce and Policy	6	5.6	2	6.3	4	5.3	1	20.0

*The categories "academic" and "grey" literature were applied to articles during the review phase and do not necessarily reflect the database that returned them. This was done to overcome instances where academic articles appeared in the grey literature.

4.4.1.2 First author institutional affiliation of SDOH literature

We assigned each article a study setting, based on the first author's institutional affiliation. We identified two types of settings: academic (e.g., university professor, fellow, student), and non-academic (e.g., government ministry or department, non-profit organization, or regional health authorities). We recognize that these categories may at times overlap, especially where authors collaborate with co-authors from other institutional settings or where authors have multiple affiliations but publish only under a certain one (e.g., a government employee publishing under their academic affiliation). However, these categories do provide insight into the different sectors involved in producing and contributing to SDOH literature.

The majority of articles in this review (70.4%) were published in an academic setting by authors who were affiliated with health research (Table 4.1). Authors came from a variety of academic disciplines that included health-related disciplines such as public health,(63, 77) population health,(26) nursing,(70) medicine,(78) social work,(79) epidemiology,(80) and social science disciplines, such as sociology,(9, 68) sociomedical or social sciences,(21, 81, 82) geography,(18) governance,(83) social policy,(84) communication,(85) and economics.(22)

The rest of the articles (29.6%) were published by individuals or groups working in or affiliated with government departments and ministries, non-profit or professional organizations, or health authorities (Table 4.1). Some publications were authored by representatives of government organizations, such as the UK National Health Service,(86) Chief Medical Officer of Health,(87) Public Health Agency of Canada,(15) Health Canada,(88) or the United States (US) Department of Health and Human Services.(89) Other articles were authored by professional associations, such as the Canadian Public Health Association,(90) Canadian Nurses Association,(91) Canadian Medical Association,(92) or the Health Officers Council of British

Columbia.(64) Others still were authored by practitioners from health authorities, such as Alberta

Health Services(93), or by members of knowledge translation groups, such as the National

Collaborating Centre for Aboriginal Health.(84)

Overall, the SDOH literature in the context of contemporary PPH is shown to be widely

interdisciplinary and produced by those in both academic and professional/applied settings.

4.4.1.3 Implied target audience of SDOH literature

In most cases, authors were not explicit about their audience of interest. Therefore, for

each article, we identified what seemed to be the implicit target audience, based on the paper's

purpose and recommendations (e.g., to increase understanding of something versus to make

recommendations for government action), and the level of discussion (e.g., plain language versus

complex theoretical concepts). We grouped implicit target audiences into three categories:

academics, policy and decision-makers, and the public health workforce (Table 4.1).

Many of the articles (41.7%) seem to have been written with the intent of reaching policy and

decision-makers (Table 4.1). Most of these came from the academic literature (n=27), though

some came from the grey literature (n=18). An article by O'Campo (2012), for example,

concluded that authors should focus on synthesizing evidence on multilevel determinants of

health and evaluating macro-social policies and programs so the evidence may be of use to

policy makers.(94) Other articles (34.3%) were written for the public health workforce (e.g.,

practitioners, public health physicians, nurses, etc.). One example is the Canadian Nurses

Association backgrounder considering the role for nurses in acting on the SDOH.(91) Articles

were mostly academic (n=25), though some were also from grey literature (n=12).

Finally, some articles (13.0%) appeared to be directed at an academic audience. These

articles all came from the academic literature (n=14). Examples include those written for the

purpose of research methodological clarification (e.g., Regidor's review of measurements of socioeconomic position),(24) or articles that presented theoretical positions (e.g., Link and Phelan's theory of fundamental causes (95) or Tarlov's theoretical work on the sociobiological translation (96)). Many articles were targeted to more than one audience.

4.4.1.4 Geographic setting of SDOH literature

We assigned articles a geographic setting based on the location of the first author's institutional affiliation. Just over half (52.8%) of our included publications were from Canada, followed by the US (18.5%) and the UK (13.9%) (Table 4.1). For the grey literature, an even higher proportion (71.9%) was from Canada. This was true for academic and grey literature, as well as for the studies that came from our search targeting Canadian literature on inequity (i.e., the "Canadian Sample Only" column in Table 4.1). This finding may speak to professor Dennis Raphael's observation that Canada has an international reputation as a 'powerhouse' based its written contributions to health promotion, population health, and the SDOH.(35, 61, 97, 98) However, as Manzano and Raphael (2010) have pointed out, these written contributions have not been accompanied by substantive action, and in fact Canada has increasingly weakened its commitments to improving the SDOH and health equity.(61) The many documents published by Canadian government organizations and scholars perhaps supports the claim that Canada is a document powerhouse that falls short in acting on the SDOH (e.g.,(15, 20, 22, 27-31, 56, 61, 62, 81, 97-101)).

4.4.2 Different ways of presenting and communicating the SDOH

We observed differences in the ways that SDOH were presented and communicated as a list, model, or story. Our purpose is not to evaluate these various approaches but to document their existence, features, and purposes within the literature. While we reflect on the various

approaches, we intentionally do not evaluate them in part due to our inclusion criteria, which prioritized sources that took a more narrative approach to the SDOH.

4.4.2.1 Communicating the SDOH as a list of influential factors

The list approach to organizing and communicating the SDOH has benefits and challenges. One benefit is that lists present information about the SDOH in organized ways that highlight important features to readers. This may facilitate dissemination and widespread understanding, where listed points are clear, concise, and easily reproducible (e.g., make a photocopy to share with colleagues). A challenge of communicating the SDOH in lists, however, is that lists are not exhaustive, as authors must choose what information is included. Additionally, lists may lead to confusion where many versions exist on the same topic (see, for example, Raphael's [2006] article which compares Canadian SDOH lists).(31) Some lists attempt to be as comprehensive as possible within the scope of their work, for example by compiling a glossary to accompany listed terms,(73) while others prioritize certain SDOH over others for different audiences or topics of interest.(34, 74, 80) Additionally, authors do not always state their intentions in compiling SDOH lists, which may have implications for how lists are interpreted. Some lists, for example, may be purposefully organized to list the highest priority SDOH first, while others may be less intentionally compiled (e.g., alphabetical order). Important information may be buried in this case, should readers uncritically skim lists from top to bottom. Alternatively, readers may assign greater importance to the listed elements they read first. To some extent, the above challenges could be addressed if a single list was adopted by authors. Raphael's list SDOH represents one example that has been widely adopted by Canadian authors.(34)

The list approach also presents a potential challenge for communicating the complexity of the SDOH. The SDOH represent much more than a list can convey, such as issues related to how listed SDOH intersect with one another, the social and historical nature of SDOH, or the foundational role of equity. With lists, there is also the drawback of being too inclusive or providing too much breadth to be of practical use. An overly inclusive list does not provide direction, and may direct focus to issues that are at the periphery of the SDOH, perhaps because they are or seem to be the easiest to address. However, lists do serve the needs of many authors, especially those who wish to briefly communicate pertinent elements of the SDOH to their audience. This may be especially true among grey literature publications, for example where SDOH resources are produced to inform practitioners. Academics, on the other hand, may publish as an opportunity to theoretically interrogate or expand upon the SDOH, taking a more narrative approach.

As indicated by its name, the list approach to the SDOH provides a list of factors that influence health. The British Columbia Government, for example, in their 2008 discussion paper on health inequities in the province provides readers with two lists of the SDOH – one noting upstream influences (i.e., macroeconomic policies; culture, ethnicity and values; governance; income and social status; employment and working conditions; education and literacy; and, early childhood development) and the other downstream determinants (i.e., physical built environments; social support networks; social environments; access to effective health care services; risk behaviours; personal health practices and coping skills; gender; and, biological and genetic endowment).(64) The elements of these lists appear to have been purposively chosen to expand to the discussion of policy options for action on the SDOH among a wide range of

audiences (e.g., health professionals, decision makers). We discuss the notions of upstream and downstream interventions in detail later.

4.4.2.2 Communicating the SDOH through conceptual models

The model, or conceptual framework, approach moves beyond a list of SDOH to show (often visually) how various elements interconnect and are experienced at different levels (e.g., societal, community, family, individual) to produce different outcomes (e.g., opportunities, health outcomes, distribution of opportunities). Most models share the idea that health represents a web of social influences.(102) Well-known examples of SDOH models, presented in chronological order, include Evans and Stoddart's (1990) framework, which shows how individual and social factors interact outside of the health care system,(22) Whitehead and Dahlgren's (1991) 'rainbow model' which shows concentric half-circles of influential social factors,(103) and more recently, Solar and Irwin's (2007) conceptual model produced for the WHO that shows the multiple directions through which structural and intermediary determinants impact health and health equity.(104) Lesser known examples include Fox and Meier's (2009) right to development SDOH model (21) and the model for Métis SDOH that shows interrelationships specific to this population (e.g., self-determination, land, colonization).(65) While numerous other models exist, they have been documented elsewhere (e.g., (20, 89, 93, 102, 105, 106)) and will not be reviewed here. A comprehensive and illustrative guide to various models of the SDOH, including those outside the scope of this review, is provided in MacDowell's webpage created for medical students at the University of Ottawa in Canada.(107)

The model approach also brings potential challenges and benefits to communicating the SDOH. They are particularly beneficial in that they depict the influence of social, economic, and political factors at multiple levels. Some models even identify areas where action on the SDOH

91

can be taken.(15, 108) Others serve to illustrate pathways, which are helpful to individuals in understanding the 'how' behind the SDOH. One of the challenges is that they may oversimplify (and thus misrepresent) or overcomplicate (and thus overwhelm) the SDOH. To the extent that models and lists do not resonate with members of the public, for any reason, they may not instill a sense of need or urgency to act (e.g., contact their elected representative on SDOH-related matters), to the detriment of public engagement in public policy decision-making.

4.4.2.3 Communicating the SDOH through stories or narratives

The story, or narrative, approach to communicating the SDOH provides a way to convey feelings or experiences that simply is not possible in lists and models. A well-known example is the Public Health Agency of Canada's narrative that asks the question, "Why is Jason in the hospital?"(109) The story goes on to answer increasingly structural questions about why Jason was in the hospital, had an infection, played in the junk yard, et cetera. Each answer reveals a wider set of social influences on Jason's health. While the story approach did present itself in our review, it was not common. This is likely an artifact of our review methods, which did not include searching specifically for sources aimed at members of the public.

The story approach may fill the emotive void left by list and model approaches, to make the SDOH compelling to audiences. When reading an SDOH narrative, readers may experience feelings relating to luck, privilege, or fairness, and in some cases may even be compelled to act.(110) The story approach may lack the structure required to gain credibility in policy decisions when used on its own, though it may be more effective when used in combination with lists or models in its ability to convey complex information in understandable ways. A good illustration of this combined approach comes from the WHO CSDH final report, which includes a list (three overarching recommendations for action: [1] improve the conditions of daily life; [2]

tackle the inequitable distribution of power, money and resources; and [3] measure and understand the problem and assess the impact of action (17)); a conceptual framework, or model, of the SDOH, which allows readers to visualize how certain factors work together to influence health; and a story: the report itself is written in a way that crafts a compelling narrative, such as its use of case examples and personalization (e.g., "Social injustice is killing people on a grand scale."(17, p26).

4.4.2.4 Epistemological differences in presenting the SDOH

The different ways of presenting the SDOH may align with the different epistemologies that underlie the literature. Ashcroft (2010) identifies objectivism, constructionism, and subjectivism as epistemologies present within the SDOH paradigm.(79) Objectivism was predominantly visible in articles that used statistical methods to explore and quantify the relationship between health and SDOH, where knowledge was produced in the context of epidemiology and population health.(79) Some examples include Regidor's (2006) review of methods measuring socioeconomic position (24) and Gustafsson et al.'s (2014) quantitative analysis of the life-course accumulation of neighbourhood disadvantage and allostatic load.(78) There were also examples of a constructivist paradigm apparent in this review, where articles sought to present an understanding of the SDOH based on knowledge they had collected from the experiences of others. In their interviews with Medical Officers of Health and public health unit staff, Raphael, Brassolotto, and Baldeo (2014), for example, showed how public health professionals perceived the SDOH and how their role in acting on them differed, depending on whether or not their public health unit supported activities beyond traditional public health services or programs (e.g., vaccination, health education), such as advocacy on issues like hunger or poverty, or raising public awareness of the SDOH.(30) Finally, examples of subjectivism from

this review are apparent in the articles that incorporated Aboriginal understandings and experiences of SDOH, through recognition of important influential factors such as the dispossession of land, cultural resilience, self-determination, and legacy of residential schools.(18, 65, 84, 108, 111-113)

We did not explore the literature with the explicit intent of discerning epistemologies, which limits our ability to comment on the extent to which different ones were used. However, in considering our sample at face value one thought is that academic authors may adopt more objectivist or constructivist epistemologies compared to non-academics, perhaps drawing on or developing their own conceptual models or frameworks to present their findings. This seems likely considering that non-academic authors may wish to convey the SDOH in ways more relatable and easily understood by a general audience or the public, and therefore may adopt more constructivist or subjectivist epistemologies through using lists and narratives.

4.4.3 Health equity: A key theme of the SDOH

One theme emerged prominently during our analysis: health equity as an overarching theme and binding concept for the SDOH. We furthermore found that this binding concept of health equity was conceptualized in different ways, which align with more 'upstream' and 'downstream' orientations. We describe this observation in more detail below.

4.4.3.1 Health equity as a binding concept for the SDOH

The concept of health equity, which refers to a socially just state wherein all members of a population have access to the best available opportunities for health,(55) frequently appeared as an essential element in the SDOH. Health inequity, accordingly, refers to unfair and avoidable differences in health between population groups that reflect inequitable access to those

opportunities.(17) Health equity and inequity are considered the socially produced results of systematic societal processes that contribute to distribution of resources.(114)

In the literature reviewed here, health equity was predominantly used when discussing the structural or societal-level changes needed to improve health. Studies also referred to health equity when making ethical claims (e.g., health equity as a normative concept, where a fair society is explicitly valued),(104) when discussing approaches to intervene on the SDOH (e.g., taking a targeted approach to intervention, that focuses on those living in disadvantaged circumstances),(115) and when discussing causes of ill health between social groups.(66)

Quantitative content analysis of all sources revealed the frequency of use of the above terms. Equity terms (equity, inequity, inequities) were used in 77.8% of articles (n=84). These terms were employed most frequently in WHO-related documents; namely, the WHO CSDH final report and documents that referenced this report. Other papers that frequently used the term health equity included a sociological commentary on health equity,(68) an Alberta Health Services publication on social environments and health,(93) and a paper produced by a private organization regarding the SDOH agenda in Canada.(116) Terms related to equality (equality, inequality, inequalities) were used in 79.6% of articles (n=86). Equality terms were used most frequently in two articles by Graham, in her writings on the SDOH in the context of UK government policy.(60, 102) Others included a research article comparing welfare state regimes,(81) and a commentary reviewing key tenets of the WHO CSDH.(117) The frequency of use for these terms is further broken down in Table 4.2.

Table 4.2 Counts of key terms used in the SDOH literature

Key Term	No. (N=108)	%
Equity, inequity, or inequities	84	77.8
Equity	76	70.4
Inequity or inequities	69	63.9
Equality, inequality, or inequalities	86	79.6
Equality	20	18.5
Inequality or inequalities	85	78.7
Social gradient	40	37.0
Social hierarchy	32	29.6
Social ladder	10	9.3
Social position	61	56.5

Related to health equity and inequity are the terms equality and inequality. Equality and inequality also refer to differences in health as present or absent, but do not carry the same moral undertones as equity and inequity.(114) They allow health differences to be acknowledged and discussed without necessarily adopting ethical or normative claims about what is fair and avoidable. As shown in Table 4.2, the terms (in)equity and (in)equality appeared with similar frequency. This may simply reflect that the terms are used interchangeably.(118) Alternatively, (in)equality may be intentionally employed to avoid the implications associated with the reasons for differences in health, from an SDOH point of view. Such strategic use of terms may be especially true for studies published by authors within organizations where there may be real or perceived consequences of associating SDOH-related differences as unfair (i.e., bearing political critique).(27) Finally, the use of (in)equity over (in)equality and vice versa may reflect differences in how understandings of the SDOH are conceptualized and how they operationalize different means of action (e.g., policy change, targeted health services). We expand on this third reason below.

4.4.3.2 The social gradient in health: A key concept of the SDOH

Another key concept we observed as prominent in the literature reviewed is the social gradient in health, which refers to the stepwise relationship between health and social position.(80, 119) According to the social gradient, which "runs right across society" health status is influenced by an individual's position in the social hierarchy, which itself is influenced by social, political, and economic circumstances.(80, 119)

The social gradient in health appeared in various forms in the literature that we reviewed. For example, some articles attempted to quantify the social gradient (e.g., by measuring the relationship of occupational class and health).(80) Other articles included discussion on the chances individuals had to achieve good health.(111) Finally, some articles contained content that aligned strongly with the concept of the social gradient in health but using different language – a good example is the theory of fundamental causes (i.e., that the association between health and social status endures due to the access one has to fundamental, health protecting resources such as money, knowledge, and power).(95)

To further interrogate the use of the social gradient in health in the literature, we conducted a quantitative content analysis of the social gradient in health and related terms. As shown in Table 4.2, 'social gradient' was used in 37% of our articles (n=40); 'social hierarchy' was used in 29.6% of articles (n=32); 'social position' was used in 56.5% (n=61); and, 'social ladder' was used in 9.3% (n=10). These findings suggest the wide use of this concept.

4.4.4 Conceptualizations of action on the SDOH towards health equity

While health equity was a common element of the literature we reviewed, (e.g., (17, 111, 120)), it was conceptualized in different ways. To describe the different conceptualizations, we draw on the concepts of upstream and downstream as well as the work of Graham (2004) (118)

and Whitehead (2007).(121) Graham (2004), identifies the three policy approaches to tackling health inequalities: (1) remedy health disadvantage by improving the health of poor groups (e.g., policies that target poor groups); (2) narrow health gaps by improving the health of poor groups relative to other population groups (e.g., policies that improve the health of poor groups faster than other groups); and (3) reduce health gradients by tackling the root causes of illness (e.g., policies that redistribute wealth).(118) Whitehead (2007) provides an alternate but complementary typology for actions to reduce health inequalities, where she categorizes the aims of policies or interventions as: (1) strengthening individuals (e.g., health information campaigns or life skill groups); (2) strengthening communities (e.g., building neighbourhood meeting spaces to facilitate social inclusion); (3) improving living and working conditions (e.g., improving access to adequate housing); (4) promoting healthy macro-policies (e.g., ensuring healthy labour market policies).(121) Both typologies inform our discussion of 'upstream' and 'downstream' interventions on the SDOH.

Briefly, upstream interventions seek to diminish the 'causes-of-the-causes' of illness by acting on structural determinants of health that distribute wealth, power, and opportunities at the policy level.(23) According to the Nuffield Council on Bioethics' 'intervention ladder,' which suggests that public health interventions affect people's choices in more and less intrusive ways requiring more or less justification, policy interventions tend to occur higher up on the ladder (e.g., eliminate, restrict, or guide choice through incentives or disincentives).(122) Downstream interventions, on the other hand, act on the 'effects of causes' of illness by attempting to meet the immediate needs of individuals and families by improving their access to health and social services.(23) Often, downstream interventions focus on meeting the needs of certain population groups that face adverse health outcomes. On the ladder of intervention, downstream

interventions tend to occupy lower rungs (e.g., enable choice, provide information, do nothing).(122)

Because the social gradient in health pertains to entire populations, it highlights the need for interventions that will tackle the distribution of health determinants.(118) As Graham (2004) explains, such interventions would involve structural-level policies (e.g., availability of housing for a range of incomes and life circumstances) that equalize life chances.(118) According to Whitehead's (2007) typology for action on the SDOH, this is achieved through 'upstream' actions that aim to improve living and working conditions at a societal level, or by promoting macro-policies that address the SDOH at a structural level.(121) Graham's reducing health gradients approach, and Whitehead's category 4, align closely with the WHO CSDH's recommendation to "tackle the inequitable distribution of power, money, and resources" through strengthening governance and the public sector, ensuring an accountable private sector, and leveraging health equity and collective action as issues of importance to the general public.(17, p2)

4.4.4.1 Upstream action on the SDOH

Much of the literature that we reviewed supported an upstream approach to health equity by reducing gradients and promoting healthy macro-level policies. A major emphasis among articles supporting a gradient approach was the recognition that a collaborative and integrative approach would be necessary. Some articles called for greater collaboration between disciplines, departments, or sectors (e.g., academic disciplines, government departments, public/private).(15, 17, 22, 26, 63, 74, 89, 93, 116, 123, 124) Others encouraged a 'whole-of-society' approach where citizens would mobilize themselves to bring change to societal conditions in ways that

facilitate health equity, at times transcending the health sector to areas such as education, social welfare, food and drug administration, et cetera.(17, 20, 26, 70, 77, 87, 96, 116)

A good illustration of the gradient and a healthy macro-policy approach to acting on the SDOH is Brennenstuhl et al.'s (2012) systematic review of welfare regimes and population health inequalities.(125) The authors found that a social democratic approach to governance, whereby social and economic interventions that support equality are implemented within a capitalist framework, with policies such as generous pensions, fostered population health and health equity (e.g., lower infant mortality rate).(125) It is important to note that empirical evaluative research on this social democratic approach to governance is limited.

While upstream, gradient, and healthy macro-social policy approaches seem desirable for their ability to address the root causes of health inequities and act on multiple SDOH across sectors,(17) they have also been subject to criticism. Popay et al. (1998), for instance, reviews three critiques of quantitative research on inequalities in health: (1) they may lack explanatory power in linking agency and structure relating to health inequalities, in the context of social structures, (2) macrosocial frameworks may fail to address complexities in explaining the causes of health inequalities, and, (3) the notion of place, as defined in macrosocial explanatory models, has not been conceptualized in its social and historical contexts (e.g., class, living place, gender, age, et cetera).(126) The critical population health research perspective, which "requires asking more critical questions about the social and economic causes and consequences of health inequalities…"(127, p1576) appears to have been one response these critiques that has gained momentum in recent research on SDOH (e.g., Richmond and Ross 2009; Labonté, Polanyi, Muhajarine, et al. 2005).(2, 18)

4.4.4.2 Action on the SDOH further downstream

In other articles, action on the SDOH was understood with reference to specific subgroups facing social disadvantage. This approach to 'tackling health inequalities') can be considered more 'downstream.'(102) That is, rather than addressing the wider structural (i.e., social, political, economic) influences that shape the distribution of health determinants, this approach focused more on meeting the immediate needs of individuals adversely affected by health inequality, such as by increasing access to services.(102) This conceptualization aligns with the 'remedying health disadvantages' approach presented in Graham's (2004) typology of tackling health inequalities.(118) and to approaches that, according to Whitehead (2007), involve attempts to strengthen individuals (category 1) or communities (category 2) characterized by socio-economic disadvantage, for example by developing the life skills of or building social cohesion in these communities.(121) As Graham (2004) notes, one drawback of a remedying health disadvantages approach is that it may narrow the scope of potential policy solutions to those that focus on individuals experiencing social disadvantage (i.e., a targeted approach), which may be less effective if action on broader determinants that create social disadvantage is not considered.(118) Furthermore, intervention approaches that are confined to sub-groups (i.e., 'those at the bottom'), may bring negative effects to other groups, such as the potential stigmatization that may occur when publicly identifying a vulnerable group for the purpose of intervention.(118)

In some cases, as noted by Frohlich et al. (2006), an approach focusing on disadvantaged sub-populations is necessary where certain groups may require special attention at the community level so not to be adversely affected by certain policies.(112, 128) As some authors, including Graham, have acknowledged, there is a strong moral basis for tackling health

101

inequalities at this level (especially in wealthy nations) so that those at the bottom are not denied

of their basic needs or the average standard of living enjoyed by the majority of the

population.(118) In certain circumstances (e.g., where people experience ill health or disability

as the result of social, political, and economic inequalities), it may be necessary to focus on

improving the health of those most disadvantaged so they do not fall further behind the rest of

the population. The notion of *proportionate universalism* has been put forth to recognize the

challenges posed by population-level interventions for certain groups.(129-131) The idea behind

proportionate universalism, as stated in *Fair Society, Healthy Lives: The Marmot Review*, is, "To

reduce the steepness of the social gradient in health, actions must be universal, but with a scale

and intensity that is proportionate to the level of disadvantage."(129)

While proportionate universalism was not prominent in our target literature (which makes

sense considering its recency), we found that targeted and downstream approaches to health

equity and the SDOH were prevalent in the literature. In many cases this reflected the

professional scope of the authors. The Canadian Nurses Association, for example, put forth an

idea for how individual nursing practice could act on the SDOH, by asking patients certain

questions (e.g., their circumstances relating to income or housing), considering whether patients

have access to health resources or recommended medical treatments, or knowing available

community resources that could assist their clients.(91) Other articles spoke of physicians'

"ethical duty to their patients" to act on the SDOH,(92) or the need for physicians to "be the

natural attorneys of the disadvantaged."(132, p2094)

A similar trend towards targeted and downstream approaches to action on the SDOH was

found in literature reporting on the public health workforce. McIntyre et al.'s (2013) focus group

with individuals who were affiliated with Canadian public health, for example, found that many

participants were too preoccupied with behavioural and lifestyle approaches (e.g., diet, exercise), to attempt action at broader levels that may tackle wider spheres of influence on the determinants of health (e.g., neighbourhood, environment).(133) This may in part reflect challenges identified by Raphael et al. (2014) in their work with public health units, where participants identified that they "act where [they] think that there's some prospect of actually changing something"; namely, through the provision of downstream services and programs.(29) In a related paper by Raphael's group, Brassolotto et al. (2014) found that public health practitioners predominantly considered the SDOH as things to be mindful of in practice but that occurred outside the scope of their work.(27, 30) One participant stated that, "It may be emotionally satisfying to think that we can go out and restructure Canadian society. It's self-indulgent, in my opinion, and it's not the business we're in."(27, p329) Finally, in a paper contemplating how social theory could be integrated into public health practice Potvin et al. (2005) found that public health practitioners in Canada faced difficulties acting on the SDOH because of the bureaucratic nature of their practice and its lack of instruments to implement innovative practices.(134)

An emphasis on downstream approaches to remedying health inequities may also be apparent in academic scholarship. Raphael and Bryant (2015) have asserted that, aside from a handful of critical scholars, academics predominantly do not write about action on the SDOH in ways that focus on upstream, macrosocial factors in their research.(135) Unlike the public health practitioners who face potential consequences in their place of employment, however, these authors state that "the academics don't have that excuse […] especially the tenured ones."(135)

In summary, in the literature reviewed we identified that though health equity is a common, binding concept in the SDOH, there are different ways in its conceptualization. These differences have implications for approaches to action, which range from a more upstream,

structural approach that considers the social gradient as well as the determinants and processes that distribute resources across the population, to a more downstream, community or individual-level approach that focuses on social or behavioural factors operating within specific groups (sometimes, but importantly not always, these social and behavioral factors are considered discretely or in isolation). The different approaches do not appear to have been strongly reconciled.

4.5 Limitations

The main limitations of this scoping review are threefold. First, our internet (Google) search for SDOH literature was conducted from a Canadian Internet Protocol address, which may have returned results specific to our geographic setting (Canada) and thus inflated the estimates of Canadian content. This may represent Canada's 'policy strong' reputation on the SDOH that exists in writing, but not in its government's actions, as noted earlier. Future work may consider comparing how grey literature on the SDOH in other countries differs from that produced in Canada. Another facet of this limitation is that our search for grey literature utilized Canadian databases (i.e., Canadian Research Index, Canadian Health Research Collection), which potentially over-represented literature from this setting. However, the academic literature revealed similar proportions as found for grey literature (i.e., Canada, followed by United States and United Kingdom), which suggests this may not be the case. As well, despite this limitation, our inclusion of grey literature still adds novelty and merit to existing literature reviews on the SDOH.

Second, our search included "social determinants of health" as a search term. To the extent that other countries or disciplines discuss the concept of SDOH using different language (e.g., 'social factors' instead of social determinants), we may have missed important content. Our

104

use of "public health," "population health," and "health promotion" and searching different disciplinary databases should have offset this limitation to some extent. Furthermore, we attempted to address this limitation through our iterative and nuanced approach to the search (i.e., not simply relying on the presence/absence of terms, see Figure 4.1), which we argued was essential for this literature because of its somewhat diffuse and jargonized nature.

4.6 Conclusion

In this scoping review, we set out to take stock of and synthesize SDOH literature in the contemporary context of population and public health. Our main conclusions are threefold. First, most of the literature has been published in the last decade (2005-2009), in academic settings, with the intent of reaching policy makers. This likely reflects the impact of the WHO CSDH on the population and public health community. Just over half of the literature came from Canadian sources. Second, the SDOH were communicated in three ways as a list, conceptual model or framework, or narrative or story. Each form of communication appears to have met the needs of different authors and audiences. To some extent, these forms of communicating the SDOH may have aligned with the epistemologies of objectivism, constructivism, and subjectivism. Third, we identified health equity as a binding concept and overarching theme of the SDOH. In part, this was observed in the literature through the frequent use of key terms related to health equity, such as the social gradient in health. We also found that different ways of achieving health equity, through action on the SDOH, were conceptualized as more upstream or downstream in nature. Overall, we found that the current literature did not unanimously adopt the language of health equity when presenting and discussing the SDOH. We suggest that intentional articulation of the SDOH in this way by authors may help unify the message that the SDOH are fundamentally about health equity.

This review has identified a literature gap for articles published from countries outside the global north. Very few authors were situated in developing or poor countries, which limits our understanding of the SDOH at a global level and the transferability of our findings. This is especially important considering that recent work by the WHO has called for the global redistribution of resources to achieve health equity worldwide.(17) It is imperative that countries adversely affected by international decisions regarding the distribution of economic resources have a seat at the table with the countries holding social, economic, and political power; this is important in recognition of global justice and fairness in relations between wealthy and poor nations. We encourage future contributions to the SDOH literature from those working in PPH in developing nations.

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Chapter Five: They are not my Problem: A Content and Framing Analysis of References to the Social Determinants of Health within Canadian News Media, 1993–2014

5.1 Abstract

As public support is essential for implementing policies that act on the underlying social determinants of health (SDOH), it is important to consider how the public is exposed to this issue. This article explores how the SDOH have been represented in Canadian news media articles from 1993 to 2014. Of the 113 articles that explicitly included SDOH, housing (12.9%), income (10.5%), and poverty (9.3%) were most frequently reported. Over time, the reporting of SDOH increased, with peaks of coverage occurring at different times for different determinants (e.g., housing in 2005, income in 2009). A framing analysis revealed that the SDOH are presented in multiple ways: as an actionable issue and responsibility of government, a moral responsibility, and—problematically—as an issue that only affects disadvantaged groups.

5.1.1 Keywords

5.2 Résumé

L'appui du public est essentiel pour mettre en oeuvre des politiques portant sur les déterminants sociaux de la santé (DSS). Il est donc important de tenir compte de la manière dont on informe le public sur cette question. Cet article explore comment des articles parus dans des journaux canadiens ont représenté les DSS de 1993 à 2014. Dans les 113 articles se rapportant explicitement aux DSS, les trois thèmes suivants étaient prédominants : logement (12,9%), revenu (10,5%) et pauvreté (9,3%). Au fil du temps, le nombre d'articles sur les DSS a augmenté, atteignant des sommets à des moments différents pour des thèmes différents (par exemple, logement en 2005, revenu en 2009). Une analyse des cadres a montré que les médias

représentent les DSS de manières diverses : en tant que question recevable et responsabilité du gouvernement, en tant que responsabilité morale et—de manière problématique—en tant que problème qui touche seulement les groupes défavorisés.

5.2.1 Mots clés

Déterminants sociaux de la santé; Analyse de contenu; Analyse des cadres; Journaux; Inégalités en santé.

5.3 Introduction

The social determinants of health (SDOH) refer to the complex set of political, social, and economic forces (e.g., employment, gender, income) that shape the conditions we are born into, grow, live, work, and age in.(1, 2) These conditions shape the health of individuals, communities, and jurisdictions through the distribution of wealth, power, and resources.(1)

As predictors of health at both the population and individual level, the SDOH are not only a foundational concept to population and public health but also a matter of public importance.(1, 3, 4) Despite numerous public policy documents (see Note 1) that have drawn attention to the SDOH in Canada over the last 30 years, the general public remains relatively unaware of and uninformed about the SDOH and their importance to health.(1) The findings of geographer John Eyles and colleagues Michael Brimacombe, Paul Chaulk, Greg Stoddart, Tina Pranger, and Olive Moase (2001) from their survey of Prince Edward Island health practitioners and the general public support this claim.(5) The authors (2001) found that respondents from the general public deemed personal health practices and formal health care as the most important factors to health and SDOH (e.g., income and employment) among those least important.(5) Similarly, nutrition scholar Judy Paisley and colleagues Corina Midgett, Glenn Brunetti, and Helen Tomasik (2001) found that residents of Hamilton-Wentworth, Ontario, most frequently

identified smoking and poor diet as risk factors for cardiovascular disease, despite the strength of

the association shown with SDOH, such as income inequality.(6, 7) Findings from the 2003

Canadian Population Health Initiative survey on public views of the SDOH also found that 65 to

80 percent of participants reported personal behaviours (e.g., smoking, eating, exercise) as most

influential to health.(8) Even when prompted about the SDOH, only a third of participants

reported the influence of social and economic conditions.(8)

Dennis Raphael (2009), professor of health policy and risk management, has claimed that

the general public is "woefully uninformed" (1, p85) about the SDOH, which he attributed in

part to the biomedical and lifestyle discourses that pervade mass media. As social geographer

Michael Hayes and colleagues Ian Ross, Mike Gasher, Donald Gustein, James Dunn, and Robert

Hackett (2007) found in their media analysis of Canadian national newspapers, only about 5

percent of all stories (n=4732) reported broader, social influences of health, despite 65 percent of

articles covering health.(9) Likewise, a 2003 media monitoring study of health coverage in

national, provincial, and territorial newspapers (commissioned by the CIHI) found that 30

percent of all articles (n=1467) reported on personal health behaviours, while just 14 percent

reported on social determinants [i.e., childhood 7% and employment 7%].(8) A multimedia

analysis of print, television, wire, and radio sources conducted found similar results.(10) The

authors found that of all health discourses reported from 1999 to 2003, SDOH (e.g., culture,

poverty, gender) accounted for just 3.6 percent of media coverage per year.(10) An American

study similarly found that among news articles reporting on type 2 diabetes (n=698), only 11.6

percent reported on the condition's SDOH.(11)

Aside from media coverage of the SDOH, media reportage (i.e., the act or process of

covering/reporting news) is another area where these conditions may be underrepresented or

their importance underappreciated. News geographer and communications scholar Mike Gasher and colleagues (2007) discovered through interviews with Canadian health reporters that they prioritized issues of healthcare, individual-level behaviours, and personal health habits in their work, despite the dedication to the SDOH concept they had conveyed to the interviewer.(12) Gasher et al (2007) related these findings to the work of Lawrence Wallack (1990), a professor who studies how public health is socially valued and framed by the public. Wallack (1990) noted that mass media reinforced individual-level explanations of health and disease, which trivialized the complex and systemic processes that produce health.(13)

While attention has been paid to the coverage of SDOH in news media,(11, 14-16) and its framing,(17-19) there remains a need to consider how these operate in various settings over time. The purpose of this article is to explore how the SDOH have been represented in Canadian news media articles from 1993 to 2014. Specific research questions included: (a) when were the SDOH first reported?; (b) which SDOH are most frequently reported?; (c) how has coverage of the SDOH changed over time?; (d) how are messages of the SDOH communicated to the public?; and (e) how are reports of the SDOH framed?

This article contributes to the academic literature an overview of how SDOH-related messages are communicated to the public. This can be used to inform researchers, practitioners, and decision-makers of the extent to which their intended messages are reaching public audiences and identify areas where further attention or improvement is needed. This article comes at a time when those working in population and public health have increasingly identified the need to effectively communicate SDOH-related messages to the general public (e.g., (20-22)).

5.4 Methods

Content analysis was used to answer research questions (a–d) for qualitative document analysis as follows: (1) document and identify the research problem; (2) develop a protocol and collect data; (3) code and organize data; (4) analyze data; and (5) report findings.(23) The findings from this content analysis (i.e., the codes and categories generated) were used to inform a framing analysis of the SDOH in news media reports, to answer research question (e).

Framing analysis was conducted according to the definition and function of frames identified by Entman (1993):

> to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described.(24, p52; italics removed)

The frame for this analysis was identified through rereading and constant comparison of articles, and by considering the broad themes that emerged through content analysis relating to the issues reported (e.g., the SDOH require action), the causes diagnosed to them (e.g., government cuts to healthcare spending), the moral judgments they made (e.g., inaction on SDOH is "wrong"), and their proposed solutions (e.g., poverty reduction strategy).

5.4.1 Sampling

Data was collected from the ProQuest Database, Canadian Newsstand Complete, by searching for the terms: "social determinants of health" or "social factors of health" or "social elements of health" or "social determinants" or "social aspect* of health" or "social NEAR/2 health." This search returned 860 results from 100 newspapers within the time period of 1985 to 2014. Before placing any parameters on these results, the five earliest articles were included and analyzed specifically to inform research question (a).

Study results were limited to the 25 most widely circulated English-language Canadian national newspapers; 12 (see Note 2) of these newspapers returned results. This reduced the sample to 194 articles, including the earliest five previously included. Eleven articles were removed because they did not report on the social determinants of health (four articles) or were not news articles (four book reviews; two event listings; one introduction to a series of columns). The remaining 183 articles were coded according to predetermined categories for content analysis (e.g., SDOH identified, year published, newspaper title) and framing analysis (see above). As common elements in the data became apparent, additional codes and themes were constructed to accommodate them (e.g., medicalization). NVivo qualitative analysis software was used to assist with data organization and coding.(25)

Where "clusters" of articles (i.e., three or more unique or similar stories that run in different newspapers within a short time period) appeared, they were considered as individually unique articles. They were treated in this way because an early reading of the data identified that some articles reported relevant differences; specifically, where the article elaborated on the SDOH that were reported in its clustered counterpart (e.g., (26, 27)).

5.5 Results

5.5.1 When were the SDOH first reported?

Reports of the SDOH first emerged as a cluster of articles (n = 4) published May 21 and 22, 1993, which covered a health policy conference put on by McMaster University.(28-31) Specifically, the articles reported on a keynote address delivered by Dr. Sol Levine (1922–1996), a medical sociologist and professor of health behaviour at the Harvard School of Public Health. Levine observed that, "health increases with every rung up the social ladder" (28, pB3) and used the example of income linked with chronic and degenerative diseases (e.g., cancer, hypertension,

119

and Alzheimer's) to illustrate his point. In addition to income, the reporters listed social support, stress, family, where we live, and flexibility on the job as examples of SDOH in their articles.

All four of these articles reported on Levine's identification of government accountability and responsibility for improving public health through action on the SDOH. Three articles from this cluster reported this key message verbatim, by writing that: "If we cared about health, we would not blindly accept the social structures in which we live."(28, pB3, 30, pA7, p. D17, 31, pD17)

5.5.2 Which SDOH are most frequently reported?

Of all articles analyzed (n=183), 113 (63.8%) reported and named specific SDOH. Over the course of 1993 to 2014, SDOH were reported a total 418 times. The determinants most frequently reported were housing (12.9%), income (10.5%), education (10.5%), poverty (9.3%), and food insecurity (5.9%). Less frequently reported SDOH were control over aspects of one's life (1.4%), childcare (1.4%), culture (1%), disability (2.2%), drug or alcohol abuse (1.6%), early childhood (2.6%), ethnicity and race (3.1%), family (2.2%), gender (1.2%), inequity and inequality (2.9%), homelessness (1.4%), health services (1.7%), neighbourhood (2.6%), social support (2.6%), socioeconomic status (2.4%), and welfare (2.2%).

An additional 28 items were reported as SDOH but were reported too broadly (i.e., without specification of how the determinant linked to health) or too infrequently (<2 reports) to represent an SDOH group and were therefore labelled as "other." These included factors such as: risky health behaviours (unspecified); sedentary-promoting commodities (e.g., computer games, automobiles); access to legal assistance; economy or economic aspects (unspecified); language barriers; public policies and politics; public security and safety; self-esteem; sexuality; social aspects (unspecified); stress; transit; school curriculum (e.g., nutrition, sex education); exercise;

120

free time; and, history of emotional, domestic, or sexual abuse. A summary of frequently

reported SDOH is shown in Table 5.1.

Table 5.1 Distribution of social determinants of health, where reported

	No. of times reported in news media (percent)	Terms included
Childcare	6 (1.4)	Subsidized day care, childhood care
Control	6 (1.4)	Coercion, exclusion from the decision-making process, having control over decisions in your life, lack of human rights, sense of control over life
Culture	4 (1)	Cultural beliefs
Disability	9 (2.2)	Anxiety disorder, being unable to work, mental illness, chronic health conditions
Drug and Alcohol Abuse	7 (1.6)	Drug addiction, alcohol addiction, alcohol abuse, misuse of cannabis, drug abuse
Early Childhood	11 (2.6)	Early childhood education and programs, lack of stimulation before the age of five, suboptimal early childhood experiences, child(hood) poverty, adequate child welfare
Education	44 (10.5)	Access to education, education level, inadequate education, lack of education, poor education, educational funds, literacy, illiteracy, literacy rate
Employment	24 (5.7)	Access to employment, adequacy of employment, low levels of employment, good job, seasonal job security, part-time job security, jobs, flexibility on the job, stress on the job, unfavourable work conditions, unsafe work/working conditions
Environment	18 (4.3)	(Lack of) clean water, sanitation, cleanliness of air and water, environmental aspects, (levels of) pollution
Ethnicity and Race	13 (3.1)	Race, racism, privilege of being born in Canada, Aboriginal history of trauma, colonization, and oppression, disenfranchisement
Family	9 (2.2)	Illness to family structure, family support, (poor)/parenting, having parents around, spouse
Food Insecurity	25 (5.9)	(Lack of) access to fresh produce/healthy foods, adequate nourishment, (good)/nutrition, (unhealthy)/diet, (lack of)/healthy food, food security, hunger
Gender	5 (1.2)	Gender equity, gender inequity
Healthcare	7 (1.7)	Access to advanced technology, access to doctors, healthcare, access to health services
Homelessness	6 (1.4)	Homeless
Housing	54 (12.9)	Adequate housing, affordable housing, bad housing, good housing, inadequate housing, insecure housing, low-cost housing, poor housing, living conditions (crowded, overcrowded, overcrowding)
Income	44 (10.5)	Income adequacy, adequate income, economic inactivity, economic security, family income, income gradient, income level, personal finances, secure income, income security, wealth, economic insecurity, (lack of) living wage, minimum wage, low income, savings in the bank
Inequity and Inequality	12 (2.9)	Economic inequality, health (in)/equity, inequities (unspecified), social injustice, economic inequity, social inequity, social inequality, health inequality

Table 5.1 Distribution of social determinants of health, where reported (continued)

	No. of times reported in news media (percent)	Terms included
Neighbourhood	11 (2.6)	City design, nearby pollutant-causing firm, nearby chemical factories, geography, nearby industries, remote living, walkability, where people are living, urban polarization
Other	34 (8.1)	Access to legal assistance, automobile, behaviours (unspecified), computer games, domestic abuse, economic aspects (unspecified), economics (unspecified), economy, exercise, free time, history of emotional or sexual abuse, insecurity (unspecified), language, policies (unspecified), politics, public security, related behaviours, safety, school curriculum, self-esteem, sexuality, social aspects (unspecified), social factors (unspecified), stress, success addiction, transit, and violence in relationships
Poverty	39 (9.3)	Poverty
Social Support	11 (2.6)	Having people who love you around, supportive friends, community programs, community support programs, job retraining programs, positive friendship network, social isolation, strength of community, social participation, social exclusion, social participation, social isolation
Socioeconomic Status	10 (2.4)	Economic status, social class, social status
Welfare and Social Services	9 (2.2)	Income support, job/employment support, social assistance, social services, adequate welfare support

Where explicitly identified or listed, the SDOH were reported in 209 unique ways, which are provided in a condensed format in the "Terms included" column of Table 5.1. Reports of SDOH varied widely, from individual-level behaviours such as diet, exercise, or cannabis use, to community-level influences such as community support programs or network of positive friends, to even broader, societal-level influencers such as poor public policy or public security. These vast differences among the different SDOH reported reflect the complex and widespread influence of the SDOH and the many levels at which they influence health.(2)

5.5.3 How has coverage of the SDOH changed over time?

Figure 5.1 illustrates the distribution over time of the five most frequently reported SDOH, among articles that explicitly reported them (n=113). As shown in the figure, there was

increasing news media coverage of these SDOH from 1993 to 2014. For example, where housing

was reported, it ranged from its lowest coverage in 1993 (n=0) to its highest in 2005 (n=8). As

another example, coverage for income ranged from its lowest in 1993 (n=0) to its highest in 2013

(n=9).

Figure 5.1 Distribution of main SDOH reported in Canadian news media, 1993 to 2014
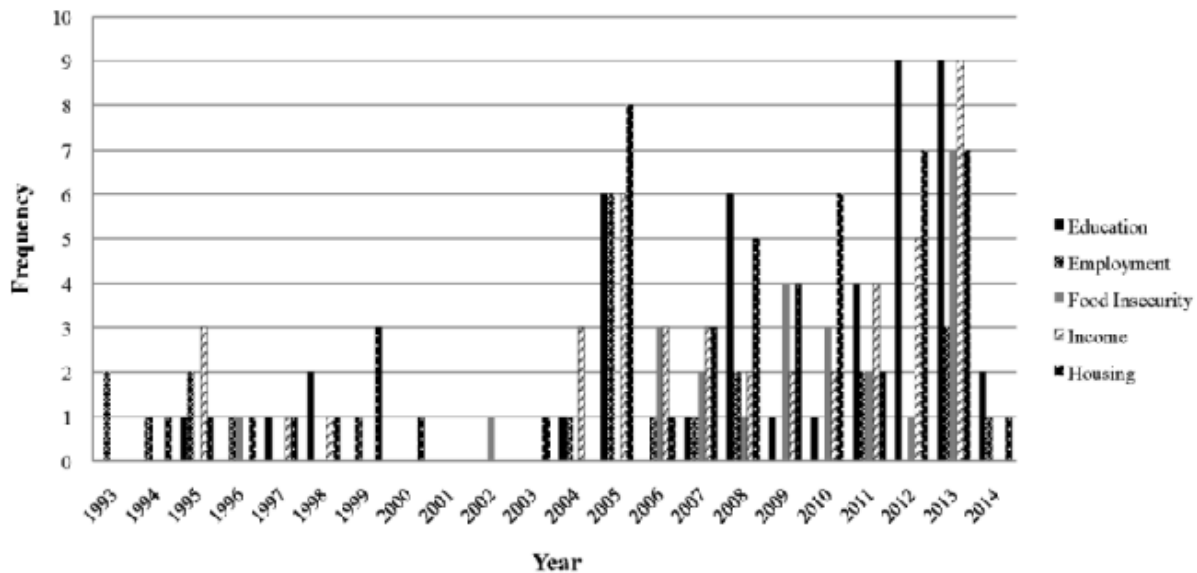
Figure 5.2 shows the distribution of all media articles included in this study (n=183).

Articles reporting on the SDOH were least frequent in 2003 (n=0) and most frequent in 2013

(n = 36). A number of spikes in coverage (shown as a marked increase in Figure 5.2) occurred in

the following years: 1993 (n=4), 2001 (n=5), 2004 (n=5), and 2005 (n=12). After 2005, the

average number of articles reporting on SDOH grew substantially, with an average of 16 articles

reported per year between 2006 and 2014. As shown by the increasing trend line in Figure 5.2,

and the more frequent spikes in coverage (i.e., 2008, n=13; 2010, n=20; 2012, n=30; 2013, n=36)

media coverage of the SDOH is shown to have risen fairly steadily since 1993.

Figure 5.2 Distribution of articles reporting on SDOH, by year, 1993 to 2014
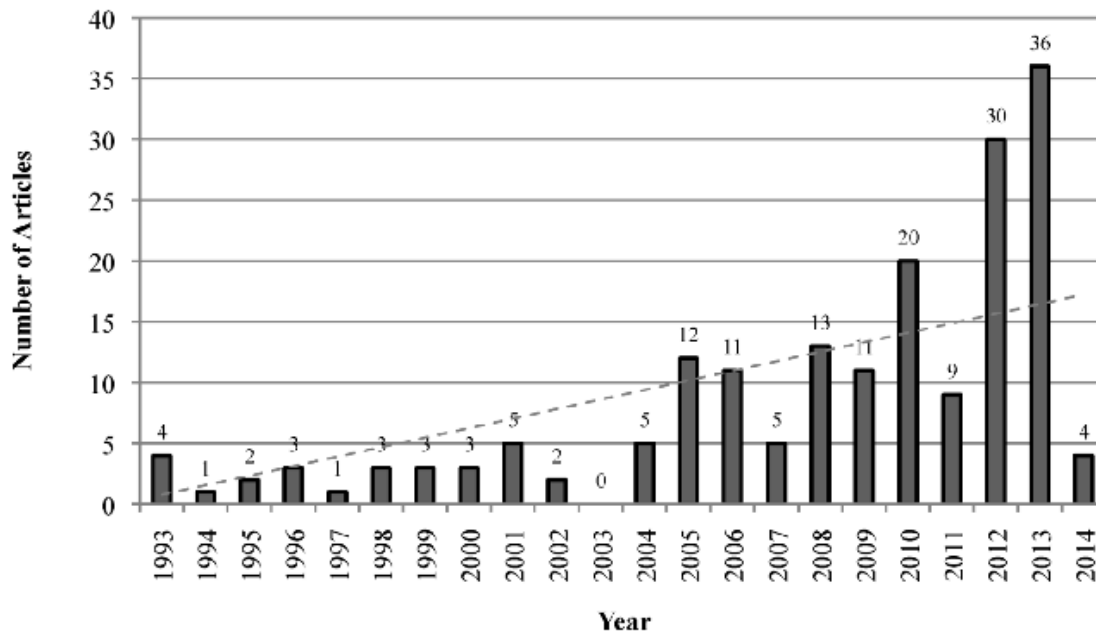
Four notable clusters occurred around articles covering SDOH. The earliest, as described previously, reported on a lecture given by Dr. Sol Levine in 1993 (n=4). The second cluster appeared in March 2005 (n=5) and marked the first spike in coverage as shown in Figure 5.2. This second cluster of articles reported on the selection of former Minister of Health and Welfare (1977–1979) and current academic, Monique Bégin, and former politician and current HIV/AIDS activist, Stephen Lewis, to serve on the World Health Organization's (WHO) Commission on the Social Determinants of Health—a prestigious, three-year panel and study that investigated the SDOH internationally.

Finally, the third and fourth clusters of articles reporting on the SDOH appeared in 2012 (n=6) and 2013 (n=13) due mainly to the activities of Dr. Anna Reid. As the 2012–2013 president of the Canadian Medical Association (CMA), Reid took an advocacy stance for the SDOH and called fellow CMA members do the same. In her first news statement given prior to

125

commencing her term in August 2012, Reid expressed her view that the federal government had "withdrawn some of its responsibility to take true leadership on the health care portfolio," and identified the "top-down, thisiswhat'sgoing-to-happen [*sic*]" (32, pA9, 33, pA10, 34, pB6, 35, pA3) approach as the cause of problems experienced by the Canadian public (e.g., suicide, addiction, mental health issues). Reid also drew attention to the "cracks and chasms" in the Canadian healthcare system, and the need for government to act on the SDOH.(32, pA9, 33, pA10, 34, pB6, 35, pA3, 36, pA6, 37)

Reid was again the subject of another cluster of articles (n=13) in 2013 when she held CMA town halls across Canada to seek public input on the SDOH, spoke to the federal Anti-Poverty All-Party Caucus, and published a CMA report on her findings. The report, *Health Care in Canada: What Makes Us Sick?* drew attention to income, housing, nutrition, and food security, and also recommended that action to be taken on them.(21) The abovementioned clusters of Reid and others illustrate how coverage of SDOH in Canadian news media has often focused on key figures and leaders who advocate action on the SDOH.

5.5.4 How are messages of the SDOH communicated to the public?

Print media reporters communicate messages about the SDOH to their readers by writing about them in a carefully organized article. In this study, messages about the SDOH varied in where reporters first made mention of this topic in their article. To determine "position" of SDOH reporting within a data source, news articles were considered as stories with the literary devices of beginning, middle, and end. Article text was searched to determine whether the SDOH was positioned in the first (beginning), second (middle), or third (end) portion of the news report.

Among the 183 articles included, 19.5 percent (n=36) reported SDOH at the beginning of

the article, 40.5 percent (n=75) at the middle, and 40 percent (n=74) at the end of the article.

Depending on how authors structured their news report, the intended message on SDOH may be

interpreted in different ways. To help understand positioning in news reports, the St. Petersburg

College Libraries (SPCL) identifies five common formats for structuring news articles: the

inverted pyramid, hourglass, nut graph, narrative, and five boxes story.(38) While each of these

formats differ in how they develop a story and report on its details, each supports presenting the

"lede" – that is, a short sentence and/or headline that conveys the main topic and captures the

reader's attention – at the beginning of the article. If we consider this to be representative of

Canadian news media reportage, we see that the SDOH are considered the main topic or most

important and interesting component of an article approximately one-fifth of the time.

The following 2010 *Edmonton Journal* article illustrates how SDOH might appear when

positioned as the lede of a story:

> Suppose I told you I was writing a column on the social determinants of health and the
> impact of substandard primary health care on acute care wait times? Unless you were a
> health-policy wonk of the most earnest kind, your eyes would glaze over. Perhaps they
> have already.
>
> So let me put this in blunt terms.
>
> Children and babies are dying needless deaths, at Third-World rates, right in the heart of
> our city.(39, pB1)

This example shows how readers are immediately introduced to the SDOH, followed by the

reassurance their eyes will not "glaze over" with boredom. This article instead frames the SDOH

as an important issue that is relevant to the general public/reader (e.g., "So let me put this in

blunt terms" (39, pB1)).

In comparing the above example—where the SDOH are reported in the beginning—with

the following 2012 *Globe and Mail* article, one can see how the SDOH message might be lost in

the middle portion of an article:

> Seven and a half more years.
>
> That's how much longer adult Ontarians would live, on average, if they could collectively overcome five unhealthy habits: smoking, excess alcohol consumption, poor diet, sedentary behaviour and stressing out.
>
> That is the conclusion of a new report from the Institute for Clinical Evaluative Sciences and Public Health Ontario. [5 paragraphs removed]
>
> Of course, lifestyle choices are just part of the equation. There is ample evidence that the social determinants of health – income, education, employment, stable housing, physical environment – have a tremendous impact on health and life expectancy. [5 paragraphs removed]
>
> The new ICES/PHO data, on the other hand, are more positive. They show that small changes can have a big payoff in life expectancy and quality of life. That should be motivating individually and inspiring collectively.(40, pA6)

As shown in this example, the message of the SDOH is not highlighted in any way to draw the

reader's attention to it. In fact, the SDOH are only mentioned after the lede of the article suggests

Ontarians "overcome five unhealthy habits." By promoting small lifestyle changes that "can

have a big payoff" and glossing over the role of the SDOH, this article detracts from the complex

nature of the SDOH regarding how different factors interact to influence health and how even

"small changes" may be out of reach for many. On the one hand, this article speaks to the

collective of "Ontarians"; however, it is framed to motivate individual behaviours as a means of

improving population health. This article exemplifies how article position can influence a

reader's understanding of the message. In this case, the SDOH may be misunderstood by readers

who gloss over its minimal coverage somewhat buried in the article. Most likely, readers may

adopt the main message of this article's frame (contrary to the SDOH) regarding the

straightforward link between personal health behaviours and population health.

As a final example of positioning, consider the following brief 2010 *Globe and*

Mail story that positions the SDOH message at the end:

> It actually makes sense to try and measure population well-being and happiness (H Is for Happiness – Focus, Dec. 4). Such measurement is a variant on the dual continuum model of mental health that measures whether people thrive or languish due to their social or health conditions. Researchers have found that 60 per cent of the population can move between thriving or languishing over a 10-year period.

> Measuring the effects of social and health conditions on well-being is good public policy and should lead to an increased focus on the social determinants of health.(41, pA14)

As exemplified in the article above, positioning the SDOH at the end of the article resonates

more with the top-to-bottom reader than the middle position, because it may contain the "kicker"

to the story. Similar to the lede, the kicker may be an important quote, comment, or conclusion

about the topic.(38) In consideration of this, the 40 percent of the SDOH messages that appear in

the end portion of articles may indicate that they are communicated with the intention of

conveying the importance of this issue. On the other hand, presenting the most key message

about the SDOH to readers at the close of an article may not adequately convey its importance,

as readers may be "simply … not willing to read beyond the first paragraph (and even sentence)

of a story unless it grabs their interest,"(42) or reporters may lack space to explain this complex

concept.

However, given the shift toward electronic-format news,(43) this raises a separate

concern relating to the different ways that individuals read electronic media. Eye-tracking studies

conducted in 2008 found that Web users read an average of just 28 percent of words per

page,(44) in an "F-shape" pattern, by reading top sections horizontally before scanning the left

margins of the article.(45) This may mean that where newspapers provide their readers with the option of reading print content in electronic format, their messages may not be read the same way as the conventional left-right, top-down approach. To exemplify the meaning of this using the results of this study, this means that readers could miss up to 80.5 percent of the messages regarding the SDOH should they decide to read the 183 articles of this study electronically. Consequently, reporters wishing to convey specific messages on the SDOH should carefully consider the format and structure of their stories.

5.6 Framing analysis and discussion

5.6.1 Frame 1: Social determinants are an urgent, actionable issue and government responsibility

One way that news media articles framed the SDOH was as an urgent and actionable issue that involved multiple actors, but was a responsibility of government. Action on the SDOH was conveyed in a number of ways, through calls for more research to initiatives such as healthcare reforms, affordable housing programs, labour policies, investment in social supports, redistributive taxation measures, or raising the minimum wage (e.g., (46-50)).

As well, many actors were considered as having a role to play in acting on the SDOH, although articles predominantly focused on those working within the healthcare system—namely nurses (e.g., "one of the key things nurses do is assess social determinants of health"(51, pF4), doctors (e.g., "If doctors begin to talk about the determinants of health, it is possible that governments will begin to act"(52, pA13)), health-related organizations (e.g., "Drawing attention to the role poverty plays in health outcomes is part of the role of the CMA" (53, pB1)) and institutions (e.g., "hospitals and medical schools are grasping the need for a workforce with the inclination and skills to care for the global village within Canada" (54, pA1)). Other actors, such

as citizens, businesses, consumer groups, and patients, were also identified but their roles were discussed to a much lesser extent, if at all (e.g., (55, 56)).

While multiple actors were identified as having a role to play in acting on the SDOH, news media reports predominantly assigned blame for inaction to governments. One reason for this may be the perceived lack of responsibility among Canadian governments for the health of its people that was reported. For instance, one article identified the federal government as having "no clear goals and a dearth of leadership" (56, pA19) regarding the sustainability of healthcare, while another identified the need for "[a] government that's really accountable for its people's health" (31, pD17) Related to this, other articles reported a lack of accountability for the SDOH in government and reported that "no one in government is talking much about this" (57, pA14) and critiqued "the pervasive Not-In-My-Backyard attitude and the denial … from civic leaders" (58, pB1) and misguided priorities of governments that detracted from creating a healthy society.(59)

Finally, many articles pointed to the action and lack thereof that government had taken against the interest of the SDOH. Some articles pointed to the Harper Government's "gnawing away at the country's social safety net" (36, pA6) or the recognition that the Progressive Conservatives had been "particularly savage on the province's poorest" during their time in power in Ontario.(57, pA14) Others spoke to the need for "the federal government to build on their commitments to reduce and eventually eradicate poverty," (60, pA16) yet understood that social policies that improve health, such as those supported by the New Democratic Party (e.g., minimum wage, employment standards, women's equality scales), were likely to "'run into heavy political opposition'" (61, pA1) with recognition that "[r]eform is only going to happen if

the political environment changes."(56, pA19) In this frame, the problems of health inequalities

were diagnosed as the result of government inaction, unaccountability, and disinvestment.

Outside of the news media, the call for government action on the SDOH has repeatedly been

resounded by those working in population and public health.(3, 62-66) Of particular importance,

in June 2009 the Senate Subcommittee on Population Health declared in its final report that,

"governments have a moral obligation to foster the social, economic, cultural and environmental

conditions that empower individuals, communities and societies to create and maintain good

health for all citizens."(67, p16) This helped to solidify the view in Canada that action on the

SDOH is a responsibility of government. Despite this, however, attention has been drawn to the

Canadian government's failure to act on the SDOH. At the federal level, Toba Bryant and

colleagues Dennis Raphael, Ted Schrecker, and Ronald Labonté (2011) have pointed to the mid-

1990s reduction of federal transfers to provinces for funding social and health services in

Canada, which increased their privatization and created an "inability of governments to influence

the provision and quality of these services," (68, p54) thus limiting their capacity to act on the

SDOH. Ted Schrecker and Vanessa Taler (2013) have suggested that governments have failed to

act on the SDOH because they lack the coordination of departments, ministries, and agencies to

achieve the "whole-of-government" approach that is necessary to address such complex

issues.(69) At the municipal level, the National Collaborating Centre on the Determinants of

Health (NCCDH) found that public health units did not see the relevance of their work to the

SDOH, which limited their attempts at taking action.(70) This speaks to the epistemological

barriers to action on the SDOH that Dennis Raphael, Ann Curry-Stevens, and Toba Bryant

(2008) identified for population and public health professionals, the government, and the general

public.(71) The authors found that in North America, the responsibility of one's health status is

placed on individuals (and their motivations and behaviours) and not on the ways that society distributes and organizes the resources that create opportunities for health (i.e., power, wealth, resources).(71)

The above studies help to explain the framing of government actors as staying aloof from acting on or bringing attention to SDOH issues. If the public, healthcare professionals, and individuals working in governments internalize health as a personal responsibility to uphold and protect, as suggested by critical health scholars,(64, 72, 73) it is understandable that this view will permeate the approach that decision-makers take to health and social policy. In light of this, there is work currently underway that attempts to bring the need for health and social policy reform into the mindset of the general public, even where health is conceptualized at the individual level. The FrameWorks Institute, for example, has been working on ways of framing the SDOH to Albertans in ways that garner public support, by choosing productive values (e.g., human potential) and emphasizing solutions that widen the context within which people think about health.(74)

5.6.2 Frame 2: Action on social determinants saves money and is the right thing to do

In reporting the importance of acting on the SDOH, two reasons dominated the narrative. First, the issue was framed in the context of rising and unsustainable healthcare costs. Readers were presented with arguments of where their tax dollars went alongside calls for action on the SDOH. One article spoke of the Ontario Ministry of Health Promotion's purpose "which seeks to keep people healthy so they don't soak up health dollars," (57, pA14) with another advising that, "It's time to put our tax dollars into the social determinants of health for families and children."(75, pA7) Dr. Anna Reid, former president of the CMA, was cited by a cluster of articles (see above) speaking to the high cost of poverty to the healthcare system (e.g., "an

estimated one in every five dollars spent on health is directly attributable to the social determinants of health" (76, pA4); "20 per cent of health care spending goes to care for diseases that can be attributed to low income and poor housing"(60, pA9)). In some cases, articles spoke to the cost of not investing in upstream health initiatives. These included statements such as, "The cost of inaction is higher than acting,"(77, pA8) the warning that we either "pay now with decent social programs or pay later with increased health costs,"(46, pA13) and the reminder of poverty's "cost to government, cost effects on health care …"(78, pA3)

Second, action was framed as important on the basis of moral claims. Based on the concepts presented in public health ethics (e.g., that governments are stewards for the public's health and that we share responsibility for health in political society), the moral claim of addressing SDOH simply because it is the right thing to do seems appropriate in the context of the government's role in protecting public health.(79) One report bluntly quoted the Canada Research Chair in Globalization and Health Equity, Ronald Labonté, on government inaction by stating that, "A failure to act now is a moral failure."(80, pA9) This statement is consistent with the social justice claims carried throughout the WHO's Commission on the SDOH, which included the claim that "Social injustice is killing people on a grand scale."(2, p26) Many reports that occurred during the proceedings of the commission also adopted this tone. Two articles quoted Michael Marmot—chair of the abovementioned commission—in stating that action on the SDOH was needed "because it's the right thing,"(80, pA7) and that, "We have the knowledge and we have the money—what we don't have is the will."(81, pA9) Similarly, Dr. Anna Reid was quoted in her town hall meetings with the statement that "Poverty kills."(55, pL6) Finally, there were some articles that posed moral questions to its readers. For example, one asked whether "we really prefer to fix damaged children rather than create the environment for them to

134

thrive …?"(82, pA8) Another article from Saskatchewan simply discussed issues of inequality

(e.g., rising food bank users, income inequality, increased mental disorders, and infant mortality)

in contrast with building a proposed domed stadium (a $431 million project).(59) As it was

worded:

> When we have fulfilled our promise to eliminate poverty, perhaps then we can talk about
> building a new Roughrider stadium since we will then have substantially reduced the
> health and social costs arising from poverty.(59, pA10)

Alongside moral claims were also statements that elicited a sense of urgency. Some examples

included reports that: "Now is the time … to call on the federal government,"(50, pA16) "we

must … invest in the smart family policy parents require now,"(83, pA23) or that "the health of

mothers, babies and families are at stake, and there is no more time to lose."(84, pA8)

The use of moral claims may be helpful in bringing action to the SDOH, as claims made

on the basis of ethical grounds may serve to motivate national actors to achieve common

goals.(85) Health maintains an intrinsic and instrumental value to society, thus naming

deprivation an injustice may bring to the fore a moral responsibility to increase individuals'

capabilities, potential, and life chances.(85) As discussed previously, however, these moral

claims have not yet translated to action on the SDOH in the Canadian setting.

5.6.3 Frame 3: Social determinants only affect the worst off

A third way that messages concerning the SDOH were framed focused on describing the

individuals or groups adversely affected by SDOH-related issues. In most cases, this frame was

used to present the results of scientific studies or surveys that described health inequalities using

measures such as income level or aboriginal status. Some examples included statements

highlighting that "the prevalence of stroke in Saskatchewan adults is almost eight times higher

for those with lower incomes than it is for higher income persons,"(86, pA11) "only 10 per cent

of high income Canadians smoke daily, compared to 33 per cent of low income Canadians,"(86, pA11) "61 per cent of non-aboriginal residents of Saskatchewan and 37 per cent of its aboriginal residents are literate,"(52, pA13) and that, "Diabetes rates for First Nations people over the age of 45 … is nearly double the 11 per cent rate of non-aboriginal Canadians."(87, pA4) After presenting health inequalities, articles tended to forgo further discussion of the issue in favour of assigning responsibility to governments, often accompanied with a call to action by these actors.

Comparing society's worst off with the better off may be an effective way of presenting health inequalities produced by the SDOH, as it serves to identify differences between groups that may otherwise be masked by population averages.(88) However, there are implications of presenting SDOH in this way that may detract from the goal of reducing inequalities. As public health researcher and sociologist Hilary Graham (2004) found in her review of policy approaches to tackling inequalities, the above described "health gaps" approach directs attention to minority groups at the highest and lowest ends of the socioeconomic spectrum and not those in the majority group (i.e., the middle class). Yet while a health gaps approach brings attention to two groups, in practice the discussion and efforts made at the policy level are aimed only at groups facing health and social disadvantage.(88) There is little, if any, attention paid to those who enjoy the health and social privileges that accompany occupying space near the top of the socioeconomic hierarchy, nor discussion of policies that seek to redistribute wealth, power, or resources—the root causes of health inequalities.(88) A second consequence of a health gaps representation of SDOH is that it collapses the socioeconomic hierarchy into a social divide (i.e., the richest and the poorest), which ignores the stepwise relation of poor health to socioeconomic position (i.e., the social gradient of health) and its ill effects on health.(88, 89)

136

5.6.4 Descriptions of disadvantage

In some cases, articles went beyond naming health inequalities and sought to describe the health disadvantages of the worst off in detail. Such descriptions may elicit emotive response and moral outrage from their readers, but as noted above, they also separate the experiences of the social and health disadvantaged from hegemonic Canadian society. One example included the report of "homeless patients with cellulitis – deep, severe and fastspreading infections in their feet and lower legs from wearing the same pair of ripped, worn and wet shoes for more than a year" (32, pA9) in the Northwest Territories. Another article from Edmonton wrote of heavy users of the emergency department, noting that, "Some come in tens of times a year with broken arms, fractured jaws, frostbite, infected wounds and pneumonia."(90, pA5) An article from Vancouver, speaking of the failure of drug treatment programs to treat addiction, wrote that "'tinkering' with individuals for an hour or so a week will not have much of an impact if they return to the bleak, blighted world of a hotel dweller."(91, pA18) Likewise, a Toronto-based article tied inadequate housing to community violence in St. James Town by referencing the "18 decaying, overcrowded high-rise residential areas squeezed into an area" where children have "seen their friends killed, they've seen people murdered, they've seen people killing themselves …"(92, pTO14) Another article reported on a woman from Mississauga who was a "mother of three, who is hard of hearing and has a heart condition, lives on disability support and never has enough money to go around. She knows her own health isn't good but it hit her like a ton of bricks recently that her inability to supply nutritious food is harming her own kids."(57, pA14) Finally, another article drew attention to the social divide by noting that the cost of "chronic street people" was "between $172,000 and $220,000"(93, pC1) per year to the healthcare system. While perhaps a legitimate observation, tying exorbitant healthcare costs to disadvantaged

groups may produce negative feelings toward these groups and further separate them from hegemonic Canadian society. Using the above example, the healthcare costs incurred by homeless populations may cause this group to be construed as a dependent "problem group" by the majority of society who fund healthcare through their taxes and occupy space in the middle of the socioeconomic hierarchy.

The above example relates to the work of critical population health researcher Lindsay McLaren and colleagues Lynn McIntyre and Sharon Kirkpatrick (2009), who noted in the context of population health interventions that focus on vulnerable groups may increase stigmatization for already marginalized groups.(94) One example from news media reports on SDOH that highlights this issue is from a report on Dr. Reid's town hall tour, which presented the following quote by her, before moving on with the story without further explanation or interrogation: "we talk about success in life in terms of working hard and going up the ladder," said Reid. "With [A]boriginal children, many won't even reach the bottom rung."(55, pL6) Of course, Dr. Reid is referring to the limited access that Aboriginal peoples have to the resources and opportunities that facilitate health compared to non-Aboriginal peoples; however, without further contextualization lay readers may draw assumptions about this population informed by the falsely constructed and racist stereotypes that pervade Canadian society (e.g., negative depictions of Aboriginal peoples as unemployed and dependent).(95) In such circumstances, the disadvantaged groups frame of the SDOH may do little else but utilize the lived experiences of disadvantaged groups to provide a compelling narrative, as they do not provide further explanation into the complexities of the SDOH or suggestions as to how readers might act toward remedying health inequalities (e.g., write their Members of Parliament in support of policies that create equal opportunities for health).

An additional layer of the disadvantaged groups frame relates to its societal function as a contemporary legend.(96) As critical population health scholar Lynn McIntyre and colleagues (2001) found, origin stories of children's feeding programs, which rested on heart-wrenching depictions of deprivation, promoted social solidarity and a charitable mindset in society, and justified these programs' existence. What these stories did not do is challenge the social structures that place these groups at disadvantage.(96) As such, stories of misery and deprivation—whether describing the health of disadvantaged or hungry children—depoliticize an issue that is fundamentally produced by our political, economic, and social structures (i.e., the inequitable distribution of power, wealth, and resources) and serve to justify Canada's history of ignoring this issue in public policy.(97)

5.6.5 *"Third World" comparisons*

At times, the health gaps frame of SDOH issues drew on comparisons to the "Third World" to highlight the poor health conditions of disadvantaged groups in Canada. These included statements that, "Children and babies are dying needless deaths, at Third World rates, right in the heart of our city,"(39, pA4) or that "… some Canadians still live in conditions often described as Third World, with residents of isolated reserves living in overcrowded homes rotten with black mould and with limited access to running water."(98, pA4) Another article suggested that "comparing incidence rates of pertussis between Cuba and Saskatoon Health Region leaves one questioning which is the Third World jurisdiction,"(99, pA9) while yet another quoted a health worker saying that "'Right here in Hamilton, we actually have Third World life expectancy'."(52, pA11)

Using the "Third World" to draw attention to disparity operates in parallel to framing the SDOH in terms of health gaps, yet on a global scale. Employment of the term "Third World"

139

may bring to mind racialized images of poverty (e.g., AIDS, starving children, disease, violence) that stereotype or patronize persons living in the global South or what Michael Mahadeo and Joe McKinney (2007) refer to as the "majority world."(100) As with the vulnerable groups focus, "Third World" comparisons serve the function of naming inequality without interrogating its root causes. Likewise, "Third World" comparisons swiftly abandon any discussion of conditions in these settings to focus on inequalities in the Canadian setting. As Priya Kurian and Debashish Munshi (2012) have suggested, these comparisons may provide "discursive distancing" of problems, such as health inequalities, to frame them as far away and to "prevent an appropriate response"(101, p993) (i.e., redistribution of wealth, power, and resources in ways that improve global health). As with the health gaps frame, "Third World" comparisons ignore the root causes of health inequality in these settings, which are deeply tied to the actions and policies of wealthy neoliberal nations.(102) This is especially true in the contemporary context of globalization, which influences health through the distribution of labour markets, power, resources, trade, finances, health systems, and other factors to the benefit of wealthy nations.(102) Furthermore, as mentioned earlier, inequality within and between nations has been shown to have negative societal and health effects. Income inequality within nations, for example, has been linked to the increased spread of infectious disease, child poverty, violence and crime, greater infant and maternal mortality rates, premature years life lost, and early dropout rates, among others.(2, 64, 103-106) Conversely, public policy approaches aimed at decreasing inequalities (e.g., increasing employment and minimizing inequalities) have been linked to improved indicators of population health (e.g., improved life expectancy, decreased infant mortality and child injury mortality rates).(105) Given the multiple commitments that Canada has made internationally in support of health and human rights, alongside the lack of action toward improving conditions, "Third

World" comparisons may serve a similar function to the contemporary legends of disadvantaged groups (described previously), as they distance the issue of the SDOH and health inequalities and justify Canada's current response of stagnant inaction.(68, 69, 97, 107)

5.7 Closing comments

In light of the above findings, equity-minded news media reporters and publications may wish to present stories on the SDOH in ways that establish collective awareness and the will to act among the general public. News media can assist by bringing public awareness to the SDOH and its complexities (e.g., reporting on research and advocacy activities) and also by reporting on the ways in which the public can get involved (e.g., supporting certain political candidates, writing members of parliament). News media can also help frame the SDOH as an issue of importance to the general public through messages that enhance understanding of the topic. Practitioners in public health have previously noted that the general public continues to misunderstand the SDOH as characteristics of individuals rather than the structural, societal-level factors that influence individuals.(108, 109) The Canadian Council on Social Determinants of Health (CCSDH) (2013) has suggested a number of ways to effectively communicate SDOH messages, such as using value-driven and emotionally compelling plain-language statements, providing context for numbers and facts, and customizing the message for different audiences. In its guidelines for common messaging, it includes specific ways to "hook" (e.g., "We want our family to be healthy") and "prime" (e.g., "Without health, opportunities for life experience are limited") the public to serve as an entry point into the discussion and increase its receptivity to the message without resorting to descriptive stories on the deprivation of vulnerable groups.(20, p10)

As with any study, this analysis is not without its limitations. First, there is the recognition that news stories serve as constructions by reporters who seek out and tell stories of certain occurrences.(12) However, news media reports on issues such as the SDOH still represent an important data source as representations of how the public may be exposed to these issues. A second limitation of this study is its focus on print media. For example, the perspectives of SDOH reported on social media, which is increasingly populated with news stories and integrated into the daily lives of many Canadians, was not captured. Future work may seek to determine how representations of the SDOH in other forums differ from print news media. Finally, due to limitations of space, it was not possible to speak to the multiple nuanced frames that exist for SDOH. Other frames that emerged in this study, which researchers may wish to explore, include examining differences in SDOH representations between newspapers and in different geographic settings, the metaphors used to call to action various actors in the SDOH (e.g., "heads in the sand," "wake-up call" (110, B11)), or the presentation of SDOH issues in terms of lifestyle and personal responsibilization.

5.8 Conclusion

This article has focused on the representation of the social determinants of health in Canadian news media from 1993 to 2014. As content analysis revealed, news media coverage of the SDOH has increased steadily since 1993, especially following the announcement of the World Health Organization's Commission on the Social Determinants of Health in 2005. As this article has described in detail, the social determinants of health were reported using a range of descriptions and definitions related to many different determinants of health and health outcomes. References to the social determinants of health were most frequently positioned in the middle or end of news media articles, which may indicate a lack of perceived importance of this

142

topic by news reporters, as well as the likeliness that messages related to the social determinants are not reaching the large proportion of readers who merely scan news articles.

A framing analysis of news articles revealed that the social determinants of health were presented as an urgent issue in which the action was framed as the responsibility of government, saving healthcare costs, and a morally just endeavour. Yet articles also framed social determinants of health and health inequalities as issues that only affect those who face the greatest health and social disadvantage in our society. This frame was illustrated through use of a health gaps approach, emotive descriptions of disadvantaged groups, and by drawing on "Third World" comparisons. Problematically, such framing may serve to disconnect hegemonic Canadian society from the issue of health inequalities and its negative societal impacts and may further the disadvantage that these groups face through stigma and marginalization. Importantly, this frame ignores the root causes of health inequalities within and between nations; that is the inequitable distribution of wealth, power, and resources.

5.8.1 Notes

1. For example, see: Epp, 1986 (111); Health Canada, 1998 (112), 2001 (113); Lalonde, 1974 (114); PHAC, 2006 (115).

2. *The Globe and Mail*, *The Vancouver Sun*, *Star – Phoenix*, *Edmonton Journal*, *Ottawa Citizen*, *The Gazette*, *Winnipeg Free Press*, *Calgary Herald*, *National Post*, *The Record*, *The Windsor Star*, *The Province*.

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Chapter Six: Poverty and Public Health: The Ebb and Flow of a Social Determinant of Health, 1900s-2010s

6.1 Abstract

The present-day understanding of poverty as a 'social determinant of health' reflects an historic issue of public health concern. When used to interpret the past, the contemporary lens of the social determinants of health can reveal new perspectives on this age-old problem. We applied this lens to explore the history of poverty in twentieth-century Canada and consider the nuances of how poverty has been conceptualized and approached by the public health community during this period. Our findings are derived from archives held at the Canadian Public Health Association and the Library and Archives of Canada, as well as oral history interviews conducted with key figures from the history of the social determinants of health in Canada. We identified five overlapping time periods through which the history of poverty unfolded: (1) 1900s-1920s; (2) 1930s; (3) 1940s-1960s; (4) 1970s-1980s; and (5) 1990s-2010s.We found that approaches to poverty in Canada have ebbed and flowed alongside the national events that occurred in Canada's social, economic, and political history, such as the Great Depression. Sometimes approaches included targeted solutions that attempted to remedy disadvantage among the poor, while other times they included solutions that sought to universally reduce gradients in health. This history provides new insight into poverty as a contextual factor of health and illness and a social determinant of health and will be of interest to historians and the public health community.

6.2 Introduction

Poverty has long been a concern of public health. For centuries, members of the public health community have documented the health problems they witnessed among the poor. In the

United States, for example, physician John Griscom (1774-1852) reported slum living conditions among the poor as "physical evils" in New York City.(1, p214) Correspondingly, English statistician William Farr (1807-1883) found increased mortality rates among the urban poor living in crowded conditions and unable to purchase their basic needs.(2)

Over the past two decades, the social determinants of health (SDOH) has emerged as an approach in population and public health. The SDOH refer to "the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole" and include income and poverty, as well as social exclusion, housing, income, race, gender, sex, religion, and education.(3, p2) A key tenet of the SDOH approach is emphasis on determinants that operate at the structural level of society, such as public policy.(4) Although the foundations of the SDOH are not new, it has only emerged as a coherent approach and field of study over the past three decades (see Chapter 8). The contemporary understanding of the SDOH approach outlined above offers a novel lens through which to interpret the past and gain new insight on the age-old problem of poverty, to inform present efforts on approaching this as a public health issue.

The purpose of this paper to explore the history of poverty as a SDOH in twentieth-century Canadian public health. Specifically, we consider three aspects of this history. First, how has poverty been conceptualized over time? Second, who, or which societal sector, has been viewed as primarily responsible for poverty and what were considered viable solutions? Third, in line with the breadth of scope of SDOH, to what extent has poverty been regarded as intersecting with other determinants, such as housing or social exclusion? Finally, as a backdrop to these three questions, we consider the prominence of poverty in relation to other issues and concerns of the public health community and Canadian society.

We believe the contributions of this work to be twofold. First, the contemporary lens of the SDOH presents a novel way of exploring phenomena that have long been embraced by public health, which can provide new insight into contemporary issues. For instance, health equity and the social gradient of health have only recently been theorized and named,(5) but represent concepts that the public health community has wrestled with for centuries. Additionally, the SDOH approach enhances existing medical histories by considering how health has been influenced by the organization and distribution of social, economic, and political resources in society. This SDOH history will therefore strengthen the institutional memory of the public health community, particularly in their advocacy efforts to eliminate poverty.

6.3 Methods

Our research process follows historical methodology, which seeks to reconstruct and interpret the past through analyzing primary source materials.(6) We utilized archival documents from the Canadian Public Health Association (CPHA) and Library and Archives Canada, located in Ottawa, Ontario. Sources included meeting minutes, annual reports, policy statements, and publications from the *Canadian Journal of Public Health* (CJPH) and its previous titles: *Public Health Journal* (PHJ) and *Public Health Journal of Canada*. We obtained access to the CPHA archives through a research agreement with its Board of Directors and to the Library and Archives Canada by following their procedures for public access.

We also conducted oral history interviews as part of a larger project on the history of the SDOH in Canada,(7) which informed this study. Through reviewing archival materials and snowball sampling, we identified and recruited seventeen participants significant to the history of the SDOH in Canada. KL interviewed participants via open-ended questions about their experiences with the SDOH.(8) Interviews were audio-recorded, transcribed, and returned to

152

participants for content verification. All participants cited in this paper agreed to having their

quotations made identifiable.(9) Together, we refer to our findings from the CPHA archives,

CJPH journal, and oral history interviews as emerging from the "public health community." As

the oldest non-government organization for public health in Canada, to some extent the CPHA

has represented issues of interest to the national public health community. It should be noted,

however, that a great deal of diversity exists within the public health community, both presently

and historically. For instance, many Canadian historians have examined issues related to poverty

and public health through critical perspectives that interrogate the public health community's

motivations, class and gender biases, and other contextual factors throughout the nineteenth

century (e.g., 138-143).

Our history differs from the above works that critically interrogate the nature of the

public health community, in that we approach this history with the view that public health is

situated in social justice and health equity. As such, we reviewed the history of poverty and

public health through the public health community's attempts to *include* certain groups to

improve population health versus attempts to *exclude* or marginalize them.

To sample and analyze our archival sources, we followed the methods of thematic

content analysis.(10) During data collection, we reviewed each document for its relevance to the

SDOH, as per criteria identified by the authors in a scoping review on the topic.(11) Relevant

documents were photographed and included in our sample. All documents, including interview

transcripts, then underwent line-by-line open coding,(12) decade by decade, to understand how

the history of poverty as a SDOH unfolded over time. Codes relevant to the issue of poverty

included income, poverty, employment, and inequality. We then considered the patterns and

relationships that existed within and between these codes over time.(12) First, we grouped codes

into thematic time periods that represented meaningful stages in the history of poverty. Then, we considered how these themes related historically to Canada's social, economic, and political context. We met regularly to discuss findings as they emerged, which resulted in the five overlapping, thematic time periods discussed below. We used NVivo 11 to assist with data management and analysis.(13)

To maintain rigour, sources were triangulated wherever possible.(14) Multiple documents were analyzed to verify the content and claims made in primary sources and provide different perspectives on issues.(14) This strategy helped to overcome the incompleteness of the historical record, an inherent characteristic of this data.

This study was approved by the Conjoint Health Research Ethics Board at the University of Calgary (REB14-1287).

6.3.1 Analytical framework for thematic analysis

To understand how poverty has been conceptualized over time, we drew on absolute and relative notions of poverty. In this paper, poverty refers broadly to a lower than minimally acceptable social and economic position and is conceptualized as either: (1) absolute poverty, considered a deprivation of basic needs and measured as one's ability to purchase material goods; or (2) relative poverty, considered as the subordinate socioeconomic status one holds in comparison to others and measured in a way that is intended to capture one's ability to meaningfully participate in society.(15, 16) These conceptualizations align well with the different understandings of health inequalities described by health sciences professor, Hilary Graham, which we use to consider how the public health community approached poverty throughout the twentieth century.(17) As Graham explains, conceptualizations of inequality fall on a continuum from those that seek to remedy disadvantage by focusing on the worst off in

154

society, narrow gaps by focusing on those worst off compared to the better off, or reduce gradients by focusing universally on all societal groups.(17) A continuum of moral arguments underlies these understandings, ranging from health as a basic need for remedying disadvantages to health as an attainable goal and human right for reducing gradients.(17)

For our analysis of who, or which societal sector, the public health community deemed primarily responsible for poverty and what solutions they deemed viable, we classified welfare approaches in two ways. We considered poverty as more of a personal or societal problem where social welfare seemed to be left to the market, with family and voluntary sector services filling in to help those in need.(18, 19) Solutions to poverty problematized in this way may include charitable giving of food and clothing, or means-tested income supplements subject to market forces.(18, 19) We considered poverty as the responsibility of governments where prominent state interventions sought to promote equality through redistributive benefits, such as a guaranteed annual income to universally provide social and economic security.(18, 19)

To consider the extent that poverty intersects with other determinants to produce a combined detriment among the poor, we borrowed from intersectionality theory.(20) This was well-suited to our analysis, as the SDOH interact to create unique experiences of disadvantage for those who suffer the effects of systemic power relations that operate on multiple axes of inequality (e.g., sex, gender, race, socioeconomic status).(21) Poor, immigrant, working mothers, for example, represent one intersectional manifestation of poverty that qualitatively differs from that of white, Canadian-born mothers in the same position, due to the multiple axes of inequality they face.

Finally, to build our historical narrative we considered how the prominence of poverty in twentieth-century Canada related to other public health issues, national events, and time periods.

We determined this implicitly through reflecting on our data and considering which thematic eras discussed poverty most frequently, explicitly, and urgently.

6.4 Findings

Interest in poverty by the public health community has ebbed and flowed throughout twentieth-century Canada, alongside national events that have influenced how this community has conceptualized and approached poverty. Although the trajectory is somewhat varied and at times uneven, our analysis revealed five overlapping time periods and corresponding themes. The following two themes emerged during the first half of the twentieth century: 1900s-1920s, when frontline workers and administrators sought to remedy disadvantage and narrow health gaps, respectively; and 1930s, when the Great Depression nuanced approaches to poverty as more people experienced it, blurring the line between who was best off and worst off in society. During the middle of the century, from the 1940s-1960s, health insurance dominated discussions in the public health community and brought a reducing gradients approach to poverty and illness. In the latter half of the twentieth century, approaches to poverty began to broaden in public health to be more inclusive of all persons in society: 1970s-1980s, when economic recession influenced efforts aimed at implementing universal solutions; and 1990s-2010s, when population health refocused attention on gradients of poverty and illness in academic circles.

6.4.1 1900s-1920s: Competing approaches to poverty in early twentieth-century Canada

The industrialization and urbanization of Canada at the turn of the twentieth century rendered poverty a visible problem.(22-24) Racial and economic inequality characterized the socioeconomic structure as one made up of a poor working class comprised of immigrants, single males, and wage-earning families; an upper class of wealthy business owners; and an emerging middle class of office workers and managers.(25) On average, middle class workers

156

made $846 per year compared to the production workers who made up 84 percent of the workforce and earned just $375 per year;(26) today, these wages correspond to roughly $18,300 and $8,100.(27) Further, 16 percent of the total income earned in 1920 Canada was concentrated in the richest one percent.(26)

Public health during this period was a newly organized, middle-class profession. It combined the efforts of voluntary sector workers employed by charitable organizations (e.g., social workers and nurses from the Red Cross or Victorian Order of Nurses) with those of non-voluntary sector workers employed by municipal or provincial health boards (e.g., professionally trained/certified scientists, medical officers, sanitary inspectors, and nurses). Religious motivation influenced the efforts of both groups, as workers espoused the Victorian-era values of white, Anglo-Saxon Protestants, during a time when 58 percent of Canadians claimed British descent and 97 percent identified as Christian.(25) Elizabeth Shortt (1859-1949), a volunteer for the National Council of Women and one of the first female physicians in Canada, described the medial class position of public health and its religious orientation in her description of public health workers as "the saviours" of the upper and lower classes.(28, p311) She noted these workers were "trying to hold back the crowding dangers of ignorance […] and vice and all the insidious evils" of the lower classes, while simultaneously seeking financial and political support from the upper classes by "calling ceaseless[ly] to the other that old Macedonian cry, 'Come and help us.'"(28, p311)

For both voluntary and professional frontline public health workers, conceptualizations of poverty were seemingly shaped through their experiences working with the poor. These workers witnessed material deprivation at its worst as they travelled through city slums and attempted to remedy disadvantage. In the voluntary sector, frontline workers operated under the centuries-old

assumption that poverty was an individual problem that was either brought on from idleness and therefore deserved, or brought on by sickness and undeserved.(29) Voluntary sector workers accepted poor relief as part of their community responsibility, moral obligation, and Christian duty,(22) and sought to improve conditions for the poor by providing them with sanitary knowledge. The religiously-oriented Visiting Housekeepers' Centre of the Canadian Red Cross, for example, dispatched housekeepers trained in hygiene, nursing, and social work to city slums to instruct the poor in thrift, cleanliness, and proper diet.(30)

However, poverty intersected with other axes of inequality that marginalized the poor as visibly different from the frontline workers they met. Individuals who looked or acted in ways different from the idealized norm were often pathologized by frontline workers as feeble-minded or mentally inferior, with their poverty and sickness blamed on the incompetence of their non-White race, non-British ethnicity or cultural values, or non-Christian religion.(31) The focus on "unskilled workers,"(32, p446) "foreign peoples,"(33, p120) and "indigent mothers" (34, p685) in articles from the PHJ illustrate some of the ways that health workers identified the poor. An alternate view may have recognized the co-occurrence of SDOH within a 'disadvantaged' view of the poor, perhaps by naming instead how systemic inequality had driven new immigrant families to accept crowded, sordid homes that promoted the spread of infectious disease (e.g., shared beds, inadequate heat, ventilation, water, waste disposal).

Those who held leadership positions in public health as academics (e.g., professors) or administrators (e.g., director of a charitable organization, medical officer) appear to have noticed the co-occurrence of SDOH among the poor, perhaps because of their distance from the issue or their knowledge of population trends. Charles-Edward Amory Winslow (1877-1957), an American public health expert, hinted at the societal (versus individual) nature of poverty and its

determinants in 1920. He wrote in the PHJ that "[p]eople do not usually live in the poorest quarters of a city or work at its underpaid employments by accident."(35, p615) Head of the Toronto Central Neighbourhood House, Mary Joplin Clarke, also viewed poverty as an issue beyond the ignorance or incompetence of individuals in another PHJ article. She critiqued her voluntary sector colleagues in their attempts to remedy disadvantage by focusing on their deficits, stating that:

> It is not sufficient any longer merely to lecture the poor for their wickedness, or to assist them in their poverty by gifts of food and clothing. […O]ften we offer advice, suggest remedies and resort to moral suasion all to no effect.(36, p498)

Statements such as Joplin's represent an alternate approach to poverty that existed for academics and administrators who occupied a higher social status. They conceptualized poverty beyond naming the disadvantage and difference of the poor to align more with Graham's 'health gaps' conceptualization and the view that the main causes of poverty were situated in societal structures.

In this view, poverty was more than one's moral, racial, or financial shortcomings, as a "product of the whole social system."(37, p159) As Frank Stapleford, General Secretary of the Neighbourhood Workers' Association explained shortly after the First World War, "…individual[s] and famil[ies are] caught in the grip of an industrial system […] based upon world conditions of supply and demand and other factors…"(37, p159) Speaking to this and the societal responsibility for poverty, professor of economics Godfrey Isaac Howard Lloyd (1875-1939), wrote that, "We are coming more and more to recognize the fact the poverty is the mark […] of social and national failure."(38, p242) The solutions proposed by academics and administrators sought to enhance the societal opportunities available to the poor, to narrow the gap between their level of health with other classes. One suggestion, published in the PHJ by

159

Bailey Barton Burritt (1878-1954), an American public health advocate, proposed raising the standard of living among the poor by providing "adequate income, [and] adequate knowledge of the essentials of health."(39, p95) Such an approach during the inter-war period, Burritt claimed, would permit poor children a "fair start" compared to others, by increasing their access to education, knowledge, and material resources.(39, p91) Other proposed solutions included legislative reform, such as workman's compensation, so that families would not be prone to destitution where wage-earners were debilitated by their work.

During this period, poverty gives the impression of having been a prominent public health issue. Significant attention was devoted to poverty, especially in the context of the Great War that prompted questions on the form Canadian society should take, after so many had fought and died for its preservation. For public health leaders, the vision of a "new world order" was one free of slum districts, preventable illness and death, and poverty. John Riddington (1868-1945), a university librarian, captured this sentiment in a 1920, stating that:

> [...] as the lengthening casualty lists were issued, and men shook hands in silent sorrow with war-bereaved friends, there grew up in Canada […] a sense of community care, of personal as well as national responsibility for those on whose behalf we labored.(40, p439-40)

Debates of social welfare following the Great War continued through the decades that followed Riddington's reflection, as economic turmoil and demographic shifts influenced understandings of and approaches to poverty in Canada.

6.4.2 1930s: The Great Depression heightens urgency and adds nuance to existing approaches

The Great Depression significantly impacted Canada's socioeconomic distribution. From 1929 to 1933, the gross national expenditure declined 42 percent,(41) which profoundly affected Canada's manufacturing industry and resulted in nationwide layoffs. Income inequality reached

an historic high, with 18 percent of wealth concentrated to the top 1 percent.(42) Earle Willard

McHenry (1899-1961), a Toronto professor of nutrition, estimated that as much as 25 percent of

urban populations received government aid in 1933.(43) The Great Depression also impacted

health outcomes. As the League of Nations' Health Section found during the 1930s,

underfeeding and food restriction led to increases in diseases such as tuberculosis and

rickets.(44)

The magnitude of unemployment and hardship described above made poverty difficult to

conceptualize as a problem of individuals during the 1930s. "The poor" became a less

demarcated group, especially as public health studies began to illustrate graded health

differences for socioeconomic groups on topics such as nutrition and diet,(45, 46) morbidity,(47)

and mortality.(48) One 1934 study on school-age children, conducted by Ontario's Director of

Maternal and Child Hygiene, John Thomas Phair (1888-1965), found that "socio-economic

differences are marked," as "over half the children from the better districts drank 3 or more

glasses of milk a day, whereas less than one-third of the children from the poorer districts did

so."(46, p383) At the time, the public health community appears to have viewed these health

differences as unfair and remediable through government intervention. Haven Emerson (1874-

1957), a Columbia University professor and keynote speaker of CPHA's 1932 conference, spoke

of the state's obligation to reach the goal "of assuring for each, life in full measure and the

highest quality inheritance permits…"(49, p477) Others resounded Emerson's implied moral

claim of health as a universal right that should be available "for each," in proposing solutions

that would focus on *all* persons, families, and parts of the country.(50, 51) Statistician and

epidemiologist Edgar Sydenstricker (1881-1936) conveyed this more candidly, stating that:

> Society has a basic responsibility for assuring, to all of its members, healthful conditions of housing and living, a reasonable degree of economic security, proper facilities for curative and preventive medicine and adequate medical care, [...and] all the environmental factors that affect physical and mental well-being."(52, p19)

Importantly, Sydenstricker's claim also recognized poverty as intersecting with other determinants (e.g., housing, economic security, medical care). The public health community sustained an understanding of the relationship between poverty, sickness, and income in the population during this period through their discussion of publicly-funded medical care (e.g., (53, 54)). In part, the provision of such care was intended to limit the detrimental effects of poverty on health. The public health community considered universal medical insurance as a means of preventing premature death and disability, especially for the poor, by removing economic barriers to treatment.(51, 55, 56)

Considering the scale on which poverty was experienced by Canadians during the 1930s, it seems to have received less attention than expected as a public health issue. The public health community instead appears to have devoted their energies on preventing future suffering for the population through efforts such as universal medical insurance.(57)

6.4.3 1940s-1960s: Universal solutions in connection with growing diversity

Following the Second World War, Canadian society underwent epidemiological and demographic shifts that influenced approaches to and understandings of poverty. The main causes of morbidity and mortality shifted from communicable diseases to chronic and degenerative diseases (e.g., arthritis), accidents (e.g., automobiles, drownings), and injuries (e.g., workplace injury).(58, 59) Additionally, the lifespan of Canadians lengthened while the birth rate increased, which resulted in a surge of young and aged populations.(60) There was also a rise in immigration to Canada, migration from farms to cities, and from cities to suburbs.(61-63) As

162

evidenced by the literature at the time, the public health community was attuned to the growing diversity of Canada's population and its health needs. For instance, some literature reported on the differences that existed for different socioeconomic groups in the population for illness,(64-66) diet and nutrition,(65, 67-72) and medical care.(73-77) Other articles highlighted differences that existed in mortality by age,(73, 78) income group,(67-69, 71, 77, 79-84) occupational class,(85) culture and ethnicity,(82, 83) and geographic region.(83, 86-88)

As in the period prior, the widespread nature of health and social issues influenced the conceptualization of poverty in the public health community as a societal issue. Poverty remained viewed as a responsibility of governments to intervene and reduce existing health and social gradients. Paul Martin, Sr. (1903-1992), Health Minister of Canada, spoke to the role of government responsibility for tackling poverty and health during a 1952 address to the CPHA membership. Speaking of the federal grants program that was introduced in 1948, which provided support to the provinces in their health planning initiatives (e.g., surveying health needs, providing hospital beds, training health workers), Martin noted it was established "after a re-evaluation of this country's responsibility for its greatest asset, its human resources."(89, p329) He also stated that building a healthy nation would require providing for all Canadians, "so that no child will go hungry, and no needy, sick or old person will be neglected."(89, p329) The focus on "no" child, needy, sick, or old in this statement suggests that the moral claim of achieving equal health for all was present in public health at the time. The establishment of the World Health Organization (WHO) in 1948 and its impact on Canadian public health at the time (e.g., (90, 91)) supports this argument. The WHO adopted a rights-based mandate that explicitly intended to "bring to everyone an equal opportunity to attain physical and mental health regardless of nationality, race, or economic status."(92)

163

During the 1940s-1960s, health insurance appeared to again be considered by the public health community as the utmost solution to equalizing health opportunities. Drawing on the moral claim of health as a human right, Henry Sigerist (1891-1957), a medical historian influential to socialized medicine in Canada, suggested to the Health League of Canada in 1944 that: "[…] all the people should have medical care, irrespective of race, creed, sex, or economic status, and irrespective of whether they live in town or country."(75, p257) Others in public health focused on the mechanics of health insurance, such as Joseph Mountin's (1891-1952) PHJ article that employed what today would be recognized as a population-wide social gradient and redistributive perspective. Mountin suggested that the "grant-in-aid program tended to equalize health opportunities," by deriving funds "from those [citizens] best able to pay, and allott[ing them] according to need."(93, p265) The above quote suggests that the public health community was sympathetic to approaches to poverty that would level the playing field for the best off and the worst off in society, by redistributing wealth more fairly.

The postwar period brought attention to human rights and issues of race, ethnicity, and economic status into public health; however, these seem to have been considered as related to health somewhat independently from poverty, suggested by the above studies on socio-economically graded health relationships. One area where the intersection of poverty with other 'social determinants' was clearly considered is seen in the public health community's discussions on economic security for the aged. The aged were recognized as one group that would require social assistance later life, due in part to their weakened physical and mental health,(94-96) as well as the problems they faced in the areas of housing, employment, finances, and loneliness from having been "caught in the undertow of our progress."(97, p219) Old-age pensions were one solution that the public health community suggested could improve conditions for the aged,

164

while also maintaining dignity and self-respect for this population (78) – language very consistent with present-day discussions of poverty and social gradients. Poverty remained largely embedded in discussions of pension schemes or medical insurance during this period. There seems to have been less prominence of poverty on its own as a public health issue compared to the previous periods examined, likely due to the urgency felt within the public health community on securing medical insurance, which was eventually implemented nationally through the *Medical Care Act* in 1966.(98) Universal schemes such as Medicare remain important for their potential to dramatically offset the effects of poverty, implicitly, through their population-wide and equitable nature.

6.4.4 1970s-1980s: Economic recession challenges universal approaches

Canada experienced economic recession during the 1970s through the 1980s, which impacted understandings and approaches to poverty. Temporary relief provided by the voluntary sector, such as food banks and hostels, proliferated to assist Canadians in meeting their basic needs,(99) and the "working poor" – those who worked one or more jobs but were unable to make ends meet – emerged as a focal point in public health. Highlighting the scope of this issue, R. E. G. Davis, former Executive Director of the Canadian Welfare Council, noted in 1973 that:

> despite the substantial amounts allocated to income maintenance programs between a quarter and a third of the population […] are still left with incomes below a strictly defined poverty level.(100, p600)

As seen during the Great Depression, the widespread nature of poverty in the population during the 1970s-1980s seems to have contributed to its conceptualization by the public health community as an issue that required a reducing gradients approach. Rights-based moral claims persisted in the public health community from the previous two periods, though they were strengthened through the health promotion movement of the 1980s. Specifically, the *Ottawa*

165

Charter for Health Promotion promoted redistributive 'healthy' public policies "that foster greater equity" and identified income, social justice, and equity as fundamental conditions and resources for health.(101) Health promotion was widely taken up in public health,(102, 103) and members of this community pressured the federal government to take responsibility for poverty by providing state-funded, universal solutions that would redistribute social and economic resources more equitably.(104)

The attempted implementation of a guaranteed annual income by Pierre Elliott Trudeau's (1919-2000) administration serves as an excellent example of a reducing gradients solution. In 1973, the newly elected Minister of Health and Welfare, Marc Lalonde, drafted legislative policy that proposed a national guaranteed annual income program funded equally by the provinces and territories.(104) When Monique Bégin became Minister in 1977, she continued to fight for its implementation, as she saw its potential benefit for all Canadians by replacing the piecemeal social benefits that targeted disadvantaged groups such as "the handicapped, the unemployed, the poor single mothers, the kids…"(105) This legislation was not implemented due to provincial opposition and a national budgetary deficit.(104, 106)

Such attempts, however, did bring attention to the intersection of poverty with other SDOH. Second Wave feminist arguments on issues such as income inequality of the sexes, sex discrimination, and unaffordable day care helped illustrate how poverty co-occurred with factors such as gender, early childhood, employment, and income. When considered collectively, these systemic disadvantages shaped the opportunities available to women, their children, families, and health. Social movements like feminism appear to have vocalized poverty and health within the public health community to greater prominence compared to other periods. Additionally, the

receptivity of tackling poverty and health by the federal government may have further highlighted this issue as one of importance.

Despite the theoretical acceptance of a universal, population-wide, reducing gradients approach to poverty by the public health community and the federal government, such efforts were limited in their implementation, due to the difficult task of challenging the structures of society that create unequal gradients. The task was particularly difficult in the neoliberal context of the 1980s and 1990s, which to some extent, seems to have thwarted the momentum for redistributive policies from decades prior. During these two decades, in the context of economic recession, the federal government began to limit funds to the provinces for their health and social programs, which the provinces responded to with cutbacks to social housing, families, early childhood, and public health and by increasingly privatizing services to raise funds.(107) In turn, this diminished the ability of governments to intervene in the provision and quality of services alongside rising rates of unemployment, child poverty, precarious work, and homelessness, which contributed to increased social and health inequalities during this period.(107)

In public health during the 1980s, health promoters who supported health equity and universal solutions, repeatedly implemented interventions that targeted the disadvantaged and "became so local, so communal, so empowerment-oriented, so non-systemic."(108) To illustrate, Maureen Law, Assistant Deputy Minister of the Health Services and Promotion Branch for National Health and Welfare, addressed the audience of CPHA's annual conference in 1980 during a keynote lecture where she spoke of gradients in mortality rates by income level in Canada, whereby "the poor [had] higher rates of infant mortality, lung cancer, cervical cancer, diabetes, heart attacks, chronic bronchitis, emphysema and asthma, cirrhosis of the liver and suicide."(109, p250) While Law conceptually supported a reducing gradients approach to

poverty reduction through achieving "Health for all […] in bringing about a sense of justice, to counter the existing sense of social inequality among the disadvantaged of our society," (109, p249) the federal initiatives she cited in support of this aim included individualized and behaviour-centric approaches that targeted poor and high-risk population groups. The programs, though seemingly coming from an equity perspective, were ultimately emblematic of a disadvantage point of view, in that they aimed to alter the behaviour of individuals, rather than equalize their opportunities for health. These included the screening of high-risk groups, promotion of breastfeeding, and the publication of a recipe book encouraging more nutritious holiday entertaining.(109) This phenomenon, which others have termed 'lifestyle drift' has become a main critique of health promotion;(110-113) it also resembles what Graham might describe as a conflating of equity and poverty.(17)

Some members of the public health community responded to the above limitations by attempting to reorient the field towards reduce health gradients. Although not without criticism,(114, 115) the population health approach emerged during the 1990s as an attempt to maintain the conceptual roots of health promotion (e.g., social justice, health equity, advocacy, prerequisites of health),(116) while adopting a wider, population-level perspective, utilizing the contemporary terminology of the social determinants of health, and explicitly adopting the goal of reducing health inequities in its mandate.(117)

6.4.5 1990s-2010s: Population health refocuses on reducing gradients

Income inequality in Canada has worsened in recent decades, from the 1990s to the 2000s;(118) the top quintile of income earners received 52 percent all income in 2007 (compared to 20 percent in 1980), and the richest 1 percent held 14 percent of Canada's total income in 2010 (compared to 8 percent in 1980).(42) In its report on income inequality in Canada, the

House of Commons Standing Committee on Finance reported rising inequality as the result of market forces (e.g., globalization, technological progress), institutional forces (e.g., declining unionization rates, stagnated minimum wages, deregulation), and demographic reasons (e.g., aging workforce receiving senior-level positions, younger workforce taking more precarious jobs) as the main reasons for income inequality.(119) Put simply, reasons for income inequality mirror those for health inequality and poverty, as the result of the unequal distribution of money, power, and resources.(4) Rising income inequality, which largely reflects government policies and global trends from the previous era, presents and represents a backdrop that is challenging to public health.(120) Statistics Canada has estimated that 40,000 preventable deaths per year in Canada are related to income inequality.(121)

During the 1990s-2010s, the public health community became more vocal on issues of health inequalities, lending to the dominant conceptualization of poverty as a remediable issue by reducing gradients and distributing society's money, power, and resources more fairly. Hundreds of studies in population health have built the evidence base for the SDOH and have identified redistributive systemic approaches as having the greatest potential to reduce poverty and prevent illness in the population. In theory, the federal government has accepted this responsibility; the Senate Subcommittee on Population Health recommended that "profound structural change in the government's approach to […] public policy" (122, p18) would be needed to reduce health gradients. In practice, however, the government has failed to implement the broad redistributive policies for which they have indicated their support.(123)

In the past decade, the role of the state in achieving health equity has become more global in scope. The WHO, in its Commission on Social Determinants of Health, and the public health community in Canada now supports the pursuit of health equity within and between countries.(4,

124, 125) Moral claims made by the Commission, in its final report, argue that reducing health gradients is "the right thing to do," as "Social injustice is killing people on a grand scale."(4, p1) These claims have been reiterated by the public health community in Canada, for example by those who have considered the impact of income inequality on preventable death in Canada.(121) In support of social justice, the Senate Subcommittee on Population Health claimed that "it is unacceptable for a privileged country like Canada to continue to tolerate health disparities."(122, p18) Though this rhetoric seems promising, it remains to be seen whether the voice for gradient-style solutions to disadvantage leads to fruition, or remains an academic debate among those in public health who largely occupy positions of privilege.

A main contribution of population health to poverty as a SDOH, is the critical discussion this approach brought to public health. Population health has questioned poverty as a homogenously-experienced issue, through new evidence and understandings regarding its diverse manifestations as a lived intersectional issue (e.g., (21)). As well, critical scholars have challenged the value of indicators used to measure relative poverty (e.g., (126, 127)), as they are limited in their ability to capture the nuanced, varied experiences of marginalized groups that experience stigma, social exclusion, and isolation. Finally, efforts have mobilized the public health community to advocate on poverty-related issues and bring positive change (e.g., (128-131)).

Today, poverty remains a contentious matter for public health and other sectors where action is stagnated, but the issue is one of utmost importance. A summary of findings is provided in Table 6.1

Table 6.1 Summary of thematic analysis for poverty as a SDOH

Era	1900s-1920s	1930s	1940s-1960s	1970s-1980s	1990s-2010s
Conceptualizations	Disadvantages/ Gradients	Gradients	Gradients	Disadvantages/ Gradients	Gradients
Who is seen responsible	Individuals/ Community	Government	Government	Government	Government
Proposed solutions	Budgeting advice/ Increased minimum wage	Universal medical insurance	Comprehensive health and social insurance	Behavioural interventions/ Guaranteed annual income	Redistributive policies
Prominence compared to other health issues in era	High	Low	Low	High	High
Extent to which poverty intersects with other SDOH*	Low	Medium	Medium	Medium/High	High
National context	Nation-building; the Great War	The Great Depression	The Second World War; Social movements	Global Economic Crisis	Rising income inequality

*Relative to other periods

6.4.6 Limitations

This paper experiences limitations comparable to other social histories in that it is unable to accommodate the diverse experiences of all groups whose histories intertwine with public health and poverty. Aboriginal and Indigenous peoples, for example, have long experienced the ill effects of poverty, systemic racism, and other determinants disproportionate to Canadians of European descent, yet this only becomes represented in our data as a major public health issue beginning in the final quarter of the twentieth century. As rich histories that give justice to the complexity of this issue have been represented elsewhere,(132-135) this paper did not attempt to summarize these diverse experiences.

A second limitation in this work is that our findings are limited by analyzing what has been preserved in the historical record. Because of the nature of the CPHA archives (i.e., unaccessioned and unindexed with no fonds numbers or finding aids) and limitations to accessing certain records (e.g., membership lists), there are aspects of this history to which we are unable to comment, such as the membership status of individuals captured in archival documents and the extent to which they continued to participate in CPHA over time. To some extent, triangulation has helped overcome this limitation. The CPHA archives themselves have

also addressed this limitation, for they represent what members have deemed important and irreplaceable over time. Additionally, the CJPH and PHJ have served as the "official organ" of the CPHA since 1910,(136, p2) and exist online almost in entirety. Both the journal articles and other documents collectively served as a lens through which to explore the history of poverty in Canadian public health. As such, we believe our work accurately represents the historical perspectives of the Canadian public health community as told through the CPHA archives.

6.5 Conclusion

As this history has shown, interest in, understandings of, and approaches to poverty by the public health community have ebbed and flowed in Canada alongside national events during 1910s to 2010s. While it is difficult to determine the contextual factors that increased and decreased interest in poverty, we found that Canada's social, economic, political, and medical factors have influenced how the public health community approached this issue. Sometimes, the public health community adopted a remedying disadvantage approach to improve conditions for the poor, while other times they adopted a reducing health gradients approach that would reduce social and health inequalities by redistributing money, power, and resources in society. While interest in poverty is unequally distributed over time, throughout this history poverty has remained understood as more than a contextual factor of health and disease for the public health community, as a SDOH.

We found that a more nuanced understanding of poverty emerged following the Great War, particularly among the perspectives that existed for academics, administrators, and frontline workers. The Great Depression very strikingly furthered these understandings as Canadians fell into poverty, making the poor a less distinct group. In Canada, governments responded by seeking universal solutions throughout the latter half of the twentieth century that would equalize

opportunities for health in society, such as through the provision of old-age pensions, medical

insurance, and guaranteed annual income. Today, however, while the public health community is

more vocal than ever, it still faces substantial challenges in addressing poverty as income

inequality continues to worsen.(137) As shown in this history, this issue has remained

throughout the twentieth century. We call for government action that targets the unequal

distribution of money, power, and resources as an urgent and fundamental step in reducing health

gradients and poverty.

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173

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Chapter Seven: "For All Those who Need Them": Efforts to Secure Equitable Access to Family Planning Services from within the Canadian Public Health Community, 1960s-80s

7.1 Abstract

Birth control and abortion were legalized in Canada in 1969, through amendments made to the *Criminal Code*. However, while these amendments did improve access to family planning services, many barriers remained following legalization. We explored the efforts of the Canadian public health community related to improving access to family planning services during the 1960s-80s, through analyzing archival materials from the Canadian Public Health Association and the *Canadian Journal of Public Health.* We identified two themes where the public health community focused their efforts: (1) access to family planning services and (2) teen pregnancy/sexual health education. For access to family planning services, the public health community was particularly interested in bringing equitable access to family planning for women of low socioeconomic status and Catholic women, as financial and religious factors presented unique barriers. For teen pregnancy/sexual health education, the public health community sought to address a rising teen pregnancy rate through sexual health education in schools. As shown through both of these themes, a key role of the public health community during the 1960s-80s was disseminating scientific evidence about abortion, birth control, and sexual health education as a means of improving equitable access to family planning services.

7.2 Background

Family planning, the practice of controlling the number of children and spacing between pregnancies,(1) represents a social, cultural, and medical phenomenon that intersects fields of law, public health, and women's rights. The family planning movement of the mid-twentieth century, which sought to increase access to methods of birth control and abortion, illustrates a

period of historical significance to the public health community and society at large. This movement brought together individuals, community groups, non-government organizations, members of the medical profession, and others who sought to strengthen the control women had over their reproductive bodies.(2)

The timing and goals of the family planning movement tie in with those of the women's movement, as both reached heightened points of activity during the 1960s-80s.(2) Family planning was adopted as a campaign of Second Wave feminism in North America, a social movement that mobilized after the Second World War with the aim of gaining equal rights for women and their greater participation in public life. Family planning held potential for women's rights to be realized; the ability to choose the timing and size of their families gave women greater control over their decisions to enter the workforce, seek higher education, pursue careers, or identify with roles other than mother or wife.(3) Through advocating for accessible birth control and abortion, feminists and activists brought widespread national and international attention to the tensions women faced in a changing society, as well as broader public demand for reproductive options and services.

In 1969, amendments to the *Criminal Code of Canada* legalized the sale and advertising of birth control, which, for this paper, refers to the contraceptive pill. Even after this amendment, however, access to birth control prescriptions varied by a woman's age, marital status, race, and religion.(4) The 1969 amendments had also legalized abortion, though only in cases where pregnancy was deemed as endangering the health of the mother.(5) As discussed in detail later, this substantially restricted women's access to this procedure.(6)

The Abortion Caravan of 1970 was the first national pro-choice protest in Canada.(6) The Caravan consisted of a group of women who drove from Vancouver to Ottawa, with overnight

stops along the way to host discussions on women's reproductive issues across Canada.(6)

Hundreds of women participated in the protests, which consisted of symbolic memorial services

and the laying a coffin at the front door of then Prime Minister Pierre Elliott Trudeau (1919-

2000) in representation of the women who lost their lives undergoing illegal abortions.(5) These

women also shut down the proceedings of the House of Commons for the first time in history,

when they interrupted the Minister of Justice's indication to Parliament that the abortion law

would not be reviewed.(6) Such events sparked public debate across the nation in ways that

eventually brought reform to the law in 1988.(5)

When considered in the contemporary context of public health, the family planning

movement of the 1960s-80s serves as an historic example of how issues of health equity and the

social determinants of health played out in the context of reproductive rights. Today, health

equity, which refers to the absence of systematically produced and remediable health

inequalities, is a fundamental goal of population and public health.(7, 8) Health inequalities arise

from inaction on the conditions in which people grow, live, work, and age, as well as the wider

social, economic, and political forces,(9) known as the social determinants of health. The family

planning movement represents one form of what today might be considered 'action on the social

determinants of health.'(10) Members of this movement fought against the laws, policies, and

social norms that created health inequalities through unequal access to health services.

Specifically, members of the family planning movement sought to remedy inequitable access to

birth control and abortion for women from different geographic locations, religions,

socioeconomic backgrounds, and ages.

Previous Canadian historiography has examined the issue of family planning from a

multitude of perspectives. Much work has focused on the birth control movement and efforts to

182

obtain contraceptives or abortion in early modern Canada, from the late nineteenth to early twentieth century.(11-14) Some histories have explored the eugenic roots of the birth control movement throughout the twentieth century, for different populations (e.g., Indigenous groups, thalidomide survivors, the 'feeble-minded').(15-23) Others have focused on the activism and prosecution of abortionists for their provision of this medical service.(24-26)

Focusing on the latter half of the twentieth century, some work has focused on the legal (27) and moral (28, 29) aspects of the abortion debate. Specific to the 1960s-80s, the historiography includes articles that have explored the impact of birth control and abortion for married women in English Canada,(30) as well as abortion policies in places where conservative religious and political values have introduced additional barriers to access, such as in the Maritime Provinces,(31, 32) Prince Edward Island,(33) and Canada as a whole.(6, 34, 35) Others yet have focused on the travel some women were required to take in order to obtain an abortion.(36, 37) Among these multiple perspectives (i.e., history, medicine, activism), a gap remains regarding this history explicitly from the perspective of public health, a field that has long been interested in family planning and its relation to child and maternal health.

This paper explores the efforts of the Canadian public health community related to the family planning movement during the 1960s-80s and consider these efforts in their wider social and historical context. This history provides new insight into the family planning movement by situating this social history in the context of public health. Also, this history considers the multiple axes of stratification (e.g., gender, religion, socioeconomics) encompassed by family planning as an early and informative example of how issues of equity play out in public policy.

7.3 Methodology

Our research process is guided by historical methodology, through which we seek to interpret the past through available primary source materials.(38) We examined archival materials from the Canadian Public Health Association (CPHA) and the Library and Archives of Canada, both located in Ottawa, Ontario. The CPHA is a national not-for-profit and voluntary organization that has provided an independent voice for public health in Canada since 1910.(39) The CPHA archives are an ideal source for this study as it is the oldest national public health association in Canada. We refer to our findings from the CPHA archives as emerging from the "public health community" because the CPHA has represented issues of concern and interest of the national public health community throughout its history. It should be noted, however, that diversity exists within the public health community, presently and historically. We review this history of public health through our contemporary understanding of this field as being rooted in social justice and health equity. As such, we review the history of family planning through the public health community's attempts to *include* certain groups to improve population health versus attempts to *exclude* or marginalize them to control their bodies. This separates our work from some of the rich historiography that exists on this topic, which explores the underlying motivations, class and gender biases, and other social factors of family planning.(141, 142) Access to the CPHA archives was granted through an agreement signed by the authors and CPHA's Board of Directors. Materials from the Library and Archives of Canada are publicly available to registered users.

Archival materials, including meeting minutes, annual reports, policy and position papers, and publications from CPHA's journal, the *Canadian Journal of Public Health* (CJPH), were reviewed and compiled during a research trip by KL in 2015. We followed the process for

sampling in content analysis outlined by Krippendorff (2004).(40) First, all potential sources were identified through consultation with CPHA staff. Each source was then reviewed for its potential relevance to the social determinants of health concept, described elsewhere.(41) Relevant documents were photographed and compiled into an NVivo Qualitative Software database as portable document files (i.e., PDFs).(42) All documents underwent line-by-line open coding,(43) decade-by-decade, to identify significant issues and events in the history of the social determinants of health. This preliminary coding was conducted by KL. Authors met to discuss potential topic areas that spoke to the history of the social determinants of health, following preliminary coding. We identified family planning as a topic worth exploring because of its overlap with the social determinants of health and public health issues (e.g., gender, sex, maternal and infant health, women's health, feminism, health services). Because of the nature of the CPHA archives (i.e., unaccessioned and unindexed with no finding aids) and limitations to accessing certain records (e.g., membership lists), there are aspects of this history to which we are unable to comment, such as the membership status of individuals captured in archival documents and the extent to which they continued to participate in CPHA and its family planning activities over time.

Because the CJPH was a particularly rich source of information, we wanted to ensure that we had not inadvertently missed any relevant material during sampling. To that end, we conducted a targeted keyword search of this journal for the terms "birth control," "family planning," or "abortion" in articles published between 1960-1989. Relevant articles identified from this search that had not been previously captured were added to our sample.

We approached our analysis from a social historical perspective, meaning that we considered how the structures of society (e.g., social, economic, and political forces) interacted

with social movements and periods of social change in the history of this public health issue.(44) This perspective aligns well with the theoretical assumptions of the social determinants of health we adopted prior to conducting this work. As noted in the conceptual work developed by Solar and Irwin (2010) for the World Health Organization's Commission on the Social Determinants of Health, the health of populations is shaped by the socioeconomic and political context, structural determinants of health inequities (i.e., the stratification that results from hierarchies of power, prestige, and access to resources), and intermediary determinants (e.g., material circumstances, psychosocial determinants, behavioural, and biological factors).(45) As will be shown throughout this paper, issues of family planning frequently highlight the interconnectedness of social determinants of health across and within these different levels. Our understanding of this overlap is informed by intersectionality theory to consider how the SDOH operate on multiple axes of stratification (e.g., race, gender, sexuality).(46, 47)

In this study, we refer to 'issues of family planning' rather than using a more positive term, such as 'women's reproductive rights.' We frame our narrative in this way not to ignore the efforts of those who fought for women's rights, but to present this history as represented in the CPHA archives. Discussed later in this paper, the family planning movement during the 1960s-80s occurred in a social and political context that brought controversy for members of the medical community who advocated for family planning. As we argue, this context is likely why family planning in the public health community, as documented in the CPHA archives, was framed predominantly as a medical issue rather than one of reproductive rights.

7.3.1 Analysis

We developed themes by considering the patterns and relationships that existed between the codes that were grouped under the family planning category. As a primary step, we compiled

186

a timeline of the events from the data, developments, and publications related to family planning. Next, we reviewed the timeline to determine which years were most active (i.e., those that had the most events in the timeline). We identified these periods as the 1910s-30s and 1960s-80s. We focused on the 1960s-80s as the period of interest, due to the novelty of examining this issue and period from the perspective of the public health community and our personal interest in this social history. We triangulated sources to ensure that multiple perspectives on family planning issues were represented and to verify the content of primary sources.(48)

Through reviewing our timeline and codes, we identified the following two themes as encompassing key issues of family planning during 1960s-80s: (1) access to family planning services; and, (2) teen pregnancy/sexual health education. Access to family planning services concerns the public health community's efforts in bringing equitable access to birth control and abortion for women of low socioeconomic status and of the Catholic faith. The second theme concerns the public health community's efforts to publicize teen pregnancy as a public health and social issue, and to bring sexual and reproductive health education into schools. We also wanted to ensure that we considered each theme in the context of health equity, and so we used a health equity tool as a guiding framework to help interpret our findings.(49) We reviewed our themes using the framework to consider how our findings might relate to issues of material disadvantage, minority culture or ethnic groups, families with children, physical or mental frailty, and gender or sexuality.(49)

7.4 Results

7.4.1 Overview

To situate our findings, we begin by briefly reviewing the history of family planning in Canada prior to the 1960s, including major developments since the late nineteenth century. We

then explore the two themes from our analysis of family planning during the 1960s-80s from the perspective of the Canadian public health community: (1) access to family planning services and (2) teen pregnancy/sexual health education. We place each theme in its social, cultural, and medical context, and consider the contributions towards equitable access to family planning services that they represent.

7.4.2 A brief history of family planning in Canada, 1860s-1960s, and the role of the CPHA

Abortion was made illegal in Canada in 1869 as an offence punishable by life in prison.(50) In 1892, further legal restrictions were implemented, through the *Criminal Code of Canada,* which decreed obtaining, selling, or advertising birth control an offence against morality that was punishable by imprisonment.(51) These restrictions on birth control were kept in place until 1969, when Bill C-150 of the *Criminal Law Amendment Act, 1968-69*, decriminalized access to contraceptives and permitted 'therapeutic abortion' under certain conditions and special permissions, described below.(2) In 1988 during *R v. Morgentaler*, the Supreme Court of Canada struck down the criminalization of abortion and removed the legal restrictions to obtaining one.(52) No further criminal laws have regulated abortion in Canada since.

Despite the illegality of birth control and abortion in the early and mid-twentieth century, women in Canada still sought these services, often through discrete and often risky ways. Some wrote to contraceptive manufacturers, magazines, and community agencies to obtain information on contraceptives, while others sought to terminate pregnancies illegally or outside of the country.(14, 27, 53-55)

The family planning movement in Canada formally developed during the Great Depression. Philanthropists and community agencies provided methods of and instruction in

birth control to poor families, with the principle aim of easing the financial burden of bearing more children.(27, 56) Information bureaus and sterilization clinics were set up throughout the first half of the twentieth century to help women obtain information on and access to birth control and other family planning services.(27, 56) By the 1950s, the movement had gained ground as public demand for services grew among Canadian women. Clinics and associations formed across the country to provide women with information, instruction, contraceptive devices, abortion procedures, and counseling in methods of family planning.(57)

7.4.3 Theme 1: Access to family planning services

While contraception and abortion were legalized in 1969,(50) the legal restrictions surrounding induced abortion resulted in differential access for women seeking this service.(5) An abortion could be obtained once a therapeutic abortion committee (TAC), comprised of three physicians not involved in conducting the procedure, considered the pregnancy as endangering a woman's life or health.(31)

Many problems existed with this arrangement. First, many non-urban hospitals in Canada did not have enough physicians to form TACs, leaving women to go without or to travel to seek this service.(36, 37) Second, TACs took time. With an average 8-week wait time, many women carried pregnancies beyond the time when early term surgical or induced abortions were feasible.(58) Third, some facilities and provinces simply refused to provide this service despite the law, for example, in 1982 Prince Edward Island refused to fund abortions and its hospitals arrested provision of this service.(58) For both abortion and birth control, two groups of women that the public health community identified as disproportionately experiencing the burden of limited access were: women who faced material disadvantage (i.e., low socioeconomic status) or who adopted (or had healthcare providers who adopted) certain cultural and religious beliefs

189

(i.e., Catholicism). Finally, the ambiguity of interpreting whether a pregnancy endangered a woman's health erected another barrier to accessing abortion procedures. Some physicians considered socioeconomic circumstances justifiable for abortion requests, while others did not.(59)

7.4.3.1 Access for women of low socioeconomic status

Lower socioeconomic status (SES) women faced multiple barriers to accessing family planning services. If higher SES women were denied induced abortions or if their hospitals did not have a TAC, they likely possessed the resources needed to travel outside their jurisdiction and have their case reviewed (e.g., in another province or outside of Canada).(31) Lower SES women, however, could not afford to go to such lengths and were often left with the option handed down to them by a panel of physicians.(37) Aboriginal, immigrant, refugee, and young women, as well as women of colour, were more frequently refused or delayed abortion referrals by health care providers than white women, and also experienced greater breaches of confidentiality, mistreatment, and insensitivity from these providers.(60) Additionally, a woman's class, marital status, age, and number of children all influenced the decision from the TAC.(37) In sum, abortions were most frequently denied to those in the most socially and economically disadvantaged circumstances: single-parent mothers living in poverty.(60)

Against this backdrop, we observed that some members of the public health community drew attention to, and in some cases, questioned assumptions around disparities in access to family planning where they observed it. This included questioning and critiquing aspects of the profession that furthered health inequalities. A 1967 example, from University of Toronto Professor of Public Health, Cope Schwenger, explicitly identified that members of the field "must not apply to the lower socioeconomic groups our middle class standards or use Anglo-

Saxon stereotypes"(61, p3) when working with these populations. He described that ill-informed or embarrassed mothers and pregnant women of lower SES faced stigma when attempting to access family planning services.(61) He noted these women were often dismissed by health workers as uninformed, ignorant, apathetic, resistant, or too hard to reach.(61) Specifically referring to the lower SES women who sought information on birth control methods, Schwenger reported that "one still hears occasional comments from patronizing and smug health personnel such as 'they like to breed like flies – they want it that way.'"(61, p7) Yet as he affirmed in defense of this population, "They certainly do not want it that way. They have simply not had the same access to birth control advice as the rest of the population."(61, p7) This position illustrates one instance where a member of the public health community stood against the inequitable access to family planning services faced by lower SES women.

Throughout the 1960s, numerous articles were published in the CJPH that documented the establishment of public family planning clinics,(57, 62-69) which suggests that the public health community was supportive of improved access to information and services on family planning. Many of these papers described in detail how the authors obtained buy-in from communities, hospitals, and the public, how they procured birth control devices, contraceptives, and medical equipment, and how they reached women in need. Through sharing these experiences the public health community, which included program planners and decision-makers, became exposed to strategies that could overcome some of the barriers to establishing equitable family planning programs. For example, the local health unit covered the entire cost of the family planning clinic to reach low SES women in Hamilton and Norfolk County, including payment for oral contraceptives, intrauterine devices, and physician fees.(57, 65) In Vancouver, free clinics such as the Research & Educational Attack on Community Health (REACH) Centre

helped women obtain care during pregnancy, provided contraceptives, and also performed induced abortions.(70) In particular, the REACH Centre provided birth control and abortion services to transient, indigent, and uninsured women as well as to the general public.(70)

Other clinics documented how they were able to provide methods of birth control free-of-charge to women from the donations they obtained from companies that made contraceptives and pamphlets.(66, 68) For example, the Family Planning Association of British Columbia used a sliding fee scale (i.e., from $0 to $15) for applicants seeking services from the Vancouver clinic according to the financial situation of the applicant.(68) The fee was determined for each applicant after the clinic's social worker and physician had taken a social history and determined a reasonable amount within the means of the applicant.(68)

In 1967, at a meeting of the CPHA Executive Committee, the organization seems to have adopted a stronger internal position in support of equitable access to family planning services and information. Despite the CPHA's public position on providing family planning services only in accordance with the law,(71) the Executive carried a motion suggesting that CJPH seek advertising from companies active in family planning.(72) This suggestion, raised by the CJPH on September 16, 1967 (72), came three months prior to the introduction of the first version of the *Criminal Law Amendment Act*, on December 21, 1967. At the time, advertising the sale of birth control was still against the law.

7.4.3.2 Access to family planning services for Catholic women

During the 1960s-80s, family planning represented a moral issue influenced by the conventions and beliefs of one's faith. By 1969, the Anglican,(73) Presbyterian, and United Churches,(74) publicly supported legalized abortion as amended in the *Criminal Code,* while others, such as the Mormon Church (75) and Roman Catholic Church, did not.(76) Instead, the

Catholic Church opposed "any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation,"(77) which included birth control and abortion. While other religions likely presented barriers for women seeking family planning services, in the CPHA archives, Catholicism appeared to be the focus. It should also be noted that undoubtedly in this history, many Catholics, their parishes, and priests were sympathetic to or supportive of abortion; in fact, even Prime Minister Trudeau – who decriminalized abortion – was himself a practicing Catholic.(78) As well, the findings presented here do not necessarily speak to the changes of Catholicism that were occurring in Québec following the Second World War. During the Quiet Revolution, when the authority of the Catholic Church was brought into question, many Québecois left the Church or chose not to follow its teachings.(140) This complicates some of the findings presented below regarding the influence of religious reasons to seek birth control or an abortion. As such, the tensions represented below may not represent the diverse experiences with Catholicism and family planning that occurred throughout Canada; rather, they illustrate only those represented in the CPHA archives.

As indicated in the CPHA archives, by the early 1960s, activities within the association and publications in the CJPH suggest that the public health community took notice of the unequal access to family planning services that resulted from religious beliefs. In 1966, one member of the CPHA delivered an address to the association's annual meeting, where he drew attention to a resolution passed by the American Public Health Association two years earlier, that family planning programs should ensure "freedom of choice of methods [and] that persons of all faiths have equal opportunity to exercise their choice without offence to their consciences."(64, p61) In this address, the member positioned family planning as a health department responsibility that could be integrated into the delivery of health services "as long as full

193

freedom was extended to all population groups […], as are consistent with the creed and mores of the individuals concerned."(64, p61) The perceived importance of and commitment to this supportive position on family planning was subsequently reaffirmed by CPHA resolutions passed in 1966,(79) 1971,(80) and 1975.(81)

Religious views seem to have affected women's access to family planning services in two ways. First, a woman's own religious beliefs could potentially limit her access to family planning services by limiting the options for birth control she considered viable (e.g., not abortion, not birth control). One study published in the CJPH that surveyed university students about their views on legalizing abortion in 1968 and 1971 found that Catholic females were more likely than others to oppose abortion for several reasons (e.g., economic reasons, child unwanted, rape).(82) A repeat of this survey by the author in 1974 and 1978 found that the views among this population had become significantly more conservative, with a decrease in the percentage who approved of legalized abortion for any reason.(83)

On the other hand, a 1973 study reported that despite the above opposition, Catholic women did undergo induced abortions.(84) In fact, 29% of the study's sample of women who underwent this procedure identified as Catholic.(84) However, there are potential limitations in interpreting the significance of this percentage, given the above description of changes that occurred regarding Canadian Catholics following the Second World War. The authors conducting this study, in surveying women who had an abortion, reported that religion was cited only as a lesser factor in these women's decision to procure one.(84) Another 1973 study, among married female heads of households in Nova Scotia, also found that religion did not appear to significantly influence the knowledge, attitudes, or practices these women held with regard to family planning.(86) This same study reported that 60.3% of Catholic women in their sample

took an oral contraceptive pill,(86) despite the Church's overt opposition to contraception.(77, 86) Considered overall, then, according to the content published in the CJPH, the personal religious views of women did not consistently appear to present an insurmountable barrier to family planning.

Access to family planning services may also have been mediated by the beliefs held by women's sexual partners and healthcare providers. For instance, a 1973 survey of general practitioners and obstetrician-gynecologists in the Ottawa area, published in the CJPH, reported unequal provision of access to induced abortion among physicians of different faiths.(59) The study found that Catholic physicians were less forthcoming in providing this procedure compared to physicians of other or no faith(s).(59) One survey question asked physicians to indicate whether they deemed socioeconomic considerations, such as constrained finances, as acceptable criteria for approving an abortion request; 85% of Jewish respondents reported yes, compared to 36% of Catholic ones.(59) This finding highlights the added barrier of cultural influence for the patients of Catholic physicians, who adopted more cautious attitudes in referring women for induced abortions. This barrier was perhaps even more pronounced for Francophone women, as French-language physicians in this survey were 95% Roman Catholic.(59)

Another CJPH publication written by Cope Schwenger in 1973, reported that Catholic women faced greater difficulty in obtaining induced abortions, compared to Protestant women.(55) In part, this likely reflected the practice of many Catholic-run hospitals or hospitals in largely Catholic communities in refusing to establish TACs or provide family planning services to their clients.(59, 87, 88) Another way that women's access to family planning services was limited concerned the need for Catholic women to consult with their parish priest

before seeking services. While the extent of this practice or the degree to which it was followed is unknown, it was reported as a requirement for Catholic clients of the Brantford County Family Planning Clinic in Ontario, in a 1967 CJPH article.(69)

An additional finding from a previously-mentioned CJPH study that surveyed university students in 1968 and 1978,(83) was that Catholic males were significantly less approving than females about the conditions under which a woman should legally be able to obtain an abortion. This finding suggests the possible influence of women's sexual partners on their access to family planning. Women may not have considered induced abortion as a viable option when they knew their partner held opposing beliefs.

The public health community appears to have attempted to promote equitable access to family planning for women of all faiths – and especially Catholic women – through its efforts to make family planning services and information about them more available. In Brantford County, where women had been required to consult their priest before accessing services, the family planning clinic maintained a separate room and a separate Catholic physician, so they could learn about birth control methods in accordance with the ethics of their faith.(66) Other public health workers sought to improve access to family planning services by establishing clinics in Catholic Hospitals, such as one in urban Ontario that taught methods of "natural family planning" to both Catholics and the general public.(89) Natural family planning methods, such as the sympto-thermal method, were acceptable to Catholics.

7.4.4 Theme 2: Teen pregnancy/sexual health education

The liberalization of Canadian society during the second half of the twentieth century encompassed the sexual revolution, a social movement that challenged the norms of sexual behavior and relationships (e.g., the institution of marriage, monogamy, and

196

heterosexuality).(90) One outcome that followed from this movement was the belief that

teenagers began to sexually experiment earlier beginning in the 1960s.(91-93) What has been

documented is the period of crisis that emerged in public discourse during the postwar period,

alongside rising statistics of illegitimate teen births.(94) In 1945, teenagers accounted for 28% of

illegitimate births in Canada, but by 1961 this number reached 37%.(94) Teen pregnancy became

a public health issue, as social workers and medical professionals found that unmarried pregnant

teens were less likely to receive prenatal care, follow medical advice, or have seen a doctor

before going into labour.(94) Perhaps as a result, teenage births were more often subject to

complications, such as stillbirth, toxemia, or infant and maternal mortality.(94, 95) Finally, teen

pregnancy was linked to a number of social problems, such as child delinquency, venereal

disease, promiscuity, family problems (e.g., parents rejecting pregnant teen), and divorce.(62, 63,

94, 96) As explored in this section, over the course of the 1960s-80s, providing sexual health

education to teenagers became an important goal of the public health community.

In the 1960s, Alberta physician Dr. Margaret S. Hutton (1910-1983) set out to document

the problems she witnessed among pregnant teens. Hutton, who was the first female obstetrician

and gynecologist in Edmonton, presented a substantive report on the social factors related to teen

parenthood in 1965 during an address at the CPHA's annual conference.(62) In 1968, Hutton

published her work from surveys with teen mothers, who at the time, made up 2.6% of the

Alberta population.(63) Hutton reported that teens experienced high rates of perinatal mortality,

potentially brought on by premature labour, antepartum hemorrhage, and low birth weight.(63)

Focusing on teen parents who were married, Hutton identified the potential role of

socioeconomic factors and socio-psychological stresses these young mothers faced, compared to

others over the age of 20.(63) Married teenage mothers were found more likely to have come

from homes of lower social status (i.e., father's occupational class), have attained lower levels of education, and have come from homes 'broken' by death, desertion, or divorce.(63) Hutton also found that the disadvantage teen parents faced as children continued later in life; compared to mothers in their twenties, teenage mothers were less likely to have medical insurance, more likely to rely on social assistance (i.e., welfare), and more likely to move residences during their pregnancy or shortly after giving birth.(63) The mobility of teenage wives and mothers, Hutton surmised, contributed to the social isolation that these young mothers reported, as well as increased stress during pregnancy.(63) These factors, which in and of themselves placed teen mothers at a material disadvantage (e.g., low income, unstable housing), as well as physical and mental frailty (e.g., low-weight infants, poor self-rated health, stress, high anxiety) could have been further exacerbated by the isolation and lack of support these mothers experienced.(63) Hutton found that married teenage mothers were also more likely to have no close friends, no friendly neighbours, and maintain more negative relationships with their husbands.(63) Importantly, Hutton suggested that family planning advice should be available to teen families, and involve teen husbands in such programs whenever possible.(63)

The suggestion of providing teenagers with family planning advice seems to have reverberated throughout the public health community during the 1960-80s, as they pursued efforts to bring sexual health education into schools.(97-101) A number of studies published in the CJPH through the 1970s-80s found that teens did not have reliable access to information on family planning or family planning services.(101-108) One 1985 study highlighted the importance of including teen sexual health education in schools, as the authors found that the knowledge and confidence of students on subjects such as male anatomy, birth control, and sexual activity were far greater among those whose teachers presented this information to them

in class.(109) Another important finding from this study was that differences existed in the sexual health education that male and female grade eight students received. While boys learned about male anatomy, their female classmates learned about birth control in a separate environment.(109) Educating students separately shifted the burden of responsibility to female students for preventing pregnancy, instead of both partners. The authors commented on the potential implications of reversing the practice of separate education, asking the following: "Might society's burden of adolescent pregnancy be lightened if males were taught also the responsibility of birth control; the very responsibilities they so easily ignore?"(109, p165)

The public health community worked to develop informative school sexual health programs for children of both sexes throughout the 1970s and 1980s. CPHA worked with public health professionals to make resources (e.g., educational videos) available to health teachers and schools for the purposes of sex education.(106, 110) They also passed a resolution in 1984 to include human sexual education as a mandatory part of the school curriculum, which was circulated among its membership that included public health and school health nurses, health promoters, and program planners.(93)

Yet despite the progress made by the public health community in developing sexual health education, this topic remained a moral and controversial issue for many parents and school boards in Canada. A 1985 position paper on sexual health education produced by the CPHA addressed these concerns with evidence-based responses to the opposition public health practitioners had met in trying to implement such programs.(111) Opponents cited fears that sexual health education would: normalize issues such as masturbation, homosexuality, abortion, and premarital sex; serve as pornography for students in disguise of teaching materials; or cause

sexual experimentation.(111) In response to such issues, the CPHA adopted a clear stance on

sexual education:

> Human beings are sexual just as they are mental and social. Sexual problems should not
> need to exist in order to educate about sexuality any more than an epidemic of rickets or
> pellagra is necessary to educate about nutrition.(111)

The association ended their position paper by urging the provincial and territorial governments

of Canada to improve on the quality of sexual health education provided in schools and include it

as a mandatory part of the curriculum.(111)

Later, in 1987, the CPHA put into practice their position on sexual health education as a

joint responsibility of parents, schools, and communities.(111) As the result of a

recommendation made in the CPHA's report on *Strengthening Community Health Services,* the

association developed a demonstration project on adolescent health that aimed to change

attitudes and give power to community groups in making local planning and funding decisions

on issues such as adolescent sexual health.(112) The project consisted of consultative provincial

workshops co-led by national government partners, that brought together school boards and

health units to discuss these issues.(112) While there is little additional information on this

project, the conversations within the organization likely influenced other members of the

association to improve on sexual health education through consultations. For example, during the

time frame of the community health services report, the Québec Public Health Association

developed a symposium on adolescent sexual health for health and education professionals,

which they highlighted in CPHA's member newsletter, *Health Digest*.(113) At this event,

participants heard presentations on several topics that addressed some of the moral issues raised

by parents on sexual health education, such as adult perceptions on sexual practices, the legal

aspects of adolescents and sex, and adolescent pregnancy and parenthood.(113)

7.5 Discussion

The examples reviewed here illustrate efforts of the Canadian public health community in promoting equitable access to family planning services during the 1960s-80s. As shown, certain barriers have existed throughout history that limited the access that some women had (i.e., teenagers, Catholics, low SES, rural) to birth control and abortion services. The public health community, through their efforts to bring information on family planning services to all women in Canada, played an important role in enhancing the evidence base on birth control and abortion as a health issue, separate from the legal debate that captured the Canadian public throughout the latter half of the twentieth century.

Existing histories on the family planning movement center on its activism and controversy; for example, the prosecution of medical professionals who performed abortion procedures, such as Dr. Henry Morgentaler (1923-2013).(114, 115) Other examples document the vocal efforts of women's groups to overcome jurisdictional barriers to accessing abortion in places such as Prince Edward Island (33) and New Brunswick.(37) Overall, previous contributions have aptly framed the family planning movement as a politically and socially-charged public issue.

Despite the many efforts and actions of the public health community to increase access to information on family planning services, this community seems to have adopted a public stance on family planning issues that was relatively silent compared to the overt advocacy taken on issues such as the provision of universal medical insurance.(116) This finding was surprising considering the anonymity that a national association such as the CPHA likely would have provided members of this community to pursue advocacy related to family planning without facing consequences from their employers, colleagues, or members of the public who disagreed

with their position.(117) It is possible the archives of the provincial branches of the CPHA (e.g., Public Health Association of Nova Scotia) reveal a different and potentially more controversial history than found here, as the smaller scale of provincial-level meetings allowed more time for in-depth discussions. Additionally, provincial associations may have more closely observed inequities in access to family planning than the national association.

Importantly, however, we do not consider the lack of controversy on issues of family planning to represent a lack of interest or involvement by CPHA or its members. This was confirmed through speaking with our public health colleagues who were active in both the organization and the issues during this time. We consider possible reasons for the relatively neutral representation of family planning issues, below.

First, members of the public health community, as represented by CPHA archives, seem to have accepted abortion as a medically necessary service long before the 1988 Supreme Court ruling that declared it so. In part, this may have been influenced by the public health community's perceived protection in the *Criminal Code*. As early as 1892, the *Criminal Code* stipulated that: "No one shall be convicted of any offence […] if he proves that the public good was served by the acts alleged to have been done."(51, p80) Practitioners of public health, a discipline founded on the principles of social justice and utilitarianism,(118, 119) may have considered their efforts in family planning exempt from prosecution. E. Aenid Dunton, former medical officer of health for Brantford County, supported this perception in a 1967 article on the establishment of a family planning clinic in the area.(69) As Dunton proclaimed of the clinic's operation, "There was no doubt here that the public good would be served."(69, p181) Dunton, however, did not specify whether abortions were available to clients of the Brantford County family planning clinic. Two years later, the CPHA passed a resolution endorsing "the

202

development and provision of family planning services for all those who need them."(71, p363) While the resolution did stipulate that family planning programs should be established in accordance with the law, it also suggested that services be available to persons of all religions, moral and ethical standards, and socioeconomic backgrounds.(71) As with Dunton, however, the CPHA resolution did not explicitly specify what was included in their definition of family planning services, such as only birth control or therapeutic abortion.

A second possible reason for the public health community's relative silence, is that members of this community who were involved in the family planning movement faced potential violent and professional consequences. Assassination attempts on the lives of physicians who performed abortions is one well-documented and extreme outcome of this controversy.(120-124) Another less violent but damaging consequence members of this community faced, was the potential character assassination of health professionals or community members who supported the provision of birth control and abortion by those who morally disagreed.(125, 126) Such consequences speak to the need for public health professionals to weigh the personal risks and benefits of their practice with those of the communities they serve. Accordingly, the topic of family planning services during the time frame of this paper may be of value to the growing field of public health ethics. This issue serves as an early example of the tension that public health professionals faced in conforming their field's utilitarian moral philosophy to the autonomy-based principles of bioethics that emerged in the 1960s and guided medical practice.(127)

Third, some members of the medical community were prosecuted by law during the period examined for providing abortion services in ways that the *Criminal Code* did not support (e.g., without having established a therapeutic abortion committee).(115) Within the public health community, however, CPHA members routinely published on issues related to family

planning and abortion, including a 1968 article that documented in detail "The forming of a family planning clinic."(66) Overall, published material (e.g., CJPH articles) presented family planning issues from a position of information and scientific neutrality. It is possible that this was due to the journal authors' own recognition of potential negative consequences of taking a stance, described above.

On the other hand, the CPHA should be recognized for its early support of family planning programs, which it first affirmed in 1969. This position came earlier than the 1971 recommendations put forth by the Canadian Medical Association and the 1971 statement by the Canadian Nurses Association.(128) In 1971, the CPHA also developed recommendations that went beyond those provided by these two other associations. Specifically, the CPHA recommended that education in family planning should be adopted as part of medical practice, and that family planning services should be provided to all women, including those who were 'promiscuous' or single with children.(128)

There are several limitations of this study. First, it is difficult to assess the direct impact that the efforts of the public health community had on changing laws, opinions, and practice. One conclusion that can be drawn from the issues reviewed is that the public health community saw access to family planning services as an important public health issue, as evidenced through the large number of position statements in support of this end. Second, as with any historical work this study is limited by the incomplete and potentially biased nature of the historical record. To overcome this limitation, triangulation amongst sources was used to verify the content and claims made in primary sources.(48) Additionally, all documents were subject to critical evaluation by the author, by considering the source's author, intended audience, and values that were present in each text and interview.(38)

In addition to the limitations of this work, there are also many strengths. First, this history represents an attempt to bring together the perspectives of the social determinants of health and health equity in interpreting public health history. This approach has revealed that health equity was a core element of the public health community's efforts around family planning, in terms of bringing equitable access for all Canadian women. It has likewise presented an early example of the social determinants of health concept in practice, as the public health community considered the influence of social, economic, and political factors on women's access to family planning services for women of low SES, the Catholic faith, and teenagers. Finally, this work contributes to the historiography on women's health, public health, and social issues, by utilizing a novel data source – the CPHA archives.

Many questions remain unanswered from this paper that could benefit from future research. For example, valuable context to this history would be added by assessing the impact of the public health community's efforts on policy and program reform. Additionally, interrogating the extent to which activists were a part of the CPHA and influenced its efforts in family planning represent another interesting area for future research. Finally, comparing the efforts of this national organization with its provincial branches may provide additional insight into the issue of family planning from a public health perspective, especially in provinces where at least some family planning services have historically been less accessible (e.g., Prince Edward Island, New Brunswick).

Today, access to family planning services remains difficult for many Canadian women. While unrestricted access to abortion became a legal right for women in 1988, limitations still exist across the country for women who seek this service. The availability of services varies by province; in British Columbia and Ontario, facilities exist in urban and rural areas. However,

very few facilities exist outside of urban areas in the Prairies, Territories, and the Atlantic Provinces.(76, 129, 130) As recently as 2016, Prince Edward Island announced that the province would be implementing abortion services for the first time in nearly 35 years.(130) In the Territories, nurses and nurse practitioners are the only medical point of contact for many communities in the Yukon, Northwest Territories, and Nunuvat, meaning that women in those areas who seek abortion services must travel to their territory's capital city to obtain an abortion during a time when a doctor is on-site.(129) The travel and procedure is funded through territorial health insurance; however, women are not compensated for the missed work and wages they incur.(129) Should women from the territories require a later-term abortion (over 12 weeks), they are required to travel to Ottawa, Winnipeg, Vancouver, Edmonton, or Calgary.(129) As student and activist, Sarah Frey wrote, this represents "an unnecessary barrier and hardship for a medical decision that is a constitutional right."(129)

7.6 Conclusion

Though important progress has been made, much work remains to bring equitable access to birth control and abortion for Canadian women. The examples reviewed in this paper will hopefully re-energize and support current efforts in the public health community to increase equitable access to birth control and abortion throughout the country. Further efforts are required to overcome the barriers to access that have been in place since the 1960s for women to fully exercise the reproductive rights they were granted nearly a half century ago.

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Chapter Eight: "It's a Tradition of Naming Injustice": An Oral History of the Social Determinants of Health – Canadian Reflections, 1960s-Present

8.1 Abstract

The 'social determinants of health' (SDOH) approach in Canada is widely acknowledged as having emerged through contributions such as the 1974 Lalonde Report or 1986 Ottawa Charter. Drawing on original oral histories, this paper considers this history through the reflections of past and present leaders in Canadian public health. This rich information reveals three phases in the recent history of the SDOH, from a social awareness (1960s-1970s, when participants underwent training and gained exposure to social and health inequities), to a loose collection of theoretical and empirical concepts (1970s-1990s, when the evidence base on health inequities and the mechanisms behind them began to solidify), to a distinct research approach (2000s-present, when high profile events led to acceptance of the SDOH approach) that encompassed the spirit of its previous iterations. This paper will be of interest to health researchers and professionals, decision-makers, and trainees as they contemplate their own role in this ongoing history.

8.2 Keywords

Social determinants of health; health equity; oral history; population and public health; health promotion

8.3 Background

On 1 June 2008, delegates from across Canada gathered at the Canadian Public Health Association's (CPHA) annual conference in Halifax, Nova Scotia to strengthen efforts at reducing health inequities through evidence and action.(1) The conference included a keynote presentation by Sir Michael Marmot, Chair of the World Health Organization's (WHO) recently culminated Commission on the Social Determinants of Health (CSDH).(1) Internationally the

WHO CSDH, which commenced in 2005, marked a major event in the history of the social determinants of health (SDOH) for bringing mainstream attention to and interest in the root causes of illness.(2) As will be shown below, it also marked a key moment in the history of the SDOH in its development as an evidence-based approach to public health.

Canada is widely credited as having facilitated early developments in the SDOH history through catalytic contributions such as the 1974 Lalonde Report.(3-18) Known formally as *A New Perspective on the Health of Canadians: A Working Document*, the report is credited as the first government document in the western world to draw attention to the determinants of health that lay outside of the health care system.(15) Additionally, some (16) have suggested that the 1970s represent a turning point when action on the SDOH 'crystallized' as a global movement in public health. However, a gap in the literature remains concerning the history of public health in Canada during the latter half of the twentieth century; and specifically, how this context and setting contributed to the development of the SDOH approach.

I conducted in-depth interviews with individuals who held decision-maker, academic, and practitioner roles in Canadian public health. I supplemented these oral histories with the analysis of archival materials from the Canadian Public Health Association, Library and Archives of Canada, as well as academic literature and government documents. To the best of my knowledge, no previous work exists specific to the SDOH in this country or for this timespan that utilizes oral histories, although other histories of the SDOH do exist. Internationally, three rich histories on the SDOH were written to inform the work of the WHO CSDH;(16, 19, 20) in Canada some historical work has been done that aimed to inform present population and public health.(6, 21, 22) In line with the conventions of social historical research using oral

histories,(23, 24) I present my findings as a narrative. My detailed methodology is described in an accompanying supplementary file.

As described below, the contemporary SDOH (i.e., since 1960s) represent a synthesis of histories from the fields of community development, public health, health promotion, and population health. Indeed, the seventeen participants interviewed each recounted a unique telling of this history based on their diverse experiences. What binds the history of the SDOH is the strong commitment to social justice and to challenging the structures that create health inequity in society. This history begins in the 1960s, when a generation of future public health leaders embarked on a journey to make the world safer, healthier, and fairer. These individuals, who have been described as "lights at the time" (25) in public health, helped to spark a paradigm shift towards exploring the influence of social, environmental, and political factors on health. Throughout the 1980s-1990s, this community generated findings to support the growing evidence- and theory-base of the SDOH. By the early 2000s, the term SDOH was widely in use and eventually, through the work of high-profile initiatives such as the WHO CSDH, the SDOH gained prominence as a distinct and legitimate approach to public health.

8.4 Social awareness sparks a paradigm shift in public health

As a generation of future public health leaders underwent their training in medicine, social sciences, and politics during the 1960s-1980s, they gained exposure to social and health inequities locally and globally. These early exposures, which coincided with a heightened period of social activism in Canada, were essential to bringing social justice back into public health at a time when medicine "was all about engineering and technology and science."(26) Moreover, participants developed an internal commitment to act on the health and social inequities they observed, which helped shape ideas formative to the SDOH.

Ronald Labonté, Canada Research Chair in Globalization and Health Equity at the University of Ottawa, identified social change movements of the 1960s and 1970s – such as feminism, environmentalism, and political progressivism – as having an important influence on himself and colleagues during the postwar period. As Labonté explained, his "generational cohort essentially came out of the more radicalized period of the '70s or '80s and then found themselves in positions [in public health… W]e brought all that movement knowledge and tried to muck about with what we could where we were, in terms of where we worked."(27) Monique Bégin, for example, reflected on the influence of social change in her journey to becoming Canada's federal Minister of Health and Welfare. Bégin, a feminist sociologist, was working as an applied social scientist in Québec when she received the invitation from Pierre Elliott Trudeau (1919-2000) to run as a Member of Parliament (Montréal Saint-Michel) and Liberal candidate in 1972.(28) Since her youth, Bégin recalled, she understood that social change "was always about social issues, the reforms needed, and the cultural openings on the world."(29) She accepted the invitation from Trudeau's office on the basis of his 1968 leadership campaign for the Liberal Party of Canada, which promised a 'Just Society' and 'Participatory Democracy.'(29) On 30 October 1972, Bégin became the first Québec woman elected to the House of Commons. She remembered that "social reforms were still in the air" four years later when she was selected to serve on Trudeau's Cabinet.(29) Eventually, in 1977-9 and again in 1980-4, Bégin went on to become the Minister of National Health and Welfare. It was in this position, during her last year in office, that she introduced the *Canada Health Act, 1984*, which reduced barriers to medical care for Canadians through its principles of universality, portability, public administration, accessibility, and comprehensiveness.(30)

The social change perspective that Bégin and others brought into the federal government was essential in its adoption of a new approach to public health. Additionally, the innovative approach encouraged by government leaders in Health and Welfare during the 1970s further facilitated creative, non-health sector solutions to public health problems.(31) The Long-Range Planning Branch was particularly important to exposing decision-makers and public servants to new ways of thinking about health and its determinants. The Branch, which was established in 1971 by Deputy Minister of Health, Dr. J. Maurice LeClair, brought together interdisciplinary expertise from the medical specialty in Canada then known as Community Medicine (Jo Hauser) that is now named Public Health and Preventive Medicine, statistics (Jean-Marie Romeder, Gerry Hill), medical sociology (Rachel Paradis [née Richard]), law (Hubert Laframboise and department Minister Marc Lalonde), pharmacy (John Bachynsky), philosophy (Fernand Fontaine), and other disciplines.(31) Together LeClair and Laframboise led the Branch as a "free-wheeling think tank" with an "open mandate" to produce creative solutions to health problems.(31) Ultimately, the Branch developed the Health Field Concept, which suggested four interdependent determinants of health (biology, environment, lifestyle, and health care organization), introduced in the 1974 working document, *A New Perspective on the Health of Canadians.*(4)

The document initially had limited impact in Canadian government and public health.(31, 32) As recorded in the Hansard from when the report was tabled, members of the opposition dismissed Lalonde's report as "solidly in the motherhood realm,"(33, p1156) for offering ideas without concrete solutions. Outside of Canada, however, the *Lalonde Report* gained an international following in part due to medical critic Ivan Illich's (1926-2002) acknowledgement of the "courageous" report in the first pages of his 1976 book, *Medical Nemesis: The*

Expropriation of Health.(34) Eventually, and as discussed in more detail below, the Health Field concept and other ideas from the *Lalonde Report* would formally make their way back into Canadian public health with the development of health promotion in the 1980s. However, this new field emerged in a much broader social and medical context.

8.4.1 International development and community development

In the decades following the Second World War, global social and economic changes came to influence medical training in Canada and abroad, which in turn influenced Canadian medical training and contributed to a growing social awareness in public health. As European colonial powers dismantled their empires in Africa, Asia, and Indochina, countries from the global north became involved in efforts to improve conditions for impoverished and recently decolonized nations.(35) The Canadian International Development Agency (CIDA), which was established in 1968, supported a number of projects to strengthen community health services in the global south, in part by leveraging the experience of professionals and trainees in nursing, medicine, and community development.(35, 36) Gerald Dafoe, who worked as the Executive Officer of the Canadian Public Health Association (CPHA) from 1973 to 2003, recalled that many of the association's international projects had been funded through CIDA.(36) During this time, the CPHA maintained a close working relationship with the Health and Welfare department and completed many federally-funded projects and contracts on various public health issues to inform decision makers (e.g., the Canadian HIV/AIDS Information Centre). Dafoe remembered how at one time, the CPHA was working simultaneously in 45 countries to "build strength in the community so they could deliver whatever program [their international partner country] felt was necessary."(36) Over the years, CPHA's international development programs spanned issues related to literacy, nutrition, seniors, immunization, and others.(36)

In North America, some physicians who came to be very involved in the SDOH reflected on how concepts from international development were adapted and incorporated into their medical training, particularly through 'conscientizing' and community development. Conscientizing, or consciousness-raising, came from Brazilian educator and philosopher Paulo Freire (1921-1997).(37) In public health and community development, consciousness-raising was adopted as strategy to bring awareness to the inequities produced by unjust structural forces, such as macroeconomic policies.(38) The boycott of products from the food and drink company, Nestlé, in 1977 is one example that illustrates public conscientization and mobilization around a health inequity.(39) The boycott, which included 10 countries, eventually pressured Nestlé to abandon its practice of aggressively marketing infant formula in poor countries where mothers had no access to clean drinking water; formula made with contaminated water had contributed to the spread of malnutrition, communicable diseases, and infant mortality in the global south.(39-41) In community development, the work of American John McKnight also influenced medical training.(26, 38) McKnight's concept of asset-based neighbourhood development,(42) which argued for positioning health issues as political issues to inspire local action and solutions, inspired the work of public health leaders like Trevor Hancock, the physician and environmental advocate who founded the Green Party of Canada and the Healthy Cities Movement in 1983.(43) He and other participants cited work from scholars in urban development, such as that of Nancy Milio and Leonard Duhl,(44-46) as having impacted them during the 1960s-1980s, about the interconnectedness of health, public policy, city life, the environment, and economics.(26, 38, 47, 48) Additionally, participants cited the work of epidemiologist and historian, Thomas McKeown in adding layers of complexity to perspectives on the non-medical influences on health that existed at the time.(49, 50)

220

Medical doctor and nurse participants also made connections between health, inequities, and social justice through their clinical experiences.(26, 38, 47) David Butler-Jones, who served as the first Chief Public Health Officer of Canada from 2004-2014, recalled his experience working with a suicidal woman during his family medicine residency at Queen's University during the late 1970s.(47) The woman, Butler-Jones explained, "was a single mom with few friends, little education, no family around, [and a] couple of little kids that she was trying to raise on welfare."(47) He credits this experience as leading him on a path oriented in prevention that addressed social influences on health, by considering the "things that matter and that go well beyond what clinical medicine and the field of treatment […] can do."(47) Around the same time, in 1982 Lynn McIntyre, a poverty researcher and professor emerita, took a job as a staff physician in the Sioux Lookout Zone of Ontario. It was in this Aboriginal community where she witnessed "the complex context health is created in."(38) She remembered working with a particularly troubled woman whose condition was contextualized only by the explanation that she had attended residential schools. At the time, McIntyre remarked, "nobody knew what that meant"(38) other than the fact that it had disrupted the community. Her patients also faced hardship in their community from its lack of basic health needs, such as having no running water or latrines, and inadequate housing.(38) During her time with this community, she explained, she began to connect how the health conditions she treated "were really rooted in lots and lots and lots of community problems."(38) Thus, the early experiences of public health leaders working in disadvantaged communities and populations seems to have contributed to their wider understanding of health as an issue rooted in social and economic conditions. For certain population groups, such as First Nations living on-reserve, health issues were connected to even

wider issues, such as the lasting effects of residential schools on physical, mental, and spiritual wellbeing.

Marie de Loyer, a retired public health nurse, professor, and founding member of the Loyer-DaSilva Chair in Public Health Nursing, recalled her job as a nurse in the emergency department of the Ottawa General Hospital in the late 1960s. "People came from the streets with various health issues and complex problems," de Loyer reflected,

> They had very serious medical issues, but really to do anything helpful for them we had to be able to work with them from a community perspective […by making] a number of contacts with the social workers, and with the public health nurses out in the community.(51)

The desire that de Loyer expressed, to reform conditions for those suffering from social and material disadvantage, seems to have materialized for many participants early in their careers. As Butler-Jones recounted from his medical training, "Very early on […] I was really interested in the 'so what do you do about it?' as opposed to just more documentation of the problems."(47) Likewise, McIntyre also reported this interest after being challenged in her medical training to go beyond "the description of misery without an understanding of how you could actually take it apart."(38) She remembered how her professor, following up on a 1983 assignment she had completed on the epidemiology of health problems in Aboriginal communities, asked, "'Well, what are we supposed to do? You just don't stop it with [reviewing] all the problems, what are we supposed to do?'"(38) One solution that came out of the public health community was health promotion.

8.4.2 Health promotion: A paradigm shift in public health

Throughout the 1970s and 1980s, the *Lalonde Report* gained a slow and steady following in Canadian public health as it circulated among health professionals, government departments,

and policy makers. In 1974, Lalonde presented his report at the CPHA's annual meeting in St.

John's, Newfoundland, where he spoke of "possibilities for prevention […] beyond the

boundaries of the traditional health field," and the potential of a health promotion strategy to

improve health and reduce sickness through "informing and motivating individuals,

communities, and organizations, to accept more active responsibility in matters affecting

physical and mental health."(52) Over time, the new way of thinking proposed by Lalonde would

come to be known as health promotion, which was later ratified in the *Ottawa Charter on Health

Promotion* as "the process of enabling people to increase control over, and to improve their

health."(53)

      For participants, the *Lalonde Report* synthesized several ideas that had been circulating

on the root causes of illness. Trevor Hancock, recollected his first encounter with the health field

concept in early 1975:

> I think, in a sense, it confirmed and put in writing what I had already figured out in the
> back of my mind. At this point, [..] I'd gone through medical school, had my Sarawak
> [international teaching] experience, I had my ecological politics experience as an area
> organizer in '74. So I was thinking this way, but then the *Lalonde Report* came and I just
> sort of said, "Yeah, that's right, that's it." So really I was kind of a health promoter right
> from the start.(26)

For Lalonde himself, one of the main contributions to public health that he credited to the report

was its "formal government integrated approach to health issues."(54) Lifestyle, Lalonde

recalled, was adopted of the focus of the federal health department,

> because it was not a matter of jurisdictional conflict with provincial governments.
> Nowhere in the Constitution does it say 'Lifestyle is a provincial or a federal matter.'
> Everybody can do something about this.(54)

Marie de Loyer recalled how, in the years following the *Lalonde Report,* the terminology of the

non-medical determinants of health entered public health discourse and "began to be accepted in

teaching and practice."(51) Specifically, she recalled, public health began to focus "on issues that were not disease oriented. They were socially oriented."(51)

Some of the ways that health promotion was taken up in public health came directly from the federal government, such as its establishment of a Health Promotion Directorate in 1978,(55) while others came from practitioner and academic communities. A community-based example is the Health Advocacy Unit that was established by the City of Toronto in 1979 and operated until 1982.(56) The unit focused on "promotion efforts intended to influence individual and community attitudes towards man-made threats to health,"(57, p287) through combining community development, health education, and health advocacy.(26, 56) It was here, and more broadly in Toronto Public Health, where the interdisciplinary minds of individuals such as Trevor Hancock, Suzanne Jackson, Fran Perkins, David Kuhl, Lynn Elinson, Ron Labonté, and others came together to explore health issues where social and environmental factors were prominent, such as suicide,(58) poverty,(26) or the chemical society.(59, 60) As Labonté remembered from his time at Toronto Public Health, which he described as a "hot bed of activism," it was in the Health Advocacy Unit that he realized, "There is a shift that's underway."(27) A paradigm shift, defined by American scientist and philosopher Thomas Kuhn (1922-1996), is a change and professional commitment to the concepts and practices of a scientific discipline.(61) Certainly, a paradigm shift was underway within public health, as members of this community began to challenge the biomedical assumptions of disease causation and consider the social determinants of health and health promotion.(62, 63)

Another community group, led by physicians, was the Medical Reform Group that was organized by John Marshall and Philip Berger in 1979.(64) This group adopted the principle that "health care workers, including physicians, should seek out and recognize the social, economic,

occupational, and environmental causes of diseases, and be directly involved in their eradication."(64) Trevor Hancock, who was a member, later went on to co-found the Canadian Association of Physicians for the Environment with Warren Bell and Tee Guidotti in 1993, which considered the role of health care workers in addressing the relationship between environmental and health issues.(65) In the early history of the SDOH, medical doctors and nurses were prominent. Over time, however, to some degree this began to change as academics, population health researchers, and others working outside of the health care system began to challenge its approach to health.

Academic think tanks of the 1980s also brought attention to the non-medical determinants of health. The Canadian Institute for Advanced Research, discussed in detail below, is one well-known example. A lesser-known example is that of Paradigm Health, a futurist think tank that formed after the Health Advocacy Unit disbanded in Toronto. Suzanne Jackson, co-Director of the WHO Collaborating Centre in Health Promotion, remembered that the group did "future scenario work" and "causes of the causes work."(66) Paradigm Health brought together individuals who were connected with the health sector from diverse perspectives: hospitals, health planners, family physicians, and others.(67) Together, they contemplated the future of health by adopting a positive vision for health that extended well beyond the medical care system.(68) At one point, Jackson reflected, Paradigm Health presented a report they had prepared for the Ontario Minister of Health, which outlined "three major components to any health strategy or approach. Those were: learning the art of being well, providing rescue services to all, and creating a supportive environment."(66) According to Jackson, "some of the ideas from Paradigm Health were carried forward into the *Ottawa Charter* discussions."(66)

A predecessor to the *Ottawa Charter* was the 1984 conference in Toronto, "Beyond Health Care: From Public Health to Healthy Public Policy."(69) At this conference, which was organized by Trevor Hancock, over 200 delegates came together to consider the health impacts of economic and social policy, and to brainstorm new ways of developing "healthy public policy."(69) This work continued two years later at the First International Conference on Health Promotion ("the *Ottawa Charter* conference"), which present Chief Executive Officer of the CPHA, Ian Culbert, described as a "sea change" in the history of the SDOH because it "set the stage" for SDOH work, and talked about the SDOH "without using that language."(70)

8.4.2.1 An individual chapter in health promotion: Ronald Adrian Draper (1935-1997)

A key figure in the history of health promotion in Canada and internationally, is Ron Draper, a public servant who acted as the inaugural Director General of the Health Promotion Directorate when it was established in 1978. Draper, who is widely credited by his colleagues as a "master thinker,"(71) was vital to the organization of the *Ottawa Charter* conference and "hugely important"(26) in the development of health promotion. In fact, Marie de Loyer stated that, "In my view, Ron Draper really was the person who initiated [and] coined the concept of health promotion in the federal government and worked very determinedly for its acceptance."(51)

One project that benefited from Draper's influence was the Beyond Health Care conference in 1984, for which the Directorate provided some financial support.(26) At the time, Draper had also been working with Ilona Kickbush and the WHO in Europe, "because they were so interested in what the Canadians were doing"(66) on health promotion. Through Draper's initiative, Hancock invited Kickbush to the Beyond Health Care conference.(26) It was here that she heard Leonard Duhl's talk on healthy cities, which eventually led her to spearhead the

WHO's Healthy Cities Movement, a global urban planning and environmental health movement.(26)

Another "one of Ron's many great achievements," was convincing then Conservative Minister of Health, Jake Epp, of the value of health promotion and "radical things like equity and health equity and all the rest of it."(26) Peggy Edwards, who worked for Draper's Directorate at the time, recalled hearing how Draper had booked a dinner meeting with Jake Epp, where he intended to "propose to him that we write a policy document on health promotion."(71) Ultimately, the outcome of this meeting was the development of the 1986 *Epp Report,* known formally as *Achieving Health For All: A Framework for Health Promotion.* Once written, Draper and others in the Health Promotion Directorate sought to find the "right forum" at which to present the report.(71) The timing was perfect, for just as Draper began to consider possible forums, Hafldan Mahler (1923-2016), Director General of the WHO, and others from the organization proposed the "perfect venue," the First International Conference on Health Promotion to be held in Ottawa, Ontario.(71) At the 1986 *Ottawa Charter* conference, which was co-hosted by Gerry Dafoe and the CPHA in addition to the Health and Welfare department, Jake Epp delivered the *Epp Report*. Suzanne Jackson remembered how the *Epp Report* "was considered leading edge" and "really put the whole concept of healthy public policy, and citizen engagement, and 'social determinants of health' right in there."(66) Hancock even posited that the *Epp Report*, which was published and distributed at the same time as the *Ottawa Charter*, "was basically a reframing of the ideas and principles of the *Ottawa Charter* in Canadian terms."(26) This Canadian influence would come to the forefront during the proceedings of the *Ottawa Charter* conference, described below.

8.4.2.2 The Ottawa Charter on Health Promotion

In November 1986 delegates of the First International Conference on Health Promotion came together to produce the *Ottawa Charter for Health Promotion*.(72) The *Ottawa Charter* is foundational in the history of the SDOH for naming the prerequisites for health, which included broad social, economic, environmental, and political "fundamental conditions and resources for health": peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.(72)

As participants recalled, the *Ottawa Charter* was pivotal in opening new ways of thinking for practitioners in addressing the root causes of illness. Ron Labonté called to mind the following:

> In some respects I think the *Ottawa Charter* […] represented the zenith of this way of thinking, even though for some it was the introduction to this way of thinking [about the determinants of health…]. It consolidated a lot of little bits and pieces that people had been doing during the '70s and '80s and formulated it into a, sort of, simple four-page message. Now for others joining [public health and health promotion] at that point, that message was fundamentally important because it gave them permission to try to push or stretch around what their normal job duties might have been.(27)

Attesting to Labonté's interpretation, Nancy Kotani, who was a practitioner in community development and public health in Edmonton, recalled the *Ottawa Charter* as bringing a renaissance to public health in Canada because, "before that people like me didn't see themselves being able to do the work they wanted to within the normalized public health system."(48) Over the next two decades, public health would continue to diversify through the fractures and tensions that developed in the field from the many interests and perspectives of its workforce.

8.5 Fractures and tensions in public health, 1980s-1990s

Despite the enthusiasm and symbolic adoption of health promotion in federal government,

for instance by labelling programs as 'health promotion,'(71) as early as 1981, members of the

public health community began to take issue with the way that health promotion had been

implemented into practice across Canada. In some cases, critiques of health promotion arose out

of the practice base, among the same people who had expressed the enthusiasm described above.

Ron Labonté and co-author Susan Penfold, a professor emerita in child and adolescent

psychiatry, critiqued health promotion for "ignor[ing] the social context which conditions

attitudes and shapes behavior," such as the "pathogenic social structures" of poverty, sexual

inequality, racism, occupational hazards, and environmental pollution in a 1981 manuscript

(solicited by Ron Draper).(73) Rather, they continued, "actual health promotion practice ha[d]

limited its activities to motivating changes in personal 'at-risk' behaviours"(73) by focusing on

self-imposed risks and treating ill health as the result of personal choices related to diet, exercise,

drinking alcohol. Critiques such as these created tensions within the field of health promotion,

which caused some to look for ways of improving health beyond lifestyle approaches.(6)

8.5.1 The Healthy Cities Movement

One attempt at re-orienting health promotion towards recognizing the broader influences

of health was the Healthy Cities Movement, described by sociological theorist Steve Wadell as

an "international, civic-based, long-term planning effort" supported by the WHO that aimed to

change the environment to support health promotion and disease prevention.(74) Hancock

described a healthy city using language familiar to health promotion, as:

> one that is continually creating and improving those physical and social environments
> and strengthening those community resources which enable people to mutually support

each other in performing all the functions of life and achieving their maximum potential.(75)

As Hancock recalled of Healthy Cities, "it made the principles of the *Ottawa Charter* concrete and took them out on the streets.[…] I mean, you can theorize all you like, but if you don't change what you do on the ground then does it really matter?"(26) Yet, the Healthy Cities Movement was only one of many competing approaches to public health at the time, as discussed below.

8.5.2 The population health approach

Population health presented another competing intellectual framework to health promotion. This approach aimed to move beyond health promotion's focus on individuals to address the "interrelated conditions and factors that influence the health of populations over the life course."(76) By and large, population health in Canada arose out of the Population Health program of the Canadian Institute for Advanced Research (CIAR), led by its founding president Dr. James (Fraser) Mustard in 1982.(77) The CIAR was important in developing some of the SDOH's foundations, through their work interrogating the biology of "the determination of health"(78) and the "heterogeneities in health status," that is, why some population groups are healthier than others.(79) CIAR explored the interaction of genetics, environment, and society through its work on topics such as deep disadvantage and the effects of toxic stress on early child development and in adulthood.(38) Importantly, the CIAR group was essential in bringing together a number of important but disparate findings on social gradients of health that were crucial to the development of population health in Canada.

John Frank, who presently holds a chair in research and policy at the University of

Edinburgh, recalled how the interdisciplinary group at CIAR broadened his perspective outside

of his training in community medicine and epidemiology.(80) As he explained:

> That group began to acquaint me with other, broader, disciplinary perspectives –
> including health policy, health economics, and political science applied to health policy –
> because there were people who did those things, as well as qualitative ethnographers and
> cultural anthropologists. There was a clinical geneticist, Pat Baird. There were lots of
> people in that group that I would have never met at the University of Toronto […](78)

The CIAR facilitated several interdisciplinary collaborations that advanced the concept of the

SDOH. One included, "The Determinants of Health"(81) by Mustard and Frank in 1991 and *Why*

are Some People Healthy and Others Not?(82) by economists Robert Evans and Morris Barer,

with public policy and management professor Theodore Marmor. In the latter, the authors

presented "persistent and consistent gradients in health status between social groups in virtually

all industrialized countries of the world, largely independent of any particular disease

process"(83, p3) that are influenced by factors such as economic growth, early childhood

development, physical environment, health care, and work.(82) And while others before them

had made the same observations, the authors noted that health care alone would not eliminate

gradients in health.

Nancy Kotani reflected on the work of Fraser Mustard and his work in the

CIAR as follows:

> You recognize him as a noted cardiologist and you realize that […] he followed his
> science right down the rabbit hole, to the very end, and that's where he came up. And I
> think not very many scientists do that. So that was a bit of courage there [… A]t any
> point along the way he could have [taken] another path, but he followed the logic of his
> own thinking right to where he hit the source of his truth and it fundamentally shifted and
> changed how we view health and how we view this role [of health care]. And I think that
> made a profound difference on the number of people who needed the science to be able
> to move forward […] and I think that made a tremendous difference in terms of being
> able to move some of the big levers of social policy.

Indeed, the work of CIAR did have implications for developing an SDOH research agenda in Canada. As Labonté remembered in the early 1990s, "Social epidemiology wasn't that strong in Canada, as far as I can recall, and it wasn't until the CIAR's population health program came along – of course, with John Frank and Clyde Hertzman and folks like that – that it began to really develop the stronger research or academic base."(27) A contemporary impact from CIAR's work to the history of the SDOH approach, as recalled by participants, is that this institution and its members have become widely credited as founders of both the population health and determinants of health approach in Canada.

It was during this time as well that population health began to "squeeze out" (6) health promotion in public health at the national level; the approach was taken up nationally by Health Canada as a major research theme and topic of policy reform. This created a further tension in public health beyond that ongoing with health promotion and population health, which has been examined in depth elsewhere.(6, 84-88) This new tension emerged among those who supported health promotion, those who supported population health, and those who were critical of both approaches. Looking back on this period from a contemporary standpoint offers insight into how it contributed to the development of the SDOH. In the words of Labonté, "in many ways you can see social determinants of health as being where health promotion and population health battled it out with each other for a little bit."(27)

According to John Frank, during the 1990s those at CIAR "weren't trying to work very directly on policy."(78) Rather, their "goal was to understand the determination of health […] write it up and understand it, and disseminate that understanding."(78) But the CIAR did influence policy. By the early 1990s, the population health approach had gained the support of government health departments at the federal and provincial levels.(89) For example, the

232

Canadian Institute for Health Information (established in 1994) included a Population Health Initiative in 1999,(90) due largely to the influence of John Frank.(29) Later, in 1996 Tariq Bhatti and Nancy Hamilton of Health Canada attempted to overcome tensions and bridge population health and health promotion by illustrating how action on the determinants of health could be achieved through health promotion strategies in their Population Health Promotion model.(91) Though perhaps their efforts came too late, as two years prior the federal government had voiced their support for population health in a report put forth by the federal, provincial, and territorial Ministers of Health entitled *Strategies for Population Health: Investing in the Health of Canadians,*(92) which importantly included some social factors in its list of determinants of health (e.g., income and social status, social support networks, education, employment and working conditions).

8.5.3 Other contributions

Alongside Canadian developments in population health, epidemiological studies from the United Kingdom (UK) played an important role. For instance, in 1980 Sir Douglas Black, President of the Royal College of Physicians, published his report on *Inequalities in Health* from the Department of Health's Social Security Working Group.(93) In part, the *Black Report* had been commissioned by the Department to determine whether health inequalities had reduced since the National Health Service had been established in 1948.(94) Instead, the report found, inequalities had worsened, which indicated that the determinants of health must lay elsewhere.(94) The *Black Report* attributed rising health inequalities in the UK to social conditions, such as income, housing, diet, education, employment, and working conditions.(93) The *Black Report* was widely read by the public health community internationally and in

Canada, and would influence the thinking of many of public health leaders, including that of

Monique Bégin during her work as Canadian Commissioner on the WHO CSDH.(29)

Later, in 1985, UK epidemiologist Geoffrey Rose published *Sick Individuals and Sick Populations*, which championed a population approach that addressed the 'causes of incidence' over a 'high-risk approach' targeted at individuals.(95) Finally, and around the same time, early findings from the Whitehall Study (followed later by findings from Whitehall II) by Michael Marmot and colleagues were pivotal in bringing the language of health inequalities into population health research, through their demonstration of the social gradient of health among different levels of occupational classes of civil servants.(96, 97) Studies such as these furthered understandings of the complex, root causes of illness by solidifying the robust nature of social inequalities in health and the contributive role of social, economic, and political factors. Another report that drew attention to the root causes, was the 1993 World Bank report, *Investing in Health*, which examined the interplay of health, health policy, and economic development and considered how each contributed to the creation of health inequities.(98) Again, the contributions of Rose and Marmot were cited by interview participants as influential to developing their perspectives on population health and the SDOH.(27, 29, 38, 70, 78)

Some researchers within health promotion and population health focused on developing empirical and theoretical programs of research within the SDOH. Notable examples include the work of Clyde Hertzman in his development of the lifecourse model through his work on early child development, which extended the biopsychosocial model by taking into account how biological and social risks interacted throughout the lifecourse.(99) Ron Labonté began to focus in on globalization as a structural determinant of health (i.e., the social, economic, and political context of a society).(100-102) In his "Mandala of Health," Trevor Hancock adapted the

biopsychosocial model of health to include environmental components, in an effort to prompt

consideration of health as the interconnected with the entire human ecosystem.(103) Later in the

2010s, he also participated in a CPHA initiative to develop a position paper specific to the

ecological determinants of health.(104) As described in Section 8.6, understandings of the

SDOH would continue to shift alongside competing public health priorities; some examples

include HIV/AIDS and SARS.

8.6 Competing health priorities: HIV/AIDS and SARS

Perhaps somewhat predictably, alongside the period of theoretical and empirical

advancements, described earlier, came a strong and at times urgent need to re-focus public health

efforts on more pressing issues, such as communicable disease outbreaks (e.g., HIV/AIDS,

SARS). Finding a balance between disease prevention, treatment, and health promotion is a

challenge that has persisted throughout the history of the SDOH in Canadian history. Yet, as

public health tackled its priorities and issues, they did so in ways that advanced the

understanding of SDOH.

8.6.1 Human immunodeficiency virus/Acquired immune deficiency syndrome (HIV/AIDS)

The epidemic of HIV/AIDS, which was first observed as Kaposi's sarcoma during the

1970s in sub-Saharan Africa and as *Pneumocystis carinii pneumonia* or "gay-related

immunodeficiency syndrome" (i.e., GRIDS) during the 1980s in North America,(105, 144)

mobilized the public health community to act globally in attempting to stop the spread of illness,

attack its root causes, and find a cure. The HIV/AIDS pandemic seems to have harnessed the

energies of the international and community development, health promotion, and other public

health movements to "consolidat[e] everyone as a planet"(38) and brought recognition to the

influence of global forces on health. Fear grew as the HIV/AIDS epidemic began to spread in

North America, and those afflicted by the disease came to experience stigma and discrimination by their families, employers, peers, and others in the community.

Gerry Dafoe recalled a conference that the CPHA had put on with the Canadian AIDS Society in the 1980s in Vancouver, where Health Minister Jake Epp was a keynote speaker. He recalled that the venue where the conference was being held had emptied the pool of the hotel "for repairs."(36) However, the hotel pool had not been closed for legitimate repairs. Rather, uncertainty around transmission of the HIV/AIDS virus prompted closure of the pool for fear of hotel patrons contracting or spreading HIV/AIDS. Dafoe recounted how the AIDS activists at the conference:

> were carrying banners out that said 'EPP=DEATH,' big equal signs. They were against Epp because they figured he wasn't giving enough money [to AIDS research] and they were against the hotel because they shut the pool and made a stigma of everything.(36)

The stigma Dafoe spoke about entered into public health, and later SDOH, as a topic of discussion by bringing awareness to the field on meeting the health needs of persons on the margins of society. Nancy Kotani also recalled some of the ways that the HIV/AIDS epidemic impacted our understanding of the SDOH, through increased attention to stigmatized groups, saying:

> The changing nature of how we address the epidemic, I think, was largely due to an understanding of the determinants of health because the resources that were available for an early cohort of people who live with HIV were not the same as a cohesive community or other kinds of […] cohorts[, like] the injection drug users or the poor.(48)

On the one hand, the HIV/AIDS epidemic perhaps detracted attention from health promotion, population health, and other areas that led the way for SDOH. Yet on the other hand, in dealing with this health crisis, the public health community developed new ways of understanding how illness could manifest differently in communities. In this way, the HIV/AIDS epidemic

contributed to the development of the SDOH approach by illustrating how illness and health is influenced by factors such as race, sex, sexual orientation, class, and social isolation.

8.6.2 Severe acute respiratory syndrome (SARS)

Another, more recent epidemic that created competition for SDOH in being recognized as a public health priority was the SARS epidemic of 2003. The epidemic, which spread from central China to Canada "brought the health system in the Greater Toronto Area and other parts of the province to its knees."(106) At the time of the epidemic, nearly everything about the disease was unknown: its clinical course and incubation period, methods of transmission, diagnosis, symptoms, origin, infectious agent, treatment, vaccine, death and attack rates, and duration of infection.(106) Forty-four Ontarians died as a result of the outbreak.(106) While the SARS epidemic highlighted numerous weaknesses in Canada's public health system, some positive results came out of the SARS Commission that interrogated its causes. The Naylor Commission brought attention to the importance of maintaining a strong public health system, and emphasized the need for Canada to invest in the renewal of public health and preventive medicine.(107)

The Public Health Agency of Canada (PHAC) was established in 2004 to anticipate and respond to public health threats.(108) Through PHAC, Canada gained its first national Chief Public Health Officer, David Butler-Jones.(108) Since its establishment, PHAC has taken many steps towards unifying a coherent SDOH approach. First, in his first report on the status of the health of Canadians, Butler-Jones explicitly drew attention to health inequalities and SDOH in Canada,(109) though the report was critiqued for not going far enough.(110) Second, PHAC established the Canadian Council on the Social Determinants of Health in 2005 to support Monique Bégin in her role on the WHO CSDH.(70, 111) The Council, which still operates

today, has produced a number of documents to further understandings and uptake of the SDOH concept. Examples include reports on common messaging of the SDOH, health inequities in Aboriginal communities, intersectoral planning and action, synthesis of SDOH frameworks, and healthy child development.(112) Third, PHAC funded six National Collaborating Centres (NCC) for Public Health in 2003 to "increase the usefulness and accessibility of knowledge relevant to public health practices," which included a Collaborating Centre for the Determinants of Health.(113) The NCCs on Determinants of Health and on Healthy Public Policy continue to bring together high-quality, evidence-based research and theory that underlie the SDOH approach and position the SDOH in Canada as an issue about health inequities, and achieving health equity.(38)

8.7 New commitments and the distillation of a research approach

By the early 2000s, the fractures in public health and the academic disciplines related to public health (e.g., population health) began to give way to the acceptance of the SDOH as a unifying, coherent approach. This acceptance is apparent through developments that took place in government, academia, and non-government organizations.

8.7.1 Government support for the SDOH

Several government initiatives helped promote the SDOH approach in Canada. In 1996, the Federal, Provincial, and Territorial Advisory Committee on Population Health prepared the *Report on the Health of Canadians* to advise the Conference of Deputy Ministers of Health.(114) The report was also intended to communicate with the public about "the factors that influence their health" and to "serve as a tool to help policy makers, health workers, and the public measure Canada's progress in achieving better overall population health…"(114, pi) The report considered determinants of health, including income and social status, social support networks,

education, employment and working conditions, physical environments, biology and genetic

endowment, personal health practices and coping skills, healthy child development, and health

services.(114)

Three years later, Health Canada published *Toward a Healthy Future: Second Report on

the Health of Canadians* in 1999.(115) It was in this report that the well-known story "Why is

Jason in the Hospital?" was published. The "deceptively simple story," which was written by

Peggy Edwards, "speaks to the complex set of factors or conditions that determine the level of

health of every Canadian."(115, pvii) The story asks a simple question that challenges readers to

consider the social and economic factors that have contributed to Jason being in the hospital,

such as his neighbourhood and his parents' employment.(115) As Edwards recalled: "It was the

first time a [federal] health report was documenting the social determinants."(71) The report

included the influence of socioeconomic environment (income, education and literacy,

employment and unemployment, working conditions, social environment), healthy child

development, and the physical environment, which included sustainable development, and the

ecological built environment.

Another government initiative that helped solidify the SDOH approach to public health

was the establishment of the Canadian Institutes of Health Research (CIHR) through an Act of

Parliament in 2000.(116) The CIHR replaced the former Medical Research Council, the former

federal granting agency for medical research in Canada. As stated in the reading of *Bill C-13:

The Canadian Institutes of Health Research Act*, CIHR was intended to "represent a more

integrated approach to health research [than the MRC,] which would be more focused on the

underlying determinants of health and disease."(116) One of the CIHR's 13 institutes was the

Institute of Population and Public Health (IPPH), which explicitly addressed the SDOH in its

mandate. One participant, who was involved in this early stage, recalled that:

> When [establishing CIHR and IPPH] happened, I think it expanded the scope for research to go beyond just biomedical and to some extent clinical, to include health services and population and public health research. And it's that last one that really allows for research on social determinants of health to happen. There wasn't much going on before the year 2000 because in the Medical Research Council, as the name would suggest, there wasn't really funding much in this area at all. So as a result of this structural change and mandate change there was, I think, an impetus.(111)

The IPPH, in their mission statement, supports "research into the complex interactions

(biological, social, cultural, environmental), which determine the health of individuals,

communities, and global populations,"(117, p20) and also research into the application of that

knowledge to improve the health of individuals and populations. The IPPH has been and

continues to be essential to SDOH-related research in Canada. As one example, IPPH would

later fund Ron Labonté and colleagues' transdisciplinary research network on globalization and

health,(118) which according to his colleagues represents "a huge advance in terms of creating

this idea of an entire global system that creates inequities."(38)

8.7.2 The first university course on the SDOH

University courses helped to solidify a more coherent SDOH approach. Ron Labonté and

Ann Robertson are credited as having developed and taught the first course on the SDOH in

Canada in 1993/4.(119, 120) Labonté, who at the time was working as an associate professor at

the University of Toronto,(121) recalled his difficulty in bringing the concept of the SDOH into

his graduate-level Community Development course, which was radically different from the

health education concepts that students were accustomed to.(119) As Labonté remembered,

before 1993:

there had been no concentrated effort to try to theoretically draw together social epidemiology and actually do a course that talked about these non-medical determinants of health, the risk conditions of people's lives.(27)

The syllabus that Labonté and Robertson developed for their course, which was listed as a sociology of health and illness course, stated that "the course is not so much about what the social determinants of health 'are' as it is about a critical analysis of competing discourses on [the causes of] health."(122) It was novel in its bridging of health promotion, community development, and public health perspectives with critical social sciences. A 2001 version of this syllabus is reproduced in Appendix K, with permission of the instructor in Appendix L.

Dennis Raphael, who is today one of Canada's most renowned SDOH researchers, recalled his entry into the Department of Behavioural Sciences at the University of Toronto, where he met Ann Robertson. As he recalled, "So, in 1992 I became aware of health and the social determinants of health,"(120) through his interactions with Robertson. Later, Raphael began teaching a course in the social determinants of health at York University, when he was hired in 2002 by the School of Health Policy and Management.(120) Both courses continue at these institutions today.(123, 124) Another event in the development of SDOH as a research approach, is the Canadian textbook by associate professor in health and exercise, Alan Davidson, that was published on the SDOH in 2015.(125)

8.7.3 The Toronto Charter on the SDOH

The 2002 conference, "The Social Determinants of Health Across the Life-Span" was another important milestone in the evolution of the SDOH in Canada. The conference coincided with the tabling of Roy J. Romanow's final report of the *Commission on the Future of Health Care in Canada* in the House of Commons, which included recommendations to strengthen and ensure the sustainability of the health care system. At the conference, which was co-organized by

Dennis Raphael, Ann Curry-Stevens, and David Langille, over 400 delegates from health and

social sciences came together to outline policy directions for action on the SDOH. As Raphael

recalled:

> I thought when this conference was organized, [it] was going to be an opportunity to tell people about the social determinants of health. Four hundred people showed up and within an hour or two they were basically saying, 'We know about this stuff. We're here to find out what to do about it.'(120)

As Raphael's quote indicates, the public health community remained true in their past

commitment to seek solutions to health and social inequities.

However, to some degree the practice of 'conscientizing' seemed to re-enter public health

during in the 2000s, as it had during the 1970s-1980s. This time, however, consciousness-raising

occurred on the SDOH without interrogating solutions. As Raphael recalled of the 1996 release

of Richard Wilkinson's *Unhealthy Societies: The Afflictions of Inequality*, the public health

community adopted the notion that "all you had to do was tell people about the determinants and

suddenly good things would happen."(120) This idea, that raising awareness on the SDOH

would bring change, is mirrored in an earlier critique of 'conscientization' voiced by David

Butler-Jones. As Butler-Jones recalled during the community development era, an idea

circulating in public health had been that through consciousness-raising on health problems,

"The revolution will come and everything will be fine."(47) In other words, only some members

of the public health community (such as the participants interviewed) appear to have maintained

a commitment to seeking solutions that remedy health inequities.

An important outcome of the 2002 Across the Life-Span conference, which brought

together academics, professionals, and government representatives, was the development of a

Toronto Charter for a Healthy Canada, spearheaded by Michael Polanyi.(120) Toba Bryant

242

recalls that "early on Sunday morning [of the conference] they really knocked themselves out preparing that Charter."(120) And while Raphael unfortunately remembered how "nothing happened"(120) regarding action on the Charter by government or the groups that had supported it following its release, the Charter did help to synthesize ongoing ideas about the SDOH that were circulating throughout public health's not-for-profit, government, and academic networks. As Bryant recalled, the Charter included a list of SDOH that "you can affect or shape through public policy."(120) Based on the evidence available at the time, the list consisted of ten determinants: early childhood development, education, employment and working conditions, food security, health care services, housing shortages, income and its equitable distribution, social exclusion, social safety nets, and unemployment and employment security.(126) As well, the list noted that women, persons of colour, and new Canadians would likely be more vulnerable to the health effects of these SDOH than others due to the intersection of these multiple disadvantages.(126) The Charter resolved that governments, public health and health care associations, and the media move forward the evidence base on the root causes of illness to improve policymaking.(126)

An additional outcome of the conference and its Charter was the impetus that it provided Raphael to compile perspectives on the SDOH and publish a book on the topic, specific to the Canadian context. The book, which was entitled *The Social Determinants of Health: Canadian Perspectives,*(127) has evolved since its initial publication in 2004 to become a collection of critical perspectives that "goes right into the issues of public policy."(120) The third edition of this book was published in 2016.(128)

8.7.4 The WHO Commission on the Social Determinants of Health

As interest in the SDOH has waxed and waned in Canada over time, events on the international stage have maintained momentum on this topic in Canadian public health. A key event, as mentioned earlier, was the 2005 to 2008 WHO CSDH that sought:

> to support countries and global health partners in addressing the social factors leading to ill health and health inequities, […and to] draw the attention of governments and society to the social determinants of health…(129)

The decision to conclude this history with an entire section devoted to this report is because in nearly every interview, participants conveyed the importance of the WHO CSDH to advancing the SDOH approach. And while this sample of participants is not necessarily representative of any national community, this consistency is noteworthy in that it suggests the significance of the WHO CSDH to Canadian public health. In part, this significance stems from Canada's role as a member country of the WHO and the inclusion of two Canadian Commissioners (i.e., Monique Bégin and Stephen Lewis) on the WHO CSDH, though only Bégin remained for its duration. Additionally, for myself as a trainee and researcher, this report influenced my own understanding of the SDOH and health equity, as I entered graduate studies in the years following its release, when the work of the WHO CSDH received global attention (see Chapters 4 and 5).

As John Frank recalled, the WHO CSDH "was cleverly framed to appeal to people's common sense. […] At the end of the day, it's a brilliant piece of work and it just brought all the ideas that [Sir Michael Marmot] had been researching inside Whitehall into the mainstream."(78) Ian Culbert referred to the WHO CSDH as an "international movement" that "shone the light on [the SDOH] at the global level and got the media interested in it."(70) Another participant, recalled how "the nomenclature of social determinants of health […] really took hold and gained prominence" after the WHO CSDH, and "built on much health inequalities work that had been

going on by many scholars."(111) This participant, who was described earlier as involved in shaping the health research landscape of Canada through CIHR's early stages, recalled how the IPPH's second strategic plan, *Health Equity Matters* framed the SDOH in an equity way instead of a disparities way, influenced by the work of the WHO CSDH.(111) In their words, "health equity was in the water supply, essentially, meaning that it was a very prominent term in its use."(111)

Following the WHO CSDH, Canada responded to its final report and the global commitments to the SDOH that occurred thereafter. The WHO's *Rio Political Declaration on the Social Determinants of Health*, for instance, called on member nations in 2012 to address health inequities through themes such as better governance for health, or reorienting the health sector towards reducing health inequities.(130) PHAC committed to the Declaration, and in 2013 released a report documenting Canadian actions on the SDOH, such as the institutionalization of Health Impact Assessment in Québec.(130) They followed up with another report in 2015, which highlighted initiatives taken in jurisdictions throughout Canada, such as the Sudbury District Health Unit's YouTube campaign, *Let's Start a Conversation About Health… and Not Talk about Health Care at All*.(131) Another way that PHAC responded to the WHO CSDH was through its continued support of the knowledge hubs that had been created in Canada as part of the WHO CSDH: one on Early Child Development, led by Clyde Hertzman at the University of British Columbia, and one on Globalization, led by Ron Labonté at the University of Ottawa.

Non-government associations interested in health also responded to the WHO CSDH. For example, the Canadian Medical Association hosted town halls following the WHO CSDH across Canada, where they consistently heard the influence of SDOH such as income, housing, and early childhood development.(132) The association then followed up with a policy statement on

the role of the medical profession in addressing health equity and social determinants of health.(133) Other groups that responded to the WHO CSDH included the Canadian Nurses Association,(134) and Canadian Association of Occupational Therapists.(135)

In sum, the WHO CSDH has helped to unite the disparate approaches of public health, internationally, in its efforts to reduce health inequities. As described above, for example, the work of the WHO CSDH has helped unify the Canadian government's position on the SDOH through their responses and reports that followed its culmination. Additionally, the WHO CSDH synthesized existing evidence on health inequities worldwide, which moved forward the evidence-base on the SDOH, and developed a framework for action on health inequities through action on the SDOH. Finally, the WHO CSDH brought widespread attention to the SDOH approach,(136) in public health and also in the public, generally.

8.7.5 Canadian public health commitment to the SDOH

In public health, significant events have occurred in attempt to act on the political SDOH. Public health leaders, in their private lives as citizens, have attempted to engage and mobilize the public to pressure decision makers to implement equitable changes for health. One example, which some participants brought up, were the movements that were developing on the ground, such as by the CPHA in the non-profit sector.

The Canadian Public Health Association has continued to be involved in the SDOH throughout their history and have recently organized their efforts to more directly address the SDOH. Lynne McIntyre, who also served as a former president of the CPHA during 2013-4, noted how CPHA has served as an important "forum for social reformers" and for social reform "to be legitimized as in the interest of health and the collective and that we always have to argue for the unpopular and the lack of common sense ideas."(38) Speaking on the history of the

246

CPHA and its role in social reform and calling attention to the influence of the SDOH, she noted:

"It's a tradition of naming injustice, of naming individuals as being unnecessarily

vulnerable."(38) As Ian Culbert, the current Chief Executive Officer of the Association likewise

noted:

> [T]he undercurrents have always been there, they're just getting better organized as far as what the evidence is and what some of the ideas for action could be or should be. So it's taking shape, almost as a movement you would say, but certainly for people, for supporters, it's become second nature to talk about equity, to talk about social justice, to talk about taking action or the causes of causes[. It] is second nature now. So you're no longer trying to convince the choir, as it were, you have a really well-organized group of supporters. It's: how do you become evangelical about it? How do you start converting non-believers?(70)

Suzanne Jackson similarly reflected on the need to mobilize civilian action for the SDOH. She

recalled the discussions and workshops she engaged in with a colleague from Ontario, Brian

Hyndman, and how:

> he used to talk about that if we could figure out how to have a social movement about health promotion and the determinants of health and really engage the public in it, then we would be getting somewhere. But all it is, is a movement amongst the people who work in the field…(66)

Perhaps, as Jackson mentioned, the SDOH's existence as a movement in public health is why it

has not galvanized the general public as other movements have, such as feminism or

environmentalism.(66) However, Jackson's above quote suggests that the social awareness that

was sparked among members of the public health community in earlier stages of this history has

remained a shared attribute among those who work in SDOH.

8.8 Conclusions

The history of the SDOH reveals how its present-day status in public health has evolved

from a social awareness, to a loose collection of theoretical and empirical concepts, to a research

approach. This history developed alongside the overlapping histories of health promotion and

population health, their many sub-disciplines that developed, and competing public health priorities. As evidenced throughout this paper, the SDOH – which can today be understood as a research approach – is not a linear nor single history. Indeed, many perspectives exist beyond the 17 represented here that were, by necessity, left out.

In ending this paper, I wish to leave readers with the sense of optimism instilled upon me by my interview participants, as well as the many public health leaders who came before them, and after. It seems apt, therefore, in reflecting on the value and history of the SDOH approach that I end this paper with a series quotes by voices from the past and the present of public health. I believe this speaks to the field's unending commitment to social justice and I invite readers to contemplate their own role and position in the ongoing history of the SDOH.

Table 8.1 Quotes on the SDOH from past and present public health voices

On Questioning Power
"Those who have been more endowed with the talent of health, wealth, and knowledge are but stewards, who must make use of their opportunities for the common good."(137, p464)   – William Henry Atherton (1867-1950), 1911   Secretary, City Improvement League of Montreal
"[T]he other thing to always remember in this work is that public health or health promotion, to do its job, should be questioning power and equality and questioning the way things are."(26) – Dr. Trevor Hancock, 2016
"It's about perspective. I just hope that at whatever level people are working at, you have a little nagging voice like me, who is sitting at the table and saying, 'Let's look at the life circumstances of this group.' Or, 'Let's look at where they live,' you know? Before we fund a program.'"(71)   – Peggy Edwards, 2015
On a Common Purpose
"Let us never reach the stage when we cannot abandon something when shown that it is wrong or that it can be improved upon. We should not hesitate a moment when convinced that the time has come for a change. […] Time passes. Life is short. Men come and go. Possibly it is too much to hope for that the individual contribution of any one of us to the cause will be sufficient to be noticeable; but taken in the aggregate, if we carry on, play the game, give the best that is in us, […it] may cause future generations to adjudge that our labour has not been in vain."(138, p266)   –Alexander J. Douglas (1874-1940), 1930   Winnipeg Medical Officer of Health
[Referring to past public health conventions in the 1980s]. "It was just an important time to come together and to feel the unity and the purpose of a group who were invested in public health. I mean necessarily we were self-selecting, but very unifying. Because you get a spreading effect, you get people sort of infecting other people with their enthusiasm for what can be accomplished in the group who want to move things along."(25)   –Karen Mills, 2016
On Working across Disciplines on the Social Determinants of Health
"The modern tendency in medicine is to recognize more and more the importance of social conditions in disease, with the result that there is a closer relation between the general practitioner and the social worker. Social service has now its recognized place in most well appointed hospitals."(139, p275)   - George Dana Porter (1870-1963), 1926   President of the Canadian Public Health Association
"I think we're trying to start to get together, but we also have to be respectful in health, at least, that there are many sectors who have been at this for a lot longer than we have, and we've got to be respectful of the hard work that they've put into trying to keep communities healthy with very limited resources. And so it's a struggle, I would say. So health has to add its voice, but in a respectful way, and also know when to get out of the way."(111)   – Interview participant (anonymous), 2015

8.9 Supplementary file: Methodological appendix

I draw on the consolidated criteria for reporting qualitative research (COREQ) to convey the specifics of my interview process and my place within it.(140) Oral history methodology guided this research study, as memories and personal reflections of historical significance to the SDOH were collected through interviews.(24) Excerpts from interviews were pieced together to form a coherent narrative on the history of the SDOH in Canada.

I conducted oral history interviews with leaders from the Canadian public health community who played a key role in the in the history of the SDOH. Participants were identified through primary source analysis of archival materials related to the SDOH from the Canadian Public Health Association (CPHA), located in Ottawa, Ontario, where documents recorded their activities specific to the SDOH in Canada. These materials included meeting minutes, annual reports, policy and position papers, and publications from the *Canadian Journal of Public Health* from 1910-2010, and were used to inform other aspects of the history of the SDOH.(141, 142) I conducted snowball sampling from the initial sample to recruit further participants. Participants were recruited by email and telephone and in two cases, through face-to-face meetings at a national public health conference.

The interviews were conducted by myself, a female PhD candidate trained in qualitative methods. Open-ended questions asked about participants' experiences in the history of the SDOH.(23) Seventeen interviews were conducted in total. Apart from two participants who I have come to know through my training (e.g., coursework), no previous relationship was established with participants prior to recruitment. I approached interviews with the assumption that the SDOH were considered an important component of population and public health in

Canada. Only 2 potential participants declined to participate, due to the public and authoritative nature of their professional role and for personal reasons.

Interviews were conducted face-to-face in participants' homes, place of work, or at a common meeting place, over the telephone, or via online videoconference (i.e., Skype). Where interviews were conducted at home, non-participants were sometimes present (e.g., a family member in and out of the background); non-participant interactions were not included in the transcription of the interview. My sample of seventeen included 8 males and 9 females, with my oldest participant aged 88 years. The background of participants ranged from social sciences, medicine, public health, nursing, and epidemiology, from the academic, public, and non-profit sectors.

An interview guide was provided to participants in advance of the interview, which underwent a feedback process with qualitative public health researchers at the University of Calgary familiar with the history of the SDOH. For the first two interviews, the question guide was not provided in advance. After my second participant expressed they would have liked to have received the question guide in advance, I then provided it ahead of time for all subsequent interview participants. Repeat interviews were not carried out. Interviews were audio recorded and then transcribed by KL or a professional transcriptionist who had signed a confidentiality agreement. Transcripts were returned to participants for comment and correction, after which the audio file of the interviews were destroyed from the recording device. Field notes made by myself during the interview were used as a preliminary form of data analysis. Interviews ranged from approximately 40 to 100 minutes.

Transcripts underwent line-by-line open coding.(143) To some degree, the codes generated from interview analysis were informed by previous analysis that had been conducted

on archival sources, related to the key events, figures, barriers and facilitators, and concepts

relevant to the history of the SDOH. Transcripts were coded during the same period that

interviews were conducted, between November 2015 and November 2016.

Data saturation was not discussed with participants, but remained an ongoing discussion with my

supervisory committee. While participants were not explicitly contacted for feedback on the

findings, interviews were ongoing and iterative, and discussion of findings were informally

incorporated into the interviews with later participants. Except for one participant who wished to

remain anonymous, all participants identified in this work have agreed to having their quotations

included in an identifiable and attributable form.

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Chapter Nine: Conclusion

9.1 Overview

The overall aim of this dissertation was to gain a nuanced understanding of the history of the social determinants of health (SDOH) in Canada since 1910. It was anticipated that such nuance would permit insight into present challenges facing the SDOH and the academic field(s) in which it is nested, population and public health (PPH). In this chapter, I summarize the findings from each manuscript and synthesize the contributions of this dissertation to history, PPH, and public policy. I conclude with a review of this dissertation's limitations and recommendations drawn from its findings.

9.2 Summary of findings from manuscripts

9.2.1 Is the future of 'population/public health' in Canada united or divided? Reflections from within the field

In Chapter 3, I contemplated PPH as a united or divided field by examining three areas where challenges and opportunities for greater unification exist: research funding, the public health workforce, and PPH ethics. By taking advantage of opportunities in those areas, I argued, a more cohesive PPH may be achieved, which in turn would permit strengthened intersectoral action on the SDOH and health equity. In this manuscript, I brought attention to some of the ongoing disciplinary debates in PPH, which I have experienced as a trainee in this new and supposedly unified field. As I revisit in Section 9.3, that work helped me to position myself as a researcher in PPH. It set the stage for the remaining chapters of this dissertation, which are situated in PPH, past and present.

9.2.2 Taking stock of the social determinants of health: A scoping review

Prompted by the large and diffuse literature on the SDOH, which is evolving over time, my intent in Chapter 4 was to take stock of the literature, discern key concepts, and map its

geographic and disciplinary landscape. Of the 108 articles reviewed, most were published in an

academic setting, by Canadian authors, for policy-maker audiences, which speaks to the political

nature of the SDOH and the need to engage decision-makers in acting on the SDOH. I identified

health equity as an overarching theme and binding concept for the SDOH.

A key finding from this review was that most of the SDOH literature was published

between 2005-2009, a period that overlaps with the World Health Organization's (WHO)

Commission on Social Determinants of Health (CSDH). This supports one of the arguments

made throughout my dissertation, that the WHO CSDH played a pivotal role in bringing

attention to the SDOH in academia and in the public. As explored in Chapter 8, the WHO CSDH

harmonized a diverse set of voices and arguments on the SDOH to arrange them into a coherent

and impactful refrain: that the SDOH are fundamentally about the distribution of money, power,

and resources.

9.2.3 They are not my problem: A content and framing analysis of references to the social determinants of health within Canadian news media, 1993-2014

In Chapter 5, I explored how the SDOH have been represented in Canadian print news

media. In doing so, I corroborated the historical timeline for the SDOH found in the academic

literature and CPHA archives where the concept formally emerged in the 1990s. Additionally,

this paper illustrated the important point that ambiguity on the SDOH is not only present in the

academic literature, but also in the media; I found that the SDOH were reported in 209 unique

ways in the news articles reviewed. My framing analysis of news articles revealed that the

SDOH were often represented in ways inconsistent with the binding concept of health equity.

Specifically, some articles framed the SDOH and health inequities as only affecting

disadvantaged populations and not society as a whole. I proposed that this representation may

disconnect many readers from the SDOH and the negative societal effects of health inequity, which may hinder efforts to act on the SDOH by reducing broad public support for such measures. However, other articles framed the SDOH as an issue of social justice and a responsibility of governments. This latter, alternative representation aligns with the understanding that the SDOH are fundamentally about the societal distribution of money, power, and resources.

9.2.4 Poverty and public health: The ebb and flow of a social determinant of health, 1900s-2010s

In Chapter 6, I applied the interpretive and historical SDOH lens I developed in preceding manuscripts to the history of poverty in twentieth-century Canada. I found that attention to poverty, as a public health issue, waxed and waned in parallel with national events in Canada, particularly those that shifted the country's social, economic, and political conditions. The perspectives on poverty held by the public health community varied over time; sometimes there was a narrow focus on disadvantaged groups; other times the public health community showed concern with the broader socioeconomic spectrum across the population. Considering the above findings, the 'ebb and flow' response to poverty from within the public health community appears to reflect the nature of public health and the health of populations. Populations are living and dynamic entities with evolving disease profiles.(75) As such, the public health community must respond to the changing disease profiles of populations, which at times necessitate greater and lesser urgency (e.g., considering chronic versus communicable disease), and different approaches (e.g., more targeted versus more universal solutions). Ebb and flow responses may similarly have been influenced by the emergence and evolution of Canada's

welfare state, which broadened the scope of government interventions to address poverty (e.g., through housing reforms, employment insurance).(76)

In this manuscript, I considered the SDOH during a historical period when the term was not yet in use. Using the SDOH in this way, as a lens through which to explore the history of PPH in Canada, I expanded the time frame of existing historiography on the SDOH, which typically beings in 1974. While the SDOH are new in name, it is important that they be understood in the wider historical context of PPH. Positioning the SDOH as a timeworn tradition and focus of the PPH community may promote and endure its efforts to act on the SDOH.

9.2.5 *"For all those who need them": Efforts to secure equitable access to family planning services from within the public health community, 1960s-80s*

As identified in Chapter 1, public policy drives the distribution of SDOH for its role in apportioning power, money, and resources in a society. In Chapter 7, I explored the public health community's efforts to bring equitable access to family planning services following amendments made to the *Criminal Code of Canada* during the 1960s-80s which legalized abortion and the sale and advertisement of birth control. I found that to some extent, the *Criminal Code* amendments did address the root causes of health inequities for women. For example, legalizing abortion set the stage for reductions in premature death by reducing the need for unsafe, illegal abortions. As I discussed in the manuscript, however, numerous challenges remained for women seeking access to abortion, as well as birth control and sexual health education. The public health community attempted to mitigate these challenges through efforts to increase access to family planning services for all women and especially those who lacked the resources to obtain them. Key to this dissertation, Chapter 7 provided an historical example of health equity (i.e., by ensuring that women of all ages and religious backgrounds had access to family planning

services) and demonstrated how the SDOH interconnect in complex ways to shape conditions for health.

9.2.6 "It's a tradition of naming injustice": An oral history of the social determinants of health – Canadian reflections, 1960s-present

In Chapter 8, I captured the history of the SDOH as told from the perspective of individuals in leadership roles in Canadian PPH, past and present. Based on their narratives, I identified three phases in the history of the SDOH since the 1960s: first, as a growing social awareness during the 1960s-70s; then, a period of loosely connected theoretical and empirical concepts related to the SDOH during the 1970s-90s; and eventually, as a more coherent research field and approach since the 2000s. This oral history manuscript brings the history of the SDOH to life by highlighting the experiences of those who lived through and shaped this history.

9.3 Overall conclusions from this dissertation

My dissertation findings offer important contributions to the history of SDOH and PPH in Canada, as well as public policy in terms of its implications for health. In this section, I situate the findings from this dissertation by considering their contributions to the historical literature and PPH research and practice, and suggest potential policy implications.

9.3.1 Historical contributions

As a field grounded in social justice, public health has always been concerned with addressing the root causes of health and illness. Public health maintained this focus as it evolved to include the population health approach,(1, 2) which incorporated the SDOH and reducing health inequities.(3) In 1994, early in the history of PPH, John Frank and Fraser Mustard argued that economic growth acted as a SDOH throughout human history.(4) Since Frank and Mustard's 1994 article, scholars have established that the SDOH extend well beyond economic growth.

Today, the SDOH and health inequities are understood as the result of the unequal distribution of social, economic, and political sources of power, money, and resources in society.(5) I allowed for this present-day understanding of the SDOH in my research by adopting the conceptual framework put forth by the WHO CSDH (described in Section 1.2.2.1). This perspective allowed me to examine the history of the SDOH in a novel way and in greater depth than previously done in the literature. As well, my contemporary and nuanced understanding of the SDOH allowed me to consider the history of this approach, while also paying tribute to its complexity. I expanded the time scope of analysis from existing histories on the SDOH, many of which focus on the 1970s to 1990s. My expanded scope will be useful for those in PPH attempting to orient themselves in the history of the SDOH.

Two comprehensive histories of the SDOH were published in the late 2000s to contextualize the work of the WHO CSDH. One is Irwin and Scali's history of action on the SDOH.(6) The other is Cook, Bhattacharya, and Hardy's collection of manuscripts that depict the relationship between health and social factors, historically, throughout various parts of the world.(7) Both of these contributions take an international perspective to interrogating the SDOH, which is appropriate considering their role to the WHO CSDH. However, Canadian contributions have been sparsely included in these resources, despite the many contributions from this country that have been recorded elsewhere (see Section 1.3.2). Irwin and Scali (6) mention Canada only in association with the *Lalonde Report* in their twentieth-century history, whereas Cook et al. make no mention of Canadian contributions in their 364-page volume.(7) This dissertation represents the first large-scale, in-depth history on the SDOH, specific to twentieth-century Canada. It builds on previous social histories of public health and medicine that have peripherally examined the social causes of illness and health throughout twentieth-

century Canada, but which have not explicitly adopted an SDOH historical and interpretive lens in its present, nuanced understanding.(8-18)

A novel contribution of this history to the social and medical history of PPH in Canada is its use of oral history interviews. This dissertation represents the first attempt to capture and synthesize the diverse experiences and perspectives of past and present PPH leaders vis-a-vis the history of the SDOH. In doing so, this dissertation complements and enriches existing narrative histories of the SDOH with the lived experiences of those who shaped it. Second, this dissertation is the first history to utilize the entirety of the Canadian Public Health Association's (CPHA) existing archives for academic research. Previous histories written on the CPHA, such that produced by Christopher Rutty and Sue Sullivan, used alternate archival sources (see Section 1.3.2.4).(19) The CPHA is an organization that is exclusively devoted to public health in Canada and routinely engages in advocacy activities. By using CPHA archives in my dissertation, I likely gained insight into a more social and political history of the SDOH than had I focused on the archives of another organization (e.g., Sanofi Pasteur, which produces human vaccines and may adopt a narrower, biomedical definition of health).

Azalyn Manzano and Dennis Raphael published a paper on the CPHA and its historical positions on SDOH issues.(20) While the authors did not provide details of the archival sources used in their article, their review suggests that they utilized materials that were publicly available on the CPHA website or published in the *Canadian Journal of Public Health*.(20) One history on the CPHA from 1909-1979, compiled by Joan Costello in 1979, did make use of CPHA's private archives; seven short articles from Costello's work were published in the CPHA's newsletter *Health Digest* through 1980-1.(21-27) These articles, however, represent the institutional history of the CPHA and not the broader social context of public health and the SDOH in Canada.

Costello's articles and the others mentioned above were used to inform my understanding of the CPHA and the history of the SDOH in the context of Canadian PPH.

9.3.2 Contributions to PPH

A contribution of this dissertation to PPH is its attempt to clarify understandings of the SDOH approach, which is nested in the academic fields of population health and public health, through a scoping review on academic and grey literature from this field. As discussed in Sections 1.4 and Chapter 4, this was no easy task. The SDOH are complicated, the relevant literature is voluminous, diffuse, and poorly indexed, and approaches to and understandings of the SDOH vary widely. Thus, even after conducting an extensive review of this literature, I did not identify a single and coherent conceptualization of the SDOH as I had initially set out to do. Attempting to make as much sense of the literature as I could, I identified health equity as an overarching theme and binding concept for the SDOH. This finding was not new; health equity has been recognized in the literature as a core element of the SDOH and PPH long before my 2016 review.(28-32) However, my scoping review added value to the existing literature on PPH by re-affirming the importance of health equity across a diverse literature base and particularly in the Canadian setting. My media analysis of SDOH representations in Canadian news sources expanded this further. Specifically, as mentioned in Chapter 5, previous articles have found that news coverage of the SDOH is sparse and does not convey the foundational underlying concept of health equity.(33-36) The more recent reportage on the WHO CSDH, I suggest, indicates that the news landscape has to some extent shifted upstream in representing the SDOH as a structural and societal issue more so than as an individual-level issue. Framing the SDOH in a way that conveys its upstream nature is important for drawing public attention to the root causes of illness, in turn garnering support for interventions that address these at the structural level (i.e., policies

that redistribute resources). One recommendation related to this finding is that members of the PPH community refer to the key SDOH messaging guidelines produced by the Canadian Council on Social Determinants of Health when designing and delivering messages to audiences.(37) For instance, members of the PPH community who present on the SDOH in forums with media coverage or directly to media outlets (e.g., televised interview, opinion article in a newspaper) may wish to incorporate sound bites, stories, or visuals in their messages about the SDOH to engage audiences and present SDOH messages in ways that are clear and easy to remember.(37)

This dissertation has also contributed to present understandings of PPH as a coherent field of research and practice by exploring the historical evolution of this field and contemplating its present and future state in Canada. My insights on the challenges facing PPH as a united or divided field are unique to my stance as a first-generation trainee of this nascent field. I entered my PPH graduate program in 2011 as a Master of Science student at the University of Calgary, in the same decade that the Canadian Institutes of Health Research established its Institute of Population and Public Health. Now, six years later, PPH graduate programs are becoming more prevalent in Canada, as I reflected on in Chapter 3. My contemplation of the field may therefore be useful to PPH trainees as they consider their own place in PPH research, practice, and history, and as new students enter into PPH graduate programs. Additionally, Chapter 3 serves as an illustrative example of the history of the SDOH as an overlapping, interdisciplinary, and continuously evolving field.

Third, this dissertation contributes to the institutional memory of the PPH community. As evidenced in this dissertation, as well other publications that came before it (e.g., (1, 2, 6, 38)), the PPH community has long maintained an interest in social justice and the common good. The

chapters of this dissertation, especially Chapters 6 through 8, provide case histories in the SDOH that build on PPH's legacy of health equity, social justice, and the SDOH.

9.3.3 Policy contributions

The manuscripts of this dissertation, in particular Chapters 6 and 8, assert the connection between the SDOH and the policy decisions that governments make regarding the distribution of money, power, and resources.(39) The literature on the SDOH is clear: policy decisions reflect political priorities and ideologies.(40, 41) I have contributed historical evidence of how health and PPH in Canada have remained intrinsically connected to government decisions on social, welfare, criminal, and health care policy. In Chapter 6, I applied contemporary perspectives on poverty and equity to show that, historically, poverty ebbed and flowed alongside changing social, economic, and political conditions in Canada. In Chapter 7, I illustrated how policy decisions made by the Liberal Government during the 1960s-80s helped and hindered the public health community's efforts to improve access to equitable family planning services. Finally, in Chapter 8, I demonstrated how PPH leaders past and present contributed to the development of the SDOH approach and explored the social, economic, and political context in which this history occurred.

Throughout this dissertation, I have shown that the public health community and the CPHA have a long history of bringing attention to the SDOH in different settings – media, public, PPH, academia, and government. However, even with the high levels of attention that have been brought to the SDOH approach, some have argued that the message of reducing health inequities through action on the SDOH is not being translated into policy decisions.(30, 36, 42-44) As found in Chapter 4, much of the literature on the SDOH appeared to be written for an undefined and general policy-maker audience. The diffuse nature of the intended audience may

269

be problematic, in light of the many challenges that exist for transferring scientific knowledge into policy.(45) Yet, the urgency of translating evidence into policy has been reiterated over the past two decades through calls of action in the literature for PPH to advocate on policies that promote health equity.(20, 43, 46-56) The PPH community appears to be responding, as a growing body of literature is developing that aims to promote action on the SDOH in the policy process through use of tools such as health equity impact assessment in decision-making,(37, 57-63) which seeks to maximize positive and minimize negative impacts of programs or policies for specific population groups, to reduce health inequities.

Based on the context provided, international readers may consider the findings from this dissertation transferrable to their own settings, particularly in countries that share histories of public health and the welfare state similar to Canada (e.g., United Kingdom, United States of America). In reflecting on this work, one potential implication for international audiences is the importance of strong international connections and contacts in mobilizing support for paradigm shifts in public health. In the history of the SDOH in Canada, such longstanding relationships have proven especially important in maintaining support for ideas that received relatively little domestic interest (e.g., the Health Field Concept gained international support prior to its uptake in Canada) or mobilizing global commitments to achieve health equity. Some examples of this latter contribution include the First International Conference on Health Promotion, which was co-hosted by the World Health Organization (WHO), Government of Canada (i.e., National Department of Health and Welfare), and Canadian Public Health Association. Other commitments, such as the WHO Commission on the Social Determinants of Health and the Rio Political Declaration on Social Determinants of Health, also involved participation of these three groups.

9.4 Limitations

I utilized the CPHA archives, archives related to the CPHA held by the Library and Archives of Canada, and other sources to conduct this research. It is possible that the history of the SDOH, as told through the CPHA archives, differs from that of other Canadian national organizations involved in public health. Thus, my findings may not be transferrable to organizations such as for-profit associations or government health departments. To overcome this potential limitation, I triangulated sources to gain multiple perspectives on the history of the SDOH (see Section 2.7.1) to enhance the credibility and transferability of my findings.

As well, the national perspective provided here does not capture the unique histories of the SDOH that inevitably exist throughout different jurisdictions in Canada (e.g., regions, provinces, territories). However, the CPHA is the oldest non-governmental PPH association in Canada and has continually worked to represent the interests of the PPH community throughout its existence, thus it is likely that its archives provide at least a somewhat representative history. The richness of detail and the transparency of debate in the CPHA archives likely would not be found in other archives, such as those held by government where content has been redacted for legal purposes or edited to make suitable for public access. For this reason, the CPHA archives remain an opportune resource for study of the SDOH, as they capture varying, and at times conflicting, perspectives on PPH issues in Canada.

However, this dissertation is inherently limited by what has been preserved in the historical record and what I have been given permission to access. Because membership lists were not made available to me (Section 2.5.1.1), the degree to which I am able to comment on historical actors as well as their contribution and relationship to the CPHA over time is limited. Additionally, the CPHA archives serve as a living resource for its staff and members.

Consequently, some stored materials have been removed, refiled, or even destroyed at different points in the association's history for operational reasons (e.g., limited storage space, moving locations). The CPHA archives thus represent what its members and employees have deemed important and irreplaceable. There is the possibility that staff would have saved only resources that present the CPHA in a positive light, however, I did not find this to be the case in my analysis. As mentioned in Section 2.7.1, multiple sources were triangulated to ensure that findings represented as complete a history as possible. Through my use of triangulation, at times I found that some sources were better able to illustrate my themes than others. Specifically, the in-depth description of PPH issues captured in Canadian Journal of Public Health (CJPH) articles often provided greater insight than single resolutions or motions captured in CPHA meeting minutes or annual reports. For this reason, the CJPH articles may appear to overshadow other CPHA archival documents. In part this reflects the intended audience for this work (i.e., medical journals have lower word counts and less room for interpretation of sources). However, throughout my analysis I considered the CJPH as an archival source because of its relationship with the CPHA and the participation of the journal's authors in this institution, particularly during the first half of the twentieth century (i.e., the same historical actors who authors CJPH articles appeared to be active in the CPHA).

A limitation of the oral history interviews is that I recruited individuals who were identified through the CPHA archives as having contributed to the SDOH in Canada, who I alternatively refer to as "PPH leaders." I inevitably missed perspectives and contributions by using this approach, as PPH in Canada is replete with talented individuals who have helped shape the history of the SDOH. I may have missed potentially highly informative participants through my focus on leaders; some individuals naturally gravitate towards leadership positions,

while others seek impact behind-the-scenes. Other potential participants may have been missed

through my use of the CPHA archives to identify them. I overcame this limitation through

snowball sampling (see Section 2.5.1.4.1), which in some cases did identify non-CPHA

members. For feasibility, I limited my sample size to seventeen participants. I attempted to make

my sample representative of the PPH community by interviewing participants from different

disciplinary backgrounds, with careers spanning different time periods in PPH. I also attempted

to ensure that my sample represented a perspective that was at least somewhat generalizable to

the PPH community, by prioritizing interviews where prospective participants were named by

multiple participants.

A final limitation of this dissertation is its potential "presentist" bias. Christopher Green,

the former editor of the *Journal of the History of Behavioral Sciences*, defines presentism as "the

imposition of modern epistemic categories and values on the actions of people from the distant

past […] who did not share our categories and values…"(64) From this perspective, my

dissertation may be viewed as imposing present understandings of and actions on the SDOH onto

past generations and contexts. Reflecting on this potential source of bias, I offer two responses in

the following paragraph; the first concerns my role as a PPH trainee and the second concerns the

relevance of my work to PPH.

As a PPH graduate student in Community Health Sciences, it is expected that I engage

with and be competent in the present state of knowledge in PPH.(65) That being the case, my

work is inherently shaped by this training, and in fact, it was through this training that I

developed the desire to study manifestations of health inequities and the SDOH in the past.

While my contemporary interpretive lens may conflict with conventional historical research that

is diligently situated in the language of the time, it also makes the history of the SDOH

273

accessible to the PPH community, who come from a wide range of disciplinary and professional backgrounds. As argued in a 2004 article published in the *Journal of Epidemiology of Community Health*, an historical perspective can improve PPH practice by broadening the perspective on current issues, essentially since "a substantial period of time is a pre-requisite for the evaluation of progress, or lack of it, in improving health."(66, p751) From that point of view, applying a contemporary lens can be uniquely insightful and informative. However, some may argue that my use of the term "social determinants of health" in this dissertation is inappropriate, given that it only emerged in PPH during the past three decades. Yet because the PPH community was the target audience of my manuscripts, and because PPH journals require a certain degree of brevity, I pragmatically adopted the SDOH term and attempted to do justice to its social, economic, medical, and political historical context in every instance.

Another potential limitation of this thesis concerns the diffusion of the SDOH term, the long history of what is today known as the SDOH approach, and the limited scope of this dissertation in its inability to comprehensively capture every instance and iteration of the "SDOH" employed by the PPH community. As stated in the introduction of this dissertation, the SDOH refer to the complex set of social, economic, and political conditions that shape the health of individuals, communities, and jurisdictions.(5, 67) Considered as such, the SDOH have been of interest to the public health community well beyond its present understanding and moniker. Even within the CPHA archives, the concept of the SDOH was expressed in many ways throughout the twentieth century, predating the formalization of PPH or the SDOH approach. For example, as exemplified in Chapter 6 on the history of poverty, the public health community spoke of the need to "diminish sickness by measures for increasing the healthfulness of the environment of the individual, [...] to diminish poverty..."(68, p242) as early as 1915. Later in

274

the century (see Chapter 8), new and more specific terms emerged to refer to the SDOH, such as "determinants of health,"(69) "societal determinants of health,"(70) "ecological determinants of health,"(71) or "social determinants of health inequalities,"(72) among others (see Chapters 3 and 4). Because of the breadth of SDOH terminology used presently and historically throughout the twentieth century, I employed the term "SDOH" to achieve a degree of consistency throughout this dissertation.

To overcome the above limitation, I used the SDOH term broadly to include the many relevant histories intertwined with and relevant to the SDOH approach, as was the aim of this dissertation. As my dissertation aimed to understand the history of the **social** determinants of health approach and not its relevant counterparts (e.g., prerequisites of health, determinants of health), it seemed appropriate to use the term "SDOH." Nonetheless, from my interviews with PPH leaders I have come to realize that some debate exists regarding the terminology used to describe the SDOH approach. For instance, some feel that the SDOH do not allow for consideration of the ecological determinants of health or the Aboriginal determinants of health. As the aim of this dissertation was to map the history of the SDOH approach, and not specifically to trace changes of terminology related to this approach, I am unable to advocate the use of one term over others. Throughout this dissertation, however, I have conceptualized the SDOH broadly enough so that other, non-social determinants (e.g., cultural, political) of health would be captured and included as relevant for this study.

9.5 Concluding remarks and recommendations

This dissertation and the manuscripts that comprise it have provided a history of the SDOH in Canada since 1910. I conclude with final remarks and recommendations.

In Chapter 3 (on PPH as a united or divided field), I argued that the landscape in Canadian PPH seems conducive to a more coherent discipline (e.g., through the integration of social sciences into health research in federal funding agencies). However, from my perspective as a PPH graduate trainee and emerging PPH researcher seeking my own place in this field, I believe that further reflection and debate is needed. One potential forum for exploring the future of PPH, for example, could be through a workshop and discussion at CPHA's annual conference – the largest national meeting for public health in Canada that brings together practitioners, academics, trainees, and others from the field.

Together, the findings from Chapters 4 (scoping review on the SDOH) and 5 (media analysis on representations of the SDOH in Canadian print news media) represent what has been identified as "lifestyle drift," where attention is initially focused on the need for upstream action on the SDOH (e.g., redistributive income policies to alleviate poverty and food insecurity), but then "drifts" downstream to focus on individual and lifestyle factors (e.g., labelling of nutritional information on food packaging so individuals can make healthier dietary choices).(73) Contributing factors to lifestyle drift include the relatively short terms held by elected office held by decision-makers and the siloed nature of democratic governments (e.g., departments of health working in isolation from departments of environment).(73) These conditions pressure decision-makers to implement short-term policies or programs targeted at the individual level rather than addressing wider social and economic conditions.(73)

As Chapter 4 showed, in recent decades, academics have targeted decision-maker audiences in conveying the key messages of the SDOH and identifying potential courses of action to address the SDOH. However, some academics in PPH have suggested that policy makers are not responding (see Section 9.3.2). Considering this, one recommendation for future

research on the SDOH is that PPH scholars seek to engage and communicate more broadly with decision-makers, beyond publishing policy recommendations in scientific manuscripts. This speaks to the disconnect that former Canadian Policy Research Networks fellow, Patrick Fafard, suggests exists between how health researchers view policy-making as a linear process wherein evidence informs decision-making, versus how it operates in practice as a complex social process that consists of linear and non-linear stages and cycles, competing frames and discourses, citizen engagement, and advocacy coalitions.(45) Considering this disconnect and the above findings, one recommendation for PPH trainees and researchers is that we seek opportunities to better understand how policy is made, to maximize the impact of our policy recommendations regarding action on the SDOH. One example of a training opportunity that has emerged in attempt of filling this knowledge-practice gap, is the Mitacs Canadian Science Policy Fellowship program, which places faculty and postdoctoral candidates in government settings to bridge research and policy expertise.

In Chapter 5, I illustrated how framing the SDOH in news media articles carry implications for action on the SDOH. Reporting and framing the SDOH as an issue of personal responsibility, government responsibility, or as a problem that only affects disadvantaged groups can influence how readers view themselves in relation to the SDOH. It is important that readers view the SDOH as a societal issue, for public pressure is necessary to act on the SDOH at the macro-policy level. However, it is likewise important that the PPH community understand their own relationship to news media (i.e., a for-profit business) and their role within it (e.g., as public health communicators). To overcome some of the present limitations of SDOH framing in news media, the PPH community may consider partnering with journalism schools and industry to explore opportunities for health reporting that is both profitable and constructive to population

health. Further, the PPH community may wish to incorporate communications training specific to SDOH messaging among Public Health and Preventive Medicine residents, who often become the public face of epidemics and other health issues in their role as Medical Officers of Health.

In Chapters 6, 7, and 8, I found that throughout the history of the SDOH and across a breadth of issues (e.g., poverty, family planning, health promotion), the PPH community has at times focused on more individual-level, targeted interventions and other times focused on more upstream, population-level interventions in their pursuit of health equity. Targeted interventions have remained constant throughout the history of the SDOH to improve the health of those who are worst off. Interest in universal interventions, however, has ebbed and flowed throughout the history of the SDOH in Canada, and has been influenced by national social, economic, and political events. Solutions that improve health for all and address the SDOH are desirable PPH goals that may be achieved through universal solutions.(5) However, as the above findings for Chapters 6 through 8 suggest, it may be difficult to sustain interest in and resources for such actions, especially where disadvantaged groups require additional support through the provision of targeted health and social welfare services. For this reason, it is recommended that practitioners, program planners, and decision-makers ensure that where targeted individual-level interventions are implemented for disadvantaged groups, they do so in a way that simultaneously improves individuals' health and socioeconomic position. As health sciences professor Hillary Graham has identified, to improve the health of the worst off, targeted interventions must improve the health of disadvantaged groups at a rate faster than other socioeconomic groups to truly narrow health gaps, reduce disadvantage, and achieve health equity.(74)

Another important finding from Chapters 6 through 8 relates to the importance of integrating different research methods to tackle complex questions of history, PPH, and society.

Specifically, these chapters utilized oral history interviews and analyzed archival materials. Together, these methods highlighted the long and robust roots of the SDOH in Canadian PPH, even within a single organization such as the CPHA.

In reflecting on this history and my dissertation, I have developed a renewed sense of optimism for the future of PPH and the SDOH. Considering the history of the SDOH, it seems likely that the present – and arguably stagnant – status of the SDOH agenda in Canada is also an artifact of time and place. Action on the SDOH, as well as its barriers and facilitators, have twisted and turned throughout the history of PPH. My dissertation has likewise shown that seeking action on the SDOH, particularly through changes made at the macro-policy level, is a long and non-linear process. The mutual interests of many groups (e.g., government, public, industry) must align with the social, economic, medical, and political context of time and place to create windows of opportunity for policy change.(77) It is therefore imperative that the PPH community and allied professions continue to advocate for and work towards achieving health equity, despite the long-lasting challenges they face. Armed with the benefit of hindsight from having completed this history of the SDOH, I anticipate that in the future the PPH community will persevere in its commitment to social justice and health equity throughout changing social, economic, and political conditions.

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**HPCDP Journal – Chronic Diseases and Injuries in Canada:
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Reflections from within the field
July 2017; Volume 37, No. 7**

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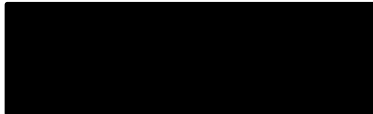
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From: Richard Smith ████████████████████████████
Subject: Re: Request: permission to include my article from CJC 41(4) in dissertation
Date: May 8, 2017 at 7:26:45 AM MDT
To: "permissions@cjc-online.ca" <permissions@cjc-online.ca>, Kelsey Lucyk <kelseylucyk@gmail.com>
Cc: Marilyn Bittman ████████████████████

That is fine with us, Kersey.

We would just ask that acknowledgement is provided and include a link to the original article.

████████████████████
████████████████████

From: Kelsey Lucyk ████████████████████████>
Sent: Monday, May 8, 2017 5:56:48 AM
To: permissions@cjc-online.ca
Subject: Request: permission to include my article from CJC 41(4) in dissertation

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I am writing to request permission to include the following article, entitled "They are not my problem: A content and framing analysis of references to the social determinants of health within Canadian news media, 1993-2014," in my dissertation. This article was published in Vol.41, no.4 (2016) in *Canadian Journal of Communication (CJC)*.

My understanding is that 1 year following publication, authors are allowed to circulate their papers and reproduce them. However, I will be required to circulate a copy of my <u>unpublished</u> dissertation (with the above manuscript included) to my thesis examining committee on June 6. Following my defence, I will submit my thesis to the Faculty of Graduate Studies by July 11. This predates the one year period set by CJC, and therefore I am requesting special permission.

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should you require further details.

Sincerely,

Kelsey

PhD Candidate (Population/Public Health)
Community Health Sciences, Cumming School of Medicine
University of Calgary, (3rd Flr.) TRW
3280 Hospital Drive NW
Calgary, AB   T2N 4Z6

Appendix D: Permission from co-authors to include Chapters 3, 4, 6, and 7 in this dissertation

The following permissions from the co-authors of Chapters 3, 4, 6, and allow for these manuscripts to be included in this dissertation**.**

From: **Lindsay McLaren** ███████████████
Subject: RE: Permission Request: Dissertation manuscripts 4 and 5 (Chs. 6 and 7) - Response required by June 1
Date: May 29, 2017 at 3:39 PM
To: Kelsey Lucyk klucyk@ucalgary.ca

Hi Kelsey, yes, you have my permission

Lindsay

From: Kelsey Lucyk
Sent: Monday, May 29, 2017 10:20 AM
To: Lindsay McLaren ███████████████
Cc: Kelsey Lucyk <klucyk@ucalgary.ca>
Subject: Permission Request: Dissertation manuscripts 4 and 5 (Chs. 6 and 7) - Response required by June 1

Dear Lindsay,

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2. Lucyk K, McLaren L. Taking stock of the social determinants of health: A scoping review. *PLOS ONE* 2017;12(5): e0177306. Available from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0177306

3. Lucyk K**,** Stahnisch FW, Russell ML, Gilmour L, McLaren L. Poverty and public health: The ebb and flow of a social determinant of health, 1900s-2010s. [Unpublished. In the process of preparing for submission to *Critical Public Health*]

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Thank you,

Kelsey

PhD Candidate (Population/Public Health)
Community Health Sciences, Cumming School of Medicine
University of Calgary, (3rd Flr.) TRW
3280 Hospital Drive NW
Calgary, AB   T2N 4Z6

Dear Kelsey,

I agree with all three requests: the inclusion of the two manuscripts in your dissertation, and the submission of the manuscript to the UofC thesis vault.

Sincerely,

Frank

From: Kelsey Lucyk
Sent: May 29, 2017 10:17 AM
To: Frank W. Stahnisch
Cc: Kelsey Lucyk
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Kelsey

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From: **Margaret L. Russell** ▮▮▮▮▮▮▮▮▮▮▮▮▮
Subject: RE: Permission Request: Dissertation manuscripts 4 and 5 (Chs. 6 and 7) - Response required by June 1
Date: May 29, 2017 at 10:20 AM
To: Kelsey Lucyk klucyk@ucalgary.ca

Permission granted (happily)!
Margaret Russell

From: Kelsey Lucyk
Sent: Monday, May 29, 2017 10:18 AM
To: Margaret L. Russell
Cc: Kelsey Lucyk
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Thank you,

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PhD Candidate (Population/Public Health)

PhD Candidate (Population/Public Health)
Community Health Sciences, Cumming School of Medicine
University of Calgary, (3rd Flr.) TRW
3280 Hospital Drive NW
Calgary, AB   T2N 4Z6

From: **Loreen Edith Gilmour** ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮
Subject: Re: Permission Request: Dissertation manuscripts 4 and 5 (Chs. 6 and 7) - Response required by June 1
Date: May 29, 2017 at 10:36 AM
To: Kelsey Lucyk klucyk@ucalgary.ca

You have my permission.

Loreen

Sent from my iPhone

On May 29, 2017, at 10:22 AM, Kelsey Lucyk <klucyk@ucalgary.ca> wrote:

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2. Lucyk K, Stahnisch FW, Russell ML, Gilmour L, McLaren L. "For all those who need them": Efforts to secure equitable access to family planning services within the Canadian public health community, 1960s-80s. [Unpublished. In the process of preparing for submission to *International Journal of Health Equity*]

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PhD Candidate (Population/Public Health)
Community Health Sciences, Cumming School of Medicine
University of Calgary, (3rd Flr.) TRW
3280 Hospital Drive NW
Calgary, AB   T2N 4Z6

Phone: ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮
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Appendix F: Research Agreement with the Canadian Public Health Association

Terms of Reference for Research Project: *Canadian Concepts of Health: Emergence and Evolution from a Social History Perspective, 1910-2012*

Preamble: Mr. James Chauvin of the Canadian Public Health Association (CPHA), and Drs. Lindsay McLaren, Frank Stahnisch, and Ms. Kelsey Lucyk of the University of Calgary have developed a research project titled "*Canadian Concepts of Health: Emergence and Evolution from a Social History Perspective, 1910-2012*," which Ms. Lucyk will pursue as her PhD research at the University of Calgary, beginning Fall 2013 (see abbreviated research proposal, enclosed). The following document outlines Terms of Reference for involved parties.

1. The project will analyze CPHA documents, from 1910 to the present.
   - Documents include, but are not limited to: meeting minutes, conference programs, *Canadian Journal of Public Health*, *Public Health Journal*, CPHA resolutions and position documents.
2. Ms. Lucyk and her supervisors will consider information unrelated to the research questions confidential and will not be included for study.
3. The CPHA will grant Ms. Lucyk and her supervisors access to CPHA documents in person or print, electronically, or by microfiche.
4. Information regarding research and analysis will be stored in a password-protected, encrypted file on Ms. Lucyk's personal computer. Hard-copy documents will be stored in a locked drawer at her, or her supervisor's workspace in Calgary.
5. Ethics approval will be obtained from the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary
6. The CPHA will appoint Mr. Chauvin, or a designated representative, to provide an advisory role to Ms. Lucyk's work on this project.
7. Ms. Lucyk commits to providing the CPHA with an annual progress report for this project.
8. The CPHA may disseminate some or all of Ms. Lucyk's work relating to this project on its website and through other media (e.g. the CPHA Health Digest), to its members and to the public health community in its original or abridged form, with acknowledgement of her authorship.
9. The CPHA will also review for approval other PR-related publications for this project, such as those for the Calgary Institute for Public Health (website, newsletter, etc.).
10. Ms. Lucyk will retain intellectual ownership over her research findings, and may publish in the academic literature with the CPHA's input.

These Terms of Reference were approved by all parties on February 21, 2013.

Appendix G: Question guide for qualitative interviews

Preamble [after Consent Form has been reviewed and signed]
First of all, thank you for taking the time to speak with me today. My name is Kelsey and I would like to talk to you about the social determinants of health concept in Canada. Specifically, I am interested in the history and adoption of this concept in Canada and the experiences and interactions that individuals working within population and public health have had with this concept over the course of their career. Your interview will help to enrich our current understandings of the social determinants concept.

Background

(1) Can you tell me about the current work that you are involved in?
  Prompt: How long in current field; "health" generally
  Prompt: How did you end up this field? Previous work?

SDOH Concept, History, Experience

(2) Can you tell me what it means to you when I say "social determinants of health?"
  Prompt: Definition
  Prompt: Pertinent research or papers
  Prompt: Conditions

(3) Can you recall the first time you heard the term, "social determinants of health"?
  Prompt: Why might this have stood out
  Prompt: Do you recall your thoughts
  Prompt: What did you think of this; was this different from your colleagues' thoughts
  Prompt: Did this change the way you approached your work (why or why not)
  Prompt: Do you feel you were already using this concept (why or why not)
  Prompt: When do you recall issues of power, resources, and structural determinants of health entering the discussion? (vs. more downstream determinants)
    In your mind, have social justice and equity always been part of this discussion?

(4) Can you give me a recent example of how you addressed the SDOH in your work? Past example?
  Prompt: Perceived contribution/impact of work related to the SDOH (your own; of others)

(5) How do you view the changes that have happened in your field regarding the SDOH?
  Prompt: When did you start to notice a difference (particular event?)
  Prompt: What might have motivated this change
  Prompt: How do you feel about that

Barriers and Facilitators to the SDOH Concept

(6) Can you identify any resistance to the SDOH concept?
  Prompt: From whom (government, health, funders, public…)
  Prompt: Why or why not might this have occurred

(7) Can you identify anything that contributed to the acceptance of the SDOH concept?
  Prompt: From whom (government, health, funders, public…e.g., CPHA?)
  Prompt: Why or why not?
      -"Evidence" on SDOH (e.g., Whitehall study)
      -Role of government attention (e.g., *Lalonde Report*; strategic priorities)
      -Role of media attention? (e.g., news coverage of WHO Commission on SDOH)
  Prompt: Any lessons for advocacy on the SDOH?

Current state of SDOH

(8) What role do you see the SDOH playing today?
  Prompt: Accepted concept? (barriers, facilitators)
  Prompt: Important concept?
  Prompt: Things in need of change, or things that are helping its acceptance?

Specific Questions (from CPHA archival research)

(9) Before taking on a leadership role in CPHA, you had been president of PHANS for a number of years in the early 1990s.
  a. Can you comment on the relationship between the provincial organization and the national organization?
    i. How did the CPHA support provincial initiatives?

(10) You were also involved as a stakeholder in one of CPHA's large projects in the late 1990s – Perspectives on Health Promotion, which later led to the organization's action statement on health promotion. In the discussions that seem to have occurred through this project, one topic of conversation was around the issue of population health – which, at the time, was seen by some in the public health community as squeezing out health promotion.

  a. Can you comment on how you viewed this shift in the field?
  b. Why do you think population health was favoured over health promotion?
  c. Were these feelings shared among your colleages?

(11) You have worked in both community health/public health settings and in more direct advocacy roles. (CPHA, PHANS; AHS, U.Calgary)
  a. Can you reflect on the differences between pursuing advocacy in these different settings?
    i. Paper on Group 1 and Group 1 perceptions on the SDOH by groups affiliated with public health in Canada
      1. Group 1 – value neutral, pragmatic
      2. Group 2 – HP, healthy public policy, reorienting health services

Closing Thoughts

(12) Is there anything else you would like to share with me?
  Prompt: Any questions I have not asked, that I should have?

(13) Would you be comfortable sharing your age, for publication of historical works only?

  Age: _____

Appendix H: Summary of interviews and participant demographics

Participant Information	
Total Participants	17
Age	
Youngest	40 years (estimate)
Oldest	88 years
Sex	
Female	8
Male	9
Employment	
Retired	7
Working	10
Current Place of Residence	
British Columbia	2
Alberta	2
Ontario	11
Québec	1
Outside of Canada	1
Training Background	
Academic	5
Medicine	4
Non-Government Organization	2
Nursing	2
Politics	2
Practitioner (Health Promotion)	2
Interview Information	
Approximate Length of Interview	
Shortest	40 minutes
Longest	100 minutes
Method of Interview	
Face-to-Face	10
Telephone	4
Videoconference (Skype)	3

Appendix I: Oral history interview consent form

UNIVERSITY OF CALGARY

CONSENT FORM

TITLE: A history of the social determinants of health through the lens of the Canadian Public Health Association, 1910-2010: Implications for present and future population health in Canada

SPONSOR: University of Calgary

INVESTIGATORS: Dr. Lindsay McLaren, Associate Professor (Principal Investigator)

Dr. Frank Stahnisch, Associate Professor (Co-Investigator)

Kelsey Lucyk, PhD Candidate (Co-Investigator and Student Researcher)

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Currently, there is no comprehensive history of the social determinants of health in Canada. This project will contribute to this history, by working with the Canadian Public Health Association (CPHA) and population health researchers, to trace the emergence and evolution of the social determinants of health concept in Canada. The findings from qualitative interviews with population health researchers and archival research at the CPHA will produce policy-relevant recommendations drawn from the historical lessons learned regarding action on the social determinants of health. The findings from this study will be of interest to historians, decision-makers, stakeholders, and members of the general public.

This research is being conducted as part of Kelsey Lucyk's PhD Dissertation. In addition to qualitative interviews and archival research, this project will also consist of a scoping literature review to determine how the "social determinants of health" are operationalized in current

population health literature, and a media analysis from the past 100 years to determine how the social determinants of health have been conveyed to the general public, historically. In all cases, this study will use qualitative content analysis to analyze data with the purpose of generating themes that capture historical trends on this topic.

This study will involve participation from about 20 individuals with careers working in population health, related to the social determinants of health.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of my study is to gain a comprehensive understanding of the emergence and evolution of the social determinants of health approach in Canada since 1910. It is anticipated that the findings from this study will give valuable insight into the issues and challenges currently facing the social determinants of health in population health. Knowledge generated from this study may even help to identify new ways of taking action on the social determinants on health.

WHY AM I BEING ASKED TO PARTICIPATE?

You are being asked to participate because the study's investigators have identified you as an individual who has extensive knowledge and experience working in the field of population health, relating to the social determinants of health. You were identified through your contributions to this field, by finding your name repeatedly associated with activities relating to action on the social determinants of health in academic publications and/or in CPHA archival documents.

Your history working and researching in this field will provide unique understanding and insight into the history of the social determinants of health approach in Canada. At the end of this study, the publication of Kelsey Lucyk's dissertation will share this learned knowledge with other researchers, decision-makers, and community members.

WHAT WOULD I HAVE TO DO?

The interview will take approximately 1 hour. The study investigators will audio-record this interview (with your consent) and transcribe it. Following the interview, you will have an opportunity to review your transcript and exclude information you do not wish to be included in analysis. This study will continue until completion of Kelsey Lucyk's Doctoral program, expected in late 2017. You will be provided with a 1-page document of this study's key findings, following the completion of this study.

WHAT ARE THE RISKS?

There are no anticipated risks associated with participation in this interview outside of those incurred in day-to-day living. Due to the semi-structured nature of this interview, participants may experience psychological stress if the interview enters subject matter that is sensitive or emotional for the participants. Should this occur, the interviewer will ask if the participant

Ethics ID: REB14-1287
Study Title: A history of the social determinants of health through the lens of the Canadian Public Health
Association, 1910-2010: Implications for present and future population health in Canada
PI: Dr. Lindsay McLaren
Version number/date: Version 2: November 12, 2014
Page 2 of 6

wishes to continue, take a break, terminate the interview, or withdraw from the study. The interviewer will follow the interview guide to maintain a conversation that is relevant to the purpose of this study. By signing this consent form, the participant acknowledges that they accept this risk and may decide which experiences they wish to talk about and which they do not.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. The information we get from this study may help us in taking more effective action on the social determinants of health from a population perspective. As such, this study will have benefits to the scientific/scholarly community, which may potentially lead to improvements in population health.

DO I HAVE TO PARTICIPATE?

Participation is entirely voluntary. During the interview the participant may request to stop recording at any time to discuss or clarify how they wish to respond to a question or topic before proceeding. The researcher may withdraw the participant in the case of an unusable or offensive interview, or information that is non-relevant to the study. If any new information becomes available that might affect the participant's willingness to participate, the participant will be informed as soon as possible.

In the event you should wish to withdraw during the interview, any recording made of the interview will be destroyed, and no transcription of the interview will be made. It is a University of Calgary requirement that all raw study data is retained in secure archival rooms for a five-year retaining period. After your interview is transcribed, the audio recording will be erased from the device and your transcript will remain under lock and key in the Department of Community Health Sciences for a five-year period following completion of this study. After this period, this file will be destroyed.

The participant will be provided with the opportunity to make revisions or restrictions to the transcription prior to its inclusion in the researcher's analysis. This must be requested completed within a two-week period of the participant's receipt of transcript by the interviewer.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not receive any form of payment, nor do you have to pay for your participation in this study.

WHAT TYPE OF INFORMATION WILL BE COLLECTED?

The interviewer will ask you questions about your history working and researching in the field of population health, relating to the social determinants of health. As such, it is likely that identifiable information for participants will be revealed. As mentioned above, it is not anticipated that the subject matter of questions (and respective answers) would lead to any risk (professional or personal) greater than those incurred in everyday living.

Should you agree to participate, you will be asked to provide your age. This may be used in publication when introducing you as a key historical figure (e.g., John A. Macdonald (1815-1891) was the first Prime Minister of Canada.).

Participants are encouraged to consider attaching their name to their interview. This will help to provide authenticity to the interview as a historical source and increase the study's accuracy. This is consistent with oral history interviews, where participants are considered "bearers of tradition" who represent "living links in the historical chain, eye witnesses to history, and shapers of a vital […] way of life." (Smithsonian Institution 2003).

While we do ask participants to **consider** attaching their name to their interview, **there are several options for you to consider if you decide to take part in this research. You can choose all, some, or none of them.** Please review the each of these options and choose Yes or No.

I grant permission to be audio taped: Yes: ___ No: ___

I grant permission to have my company's name used: Yes: ___ No: ___

I wish to remain anonymous: Yes: ___ No: ___

I wish to remain anonymous, but you may refer to me by a pseudonym: Yes: ___ No: ___

    The pseudonym I choose for myself is: _____

You may quote me and use my name: Yes: ___ No: ___

WILL MY RECORDS BE KEPT PRIVATE?

Regardless of whether interview participants choose to remain anonymous or not, their interview and transcript produced from it will be treated as private and confidential. Audio recordings of interviews will be erased from the recording device and all study members' computers once transcription of the interview is complete. A hard copy of this consent form and the interview transcript will be stored in a locked filing cabinet in the Department of Community Health Sciences for 5 years following the completion of this study, and will then be destroyed. Raw (unanalyzed) interview transcripts will never be shared with persons other than the investigators listed at the start of this form, or a hired transcriptionist who has signed a Confidentiality Agreement.

The University of Calgary Conjoint Health Research Ethics Board will have access to these records, as they constitute a major part of Kelsey Lucyk's dissertation.

By signing this form, you consent to having copies (for purposes of analysis) of the interview transcript stored on Kelsey Lucyk's computer. Her computer is virus protected, password locked, and all files pertaining to this study will be password-protected and encrypted using 128-bit encryption.

CONSENT TO THE USE OF INFORMATION IN RESULTING ACADEMIC PUBLICATION:

Participants may wish to include photographs or personal materials to help illustrate their stories. These may be used in academic publication by the investigators, to add context to this historical work. If you allow the investigators to publish a reproduction of your personal materials (e.g., photograph, conference program, certificate of achievement), please describe the item below:

Type and subject of material (Photographs? Documents? Other?):

_____

_____

_____

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Kelsey Lucyk ███████████████

Or

Dr. Lindsay McLaren ███████████████

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Ethics ID: REB14-1287
Study Title: A history of the social determinants of health through the lens of the Canadian Public Health Association, 1910-2010: Implications for present and future population health in Canada
PI: Dr. Lindsay McLaren
Version number/date: Version 2: November 12, 2014
Page 5 of 6

_____   _____
Participant's Name   Signature and Date

_____   _____
Investigator/Delegate's Name   Signature and Date

_____   _____
Witness' Name   Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix J: Ethics approval for this dissertation

Content removed for online thesis submission

Content removed for online thesis submission

360

Appendix K: Syllabus for the first course on the social determinants of health in Canada, 2001 version

CHL 5105S - Social Determinants of Health

Spring 2001   **Ann Robertson**
                                                     109A McMurrich

████████████████████████

Rationale

Why are some people healthy and others not? Any attempt to answer this question is based on how health is defined and measured, as well as on the explanations we give for what determines health.

This course addresses this question through a critical exploration of the concept "social determinants of health", a concept which essentially expands the categories of disease risk (or, conversely, threats to well-being) beyond disease pathology and individual behavioural factors, to include social phenemona, such as gender, class, power, status, hierarchy, etc.

This is a course in the sociology of health (and illness) which explores different accounts of health (and illness) from a number of major theoretical approaches and conceptual frameworks, including:

* social epidemiological accounts
* structural-functionalist theories
* social constructionist theories
* structural ist theories
* poststructuralist/postmodernist theories
* gender, race/ethnicity and class accounts

The course essentially asks of all the accounts of health discussed:

1. How is health conceptualized? How are health "determinants" conceptualized?
2. What is the underlying (implicit or explicit) explanation for how health is determined?
3. What are the theoretical strengths and weaknesses of this explanation?
4. What do these conceptualizations --and their relative explanatory strengths and weaknesses-- imply for health policy and practice?

In other words, the course is not so much about what the social determinants of health "are" as it is about a critical analysis of competing discourses on health.

There are no course prerequisites, although the content assumes prior experience in graduate seminars, and some familiarity with social theory. The course format is a weekly 3-hour seminar, with emphasis placed on critical analysis and discussion of the readings assigned for the week.

Course Objectives

1. Equip students with a basic and critical understanding of major sociological theories as they apply   to the concept of social determinants of health.

2. Support students in creating and analyzing various conceptual frameworks and explanations of the determinants of health based on their own experience and initial understandings.

3. Provide students with critical theoretical tools to use in the analysis of particular health and illness issues.

Course Grading

1. Seminar Facilitations/Short Papers (50%)

   Students will be divided into 3 or 4 groups, depending on the class size. Each group will be responsible for facilitating discussion of the week's readings every 3 or 4 weeks, beginning with Class 3. Facilitation of class discussion will be focussed on the following:

   * what is the author(s) saying about health/illness and what determines it?
   * what implicit or explicit theoretical explanation underlies what the author(s) is saying?
   * what are the strengths and weaknesses of the author(s)' argument? are you persuaded?

   Each student in the group will be responsible for submitting a 3-5 page (maximum) critical engagement with the readings. This "think piece" should address one or more of the following:

   * comparison of perspectives in readings
   * application of the readings to your own knowledge/experience
   * application of the readings to your evolving conceptual framework (see Class 2)
   * application of the readings to a health (or illness) issue of interest to you

2. Final Paper (50%)

   Students will discuss their conceptual framework of the determinants of health at whatever stage of development it has reached by the end of the course. With reference to theories, concepts and issues raised in the course readings and seminar discussions, students will explicate their model by applying it to a particular health issue of interest. The paper should be 15-20 double-spaced pages (standard margins and font size) in length (not including the References) and should be referenced appropriately.

Marking Criteria for the Final Paper

The final paper is an opportunity for you to reflect on and refine your original conceptual framework for the social determinants of health in light of the readings and class discussions. The following are the criteria that will be used in grading the paper:

1. Some form of visual representation of your original conceptual framework, along with a brief discussion of what you were thinking when you developed it; that is, why you chose the determinants you did; why you grouped or arranged them as you did; what explanatory mechanism you assumed underlay these determinants.

2. A visual representation of your current conceptual framework, and a discussion of how it differs from your original one. A preliminary discussion of the explanatory mechanisms underlying the determinants of health as you now understand them.

3. A discussion of **how** you got from your original to your current conceptual framework; that is, what is it about the theoretical positions discussed in the readings and seminars, and your personal/   professional experience, that led you to change your conceptual framework as you did. (NOTE: It   will help considerably if you keep a "journal" of your intellectual jouney throughout the course)

4. Some discussion of the contingency of your conceptual framework, that is: to whom or what does   it apply (and not); in what circumstances and to what purpose is it explicitly or implicitly directed.

6. Some discussion of what remains problematic or troubling to you about your conceptual framework and where you might be heading with it.

Course Readings

The readings are organized by class into a required list and a recommended list. Required readings will be made available in a reading package. Students may find it helpful to review the required readings in the order in which they appear on the reading list. Recommended readings are available in journals and books at the Science and Medicine Library.

Although there is no text for the course, the following is a list of important books in the sociology of health and illness which, at some point in the course of your graduate studies, you should read, skim, or peruse. Excerpts or sections from some of these are included in the reader for this course.

Aggleton, P. (1990) **Health**. London: Routledge.

Annandale, E. (1998) **The Sociology of Health & Medicine: A Critical Introduction**. Cambridge, UK: Polity Press.

Armstrong, D. (1983) **Political Anatomy of the Body**, New York: Cambridge University Press.

Conrad, P. & Kern, R. (1994) **The Sociology of Health and Illness: Critical Perspectives** (4th edition)**.** New York: St. Martin's Press.

Evans, R.G., Barer, M.L. and Marmor, T.R. (eds.) **Why are some people healthy and others not? The Determinants of Health of Populations**. New York: Aldine de Gruyter.

Gerhardt, U. (1989) **Ideas about Illness: An Intellectual and Political History of Medical Sociology**. New York: New York University Press.

Hart, N. (1985) **The Sociology of Health and Illness**, London: Causeway Books.

Hayes et al. (eds) (1994) **The Determinants of Population Health: A Critical Assessment**. University of Victoria: Western Geographical Series 29.

Locke, M and Gordon, D. (eds.) (1988) **Biomedicine Examined**, Boston: Kluwer Academic Publishers.

McInlay, J. (ed.) (1984) **Issues in the Political Economy of Health Care**, New York: Tavistock.

Scambler, G. (ed.) (1987) **Sociological Theory and Medical Sociology**, New York: Methuen.

Tesh, S. (1988) **Hidden Arguments: Political Ideology and Disease Prevention Policy**. New Brunswick, NJ: Routledge.

Turner, B.S. (1987) **Medical Power and Social Knowledge**. Beverly Hills: Sage.
Wright, P. and Treacher, A. (1982) **The Problem of Medical Knowledge**. Edinburgh: Edinburgh University Press.

CLASS 1:   Course introduction
(1/10)

Overview of the course and orientation to the exercise for Class 2.

<u>Required reading:</u>

Note: Because these readings are considered general background reading, you may find it helpful to return to them from time to time during the course.

Clarke, J. (1990) **Health, Illness and Medicine in Canada** Toronto: McLelland & Stewart; Chapters 1 and 2.

Lupton, D. (1994) "Theoretical Perspectives on Medicine and Society" in **Medicine as Culture: Illness, Disease and the Body in Western Societies**. Thousand Oaks, CA: Sage Publications.

Annandale, E. (1998) "The Theoretical origins and Development of the Sociology of Health and Illness" in **The Sociology of Health & Medicine: A Critical Introduction**. Cambridge, UK: Polity Press.

CLASS 2:   What is health? Concepts of Health
(1/17)

A discussion of the following exercise:

Exercise: The Social Determinants of Health

As a start to developing your conceptual framework for the "social determinants of health", think about those things in one's personal life history and life conditions that are important "factors" in the experience of health or disease. A useful way to engage this exercise might be to place yourself (or someone else) in the centre and then "weave" around this person a logical rendering of the influences on health. Be prepared to present your conceptual framework, and to describe how the various influences are experienced as a "whole," that is, how does the person experience/interpret their interconnectedness? This exercise will also entail some discussion of how "health" and/or "disease" are understood by the person. It will be useful to others to create a visual representation of your conceptual framework.

This exercise is to be done prior to Class 2. Bring your models to class!

<u>Required Readings:</u>
Aggleton, P. (1990) **Health**. London: Routledge; Chapter 1.

Blaxter, M. (1990) **Health and Lifestyles**, New York: Routledge; Chapter 3, "What is Health?" and Chapter 10, "Conclusions and implications."

Rootman, I and Raeburn, J. (1994) "The concept of health," in Pederson et al. (eds) **Health Promotion in Canada**, Toronto: W.B. Saunders.

Recommended Readings:
DeLeeuw, E. (1989) Concepts in health promotion: the notion of relativism **Social Science and Medicine** 29(11): 1281-88.

Labonte, R. (1993) **Health promotion and empowerment: practice frameworks**, Toronto: Centre for Health Promotion; Selected sections from Chapter 2.

Noack, H. (1991) "Conceptualizing and measuring health," in Badura and Kickbush (Eds.) **Health Promotion Research: Towards a New Social Epidemiology**, WHO Regional Publication Europe No.37.

Parse, Rosemarie (1991) Health: a personal commitment. **Nursing Science Quarterly** 3(1): 136-40.

Pender, N. (1991) Expressing health through lifestyle patterns. **Nursing Science Quarterly** 3(1): 115-22.

Perry, C.L. (1985) The concept of health promotion and the prevention of adolescent drug abuse. **Health Education Quarterly** 12(2): 168-184.

Sorochan, W. (1970) "Health concepts as a basis for orthobiosis," in Hart and Sechrist (eds.) **Dynamics of Wellness** Belmont: Wadsworth Publishing, pp.2-15.

CLASS 3: What explains health? Models of determinants of health
(1/24)
Required Readings:
Aggleton, P. (1990) **Health**. London: Routledge; Chapter 3.

Antonovsky, A. (1980) **Health, Stress and Coping** Washington: Jossey-Bass; Chapters 6 & 7.

Marmot, M. (2000) "Multilevel Approaches to Understanding Social Determinants" in Berkman, L. and Kawachi, I. (Eds.) **Social Epidemiology**, Oxford: Oxford University Press.

Tesh, S. (1988) "A Multicausal Solution", Chapter 3, **Hidden Arguments: Political Ideology and Disease Prevention Policy**, New Brunswick, NJ: Rutgers University Press.

Recommended Readings:
City of Toronto (1991) **Advocacy for Basic Health Prerequisites.** Toronto: Department of Public Health.

Crawford, R. (1984) "A cultural account of health: control, release and the social body," in McInlay (ed.) **Issues in the Political Economy of Health Care**, New York: Tavistock.

Evans, R. and Stoddart, G. (1994) "Producing health, consuming health care," in Evans, R.G., Barer, M.L. and Marmor, T.R. (eds.) **Why are some people healthy and others not? The Determinants of Health of Populations**. New York: Aldine de Gruyter.

Fylkesnes, K. and Forde, O. H. (1992) Determinants and dimensions involved in self-evaluation of health. **Social Science and Medicine** 35(3): 271-79.

Hudson, R. (1994) "Can health care become a determinant of health?" in Hayes et al. (eds) **The Determinants of Population Health: A Critical Assessment**. University of Victoria: Western Geographical Series 29.

Lane, J.C. (1987) Social epidemiology: directions for the future in academic and shoe-leather risk analysis. **Journal of Community Health** 12(2,3): 130-38.

Levy, J. (1991) A conceptual meta-paradigm for the study of health behaviour and health promotion. **Health Education Research** 6(2):195-202.

McKinlay, J., McKinlay S. and Beaglehole, R. (1989) A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States. **International Journal of Health Services** 19(2): 181-208.

Mackenbach, J. etal (1989) The contribution of medical care to inequalities in health. **Social Science and Medicine** 29(3): 369-76.

WHO, Health and Welfare Canada, CPHA (1986) Ottawa Charter for Health Promotion. **Canadian Journal of Public Health** 77:425-427.

Wilkinson, R.G. (1994) The Epidemiological Transition: From Material Scarcity to Social Disadvantage. **Daedalus** 123(4): 61-77.

Wilkinson, R.G. Socioeconomic determinants of health: Health inequalities: relative or absolute material standards? (1997) **British Medical Journal** 314 (22 February): 591-594.

CLASS 4:   Social-epidemiological explanations
(1/31)

Required Readings:

Adler, N. et al. (1994) Socioeconomic status and health: The challenge of the gradient. **American Psychologist** 49(1): 15-24.

Marmot, M. and Theorell, T. (1994) "Social Class and Cardiovascular Disease: The Contribution of Work," in Conrad, P. & Kern, R. (eds) **The Sociology of Health and Illness: Critical Perspectives** (4th edition), New York: St. Martin's Press.

Kawachi, I. and Berkman, L. (2000) " Social Cohesion, Social Capital, and Health" in Berkman, L. and Kawachi, I. (Eds.) **Social Epidemiology**, Oxford: Oxford University Press.

Krieger, N. (1994) Epidemiology and the Web of Causation: Has Anyone Seen the Spider? **Social Science and Medicine** 39(7): 887-903.

Recommended Readings:

Arnoux, L. and Grace, V. (1991) "From Physical to Critical Epidemiogy," New Zealand Public Health Association Presentation (mimeo available from AR).

Douglas, M. and Wildavsky, A. (1982) "Introduction" in **Risk and Culture**, Los Angeles: University of California Press.

Frohlich, N. and Mustard, C. (1996) A Regional Comparison of Socioeconomic and Health Indices in a Canadian Province. **Social Science and Medicine** 42(9): 1273-1281.

Gorri, G.B. (1989) Epidemiology and the Concept of Causation in Multifactorial Diseases **Regulatory Toxicology and Pharmacology** 9: 263-272.

Hayes, M. (1994) "Evidence, determinants of health population epidemiology..." Chapter 6 in **The Determinants of Population Health: A Critical Assessment** ed. by Hayes, Foster and Foster. University of Victoria: Western Geographical Series 29.

Hertzman, C. and Hayes, M. (1992) "Putting up or shutting up: interpreting health status indicators from an inequities perspective," in Hayes et al. (eds.) **Community, Environment and Health**, University of Victoria. Geographical Series, Volume 27.

Kawachi, I. et al. (1997) Social Capital, Income Inequality, and Mortality. **American Journal of Public Health** 87(9): 1491-1498.

Marmot, M. et al. (1991) "Socioeconomic status and disease," in Badura and Kickbush (eds.) **Health Promotion Research: Towards a New Social Epidemiology**, WHO Regional Publication Europe No.37.

Millar, W. and Wigle, D. (1986) Socioeconomic disparities in risk factors for cardiovascular disease. **Canadian Medical Association Journal** 134: 127-32.

Murray, C. and Chen, L. (1993) In search of a contemporary theory for understanding mortality change. **Social Science and Medicine** 36(2): 143-55.

Najman, J. (1993) Health and poverty: past, present and prospects for the future. **Social Science and Medicine** 36(2): 157-66.

Raymond, J. (1989) Behavioural epidemiology: the science of health promotion. **Health Promotion International** 4(4): 281-86.

Scott-Samuel, A. (1989) "Building the new public health: a public health alliance and a new social epidemiology," in Martin and McQueen (eds.) **Readings for a New Public Health**, Edinburgh: University of Edinburgh Press.

Syme, L. and Berkman, L (1994) "Social Class, Susceptibility, and Sickness," in Conrad, P. & Kern, R. (eds.) **The Sociology of Health and Illness: Critical Perspectives** (4th edition). New York: St. Martin's Press.

Vagero, D. (1991) Inequality in health: some theoretical and empirical problems. **Social Science and Medicine** 32(4): 367-71.

Wilkins, R. and Adams, O. (1987) "Health expectancy in Canada, Late 70s" in Coburn et al. (eds.) **Health and Canadian Society** (2nd edition). Toronto: Fitzhenry and Whiteside.

Wilkinson, R. (1990) Income distribution and mortality: a 'natural' experiment. **Sociology of Health and Illness** 12(4): 391-412.

CLASS 5: Structural-functionalist explanations
(2/7)
<u>Required Readings:</u>
Aggleton, P. (1990) **Health**. London: Routledge; Chapter 4.

McIntyre, S. (1997) The Black Report and Beyond: What are the issues? **Social Science and Medicine** 44(6): 723-745.

House, J.S. et al. (1994) "Social Relationships and Health," in Conrad, P. & Kern, R. (eds.) **The Sociology of Health and Illness: Critical Perspectives** (4th ed), New York: St. Martin's Press.

Link, B.G. and Phelan, J. (1995) Social Conditions as Fundamental Causes of Disease. **Journal of Health and Social Behavior** (Extra Issue): 80-94.

<u>Recommended Readings:</u>
Cuff, E.C., Sharrock, W.W. and Francis, C.W. (1990) **Perspectives in Sociology** London: Unwin Hyman, pp.28-39.

Figlio, K. (1987) "The lost subject of medical sociology," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

Freidson, E. (1972) **Profession of Medicine**, New York: Dodd, Mead and Company, Part III: Chapters 10 - 14.

Gerhardt, U. (1989) **Ideas about Illness: An Intellectual and Political History of Medical Sociology**. New York: New York University Press.

Gerhardt, U. (1987) "Parsons, role theory and health interaction," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

Hart, N. (1985) **The Sociology of Health and Illness**, London: Causeway Books; Chapters 5.

Kasl, S. (1984) Stress and health. **Annual Review of Public Health** 5:319-41.

McIntyre, S. (1986) The patternin g of health by social position in contemporary Britain: directions for sociological research. **Social Science and Medicine** 23(4): 393-415.

Marshall, V. (1987) "Social perspectives on aging: theoretical notes," in Marshall, V. (ed.) **Aging in Canada: Social Perspectives** (2nd edition), Toronto: Fitzhenry and Whiteside.

Marshall, V. (1986) "Dominant and emerging paradigms in the social psychology of aging," in Marshall (ed.) **Later Life: The Social Psychology of Aging**, Beverly Hills: Sage.

Pratt, V. (1978) **The Philosophy of the Social Sciences**, Cambridge UK: University Press. Chapters 13 and 14.

Taylor, S. and Ashworth, C. (1987) "Durkheim and social realism: an approach to health and illness," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

CLASS 6:　　　　Social constructionist explanations
(2/14)
Required Readings:
Wright, P. and Treacher, A. (1982) "Introduction" in **The Problem of Medical Knowledge**. Edinburgh: Edinburgh University Press.

Brown, P. (1995) Naming and Framing: The Social Construction of Diagnosis and Illness. **Journal of Health and Social Behaviour** (Extra Issue): 34-52.

Lippman, A. (1991) Prenatal Genetic Testing and Screening: Constructing Needs and Reinforcing Inequities. **American Journal of Law and Medicine** XVII (1&2): 15-50.

Plumridge, E. and Chetwynd, J. (1999) Identity and the social construction of risk: injecting drug use. **Sociology of Health & Illness** 21(3): 329-343.

Recommended Readings:
Bartley, M. (1990) Do we need a strong programme in medical sociology? **Sociology of Health and Illness** 12(4): 371-90.

Bloor, D. (198-) **Knowledge and Social Imagery** Chicago: University of Chicago Press. Chapter 1 and afterword.

Bury, M.R. (1986) Social constructionism and the development of medical sociology. **Sociology of Health and Illness** 8(2): 137-69.

Davison, C., Smith G.S. and Frankel, S. (1991) Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education. **Sociology of Health and Illness** 13(1): 1-19.

Helman, C. (1988) "Psyche, soma and society: the social construction of psychosomatic disorders," in Lock and Gordon (eds.) **Biomedicine Examined**, Boston: Kluwer Academic Publishers.

Labonte, R. (1981) The perils of promiscuity: VD and victim-blaming. **Canadian Family Physician** 27: 1928-32.

Lieban, R. (1992) From illness to symbol and symbol to illness. **Social Science and Medicine** 35(2): 183-88.

Maticka-Tyndale, E. (1992) Social construction of HIV transmission and prevention among heterosexual young adults. **Social Problems** 39(3): 238-252.

Mayer, J.D. (1992) Challenges to understanding spatial patterns of disease: philosophical alternatives to logical positivism. **Social Science and Medicine** 35(4): 579-87.

Nicolson, M. and McLaughlin, C. (1987) Social constructionism and medical sociology. **Sociology of Health and Illness** (9(2): 107-126.

Riessman, C.K. and Nathanson, C.A. (1987) "The Management of Reproduction: Social Construction of Risk and Responsibility." in Aiken, L.H. and Mechanic, D. eds. **Applications of Social Science to Clinical Medicine and Health Policy**, New Brunswick, NJ: Rutgers University Press.

Robertson, A. (1990) "The politics of Alzheimer's Disease: a case study in apocalyptic demography. **International Journal of Health Services** 20(3): 429-42.

Rodin, M. (1992) The social construction of premenstrual syndrome. **Social Science and Medicine** 35(1): 49-56.

Schiller, N.G. et al. (1994) Risky Business: The Cultural Construction of AIDS Risk Groups**. Social Science and Medicine** 38(10): 1337-1346.

Swaan, A. (1989) The reluctant imperialism of the medical profession. **Social Science and Medicine** 28(11): 1165-70.

2/21 - **READING WEEK**

CLASS 7: **Mid-term reflection on models of determinants**
(2/28)

This class will be an opportunity for students to present and discuss their evolving models, focussing on issues with which they are grappling, as a result of course readings /discussions to date.

CLASS 8:   Structuralist explanations
(3/7)
<u>Required Readings:</u>
Navarro, V. (1986) "Work, ideology and science: the case of medicine," in **Crisis, Health and Medicine: A Social Critique**, New York: Tavistock Publications.

Muntaner , C. and Lynch, J. (1999) Income Inequality, Social Cohesion, and Class Relations: A Critique of Wilkinson's Neo-Durkheimian Research Program. **International Journal of Health Services** 29(1): 59-81.

Smith, B.E. (1994) "The social production of black lung disease," in Conrad and Kern (eds.) **The Sociology of Health and Illness: Critical Perspectives** (4th edition), New York: St. Martin's Press.

Laurell, A. C. (1989) Social analysis of collective health in Latin America. **Social Science and Medicine** 28(11): 1183-91.

<u>Recommended Readings:</u>
Aggleton, P. (1990) **Health**. London: Routledge; Chapter 6, pp. 112-122.

Blane, D. (1987) "The value of labour-power and health," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

Blane, D. (1985) An assessment of the Black Report's explanations of health inequalities. **Sociology of Health & Illness** 7(3):423-45.

Brown, P. (1984) Marxism, social psychology and the sociology of mental health. **International Journal of Health Services** 14(2): 237-64.

Eyer, J. (1977) Prosperity as a cause of death. **International Journal of Health Services** 7(1): 125-49.

Hart, N. (1985) **The Sociology of Health and Illness**, London: Causeway Books; Chapters 2,3.

Illsley, R. (1990) Comparative review of source, methodology and knowledge. **Social Science and Medicine** 31(3):229-36.

Illsley, R. and Baker, D. (1991) Contextual variations in the meaning of health inequality. **Social Science and Medicine** 32(4):359-65.

McKibben, W. (1996) The Enigma of Kerala. **Utne Reader** (March-April).

Muntaner, C. and Lynch, J. (1999) The Social Class Determinants of Income Inequality and Social Cohesion. **International Journal of Health Services** 29(4): 699-732.

Oakley, A. (1989) Smoking in pregnancy: smokescreen or risk factor? Towards a materialist analysis. **Sociology of Health & Illness** 11(4): 311-335.

Oliver, M. (1990) **The Politics of Disablement**. Basingstoke, UK: Macmillan; Chapter 6.

Scambler, G. (1987) "Habermas and the power of medical expertise," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

Schnall, P.L. and Kern, R. (1981) "Hypertension in American society: An introduction to historical materialist epidemiology," in Conrad, P. & Kern, R. (eds.) **The Sociology of Health and Illness: Critical Perspectives**. New York: St. Martin's Press.

Woolhandler, S. and Himmelstein, D. (1989) Ideology in medical science: class in the clinic. **Social Science and Medicine** 28(11): 1205-09.

CLASS 9: Poststructuralist/Postmodernist explanations
(3/14)
<u>Required Reading:</u>
Fox, N.J. (1994) **Postmodernism, Sociology and Health**, Introduction, Toronto: University of Toronto Press.

Bunton, R. (1997) "Popular health, advanced liberalism and *Good Housekeeping* magazine" in Petersen, A. and Bunton, R. (Eds) **Foucault, Health and Medicine**, London: Routledge.

Lupton, D. (1995) "Bodies, Pleasures, and the Practices of the Self", Chapter 5 in **The Imperative of Health: Public Health and the Regulated Body**. Beverly Hills: Sage.

Kerr, A. and Cunningham-Burley, S. (2000) On Ambivalence and Risk: Reflexive Modernity and the New Human Genetics. **Sociology** 34(2).

<u>Recommended Reading:</u>
Annandale, E. (1998) "Shattering the Orthodoxy? Foucault, Postmodernism and the Sociology of the Body" in **The Sociology of Health & Medicine: A Critical Introduction**. Cambridge, UK: Polity Press.

Armstrong, D. (1983) "Preface, Chapters 1 and 11," in **Political Anatomy of the Body**, New York: Cambridge University Press.

Armstrong, D. (1995) The Rise of Surveillance Medicine. **Sociology of Health and Illness** 17 (3): 393-404.

Bloor, M. & McIntosh, J. (1990) "Surveillance and Concealment: A Comparison of Techniques of Client Resistance in Therapeutic Commnities and Health Visiting" in Cunningham-Burley & McKeganey (eds.) **Readings in Medical Sociology**, London: Tavistock/Routledge, pp. 159-181.

Gordon, D. (1988) "Tenacious assumptions in western medicine," in Lock and Gordon (eds.) **Biomedicine Examined**, Boston: Kluwer Academic Publishers.

Katz, A.M. and Shotter, J. (1996) Hearing the Patient's Voice: Towards a Social Poetics in Diagnostic Interviews. **Social Science and Medicine** 43(6): 919-931.

Hayes, M. (1992) On the epistemology of risk: language, logic and social science. **Social Science and Medicine** 35(4): 401-07.

Hayes, M. (1991) The risk approach: unassailable logic. **Social Science and Medicine** 33(1):55-70.

Lupton, D. (1994) "The Body in Medicine", Chapter 5 in **Medicine as Culture: Illness, Disease and the Body in Western Societies**, London: SAGE Publications.

McKie, L. (1995) The Art of Surveillance or Reasonable Prevention? The Case of Cervical Screening. **Sociology of Health and Illness** 17(4): 441-457.

Nettleton, S. (1995) "The Sociology of the Body", Chapter 5 in **The Sociology of Health and Illness**. Polity Press.

Scheper-Hughes, N. and Lock, M. (1986) "Speaking truth to illness: metaphors, reification and a pedagogy for patients," **Medical Anthropology Quarterly** 17(5): 137-40.

Turner, B.S. (1987) **Medical Power and Social Knowledge**. Beverly Hills: Sage; Introduction.

Turner, B. (1991) Missing bodies--towards a sociology of embodiment. **Sociology of Health and Illness** 13(2): 265-72.

Watson, J. et al. (1996) Lay theorizing about "the body" and implications for health promotion. **Health Education Research** 11(2): 161-172.

CLASS 10:   Gender as a determinant of health
(3/21)
<u>Required Readings:</u>

Annandale, E. and Clark, J. (1996) What is gender? Feminist Theory and the Sociology of Human Reproduction. **Sociology of Health & Illness** 18(1): 17-44.

Duncan, M.C. The Politics of Women's Body Images and Practices: Foucault, The Panopticon, and Shape Magazine. **Journal of Sport & Social Issues** 18(1): 48-65.

Cameron, E. and Bernardes, J. (1998) Gender and disadvantage in health: men's health for a change. **Sociology of Health & Illness** 20(5): 673-691.

Schroedel, J.R. and Peretz, P. (1994) A gender analysis of policy formation: the case of fetal abuse. **Journal of Health Politics, Policy and Law** 19(2): 335-60.

<u>Recommended Readings:</u>

Aggleton, P. (1990) **Health**. London: Routledge; Chapter 6, pp. 122-130 (see Class 6 for Chapt 6).

Annandale, E. (1998) "Gender Inequalities and Health Status" in **The Sociology of Health & Medicine: A Critical Introduction**. Cambridge, UK: Polity Press.

Arber, S. and Ginn, J. (1993) Gender and inequalities in health in later life. **Social Science and Medicine** 36(1): 33-46.

Bransen, E. (1992) Has menstruation been medicalized? **Sociology of Health and Illness** 14(1): 98-110.

Busfield, J. (1988) Mental illness as social product or social construct: a contradiction in feminists' arguments? **Sociology of Health and Illness** 10(4): 521-42.

Calnan, M. and Johnson, B. (1985) Health, health risks and inequalities: an exploratory study of women's perceptions. **Sociology of Health and Illness** 7(1): 55-75.

Ehrenreich, B. and English, D. (1990) "The sexual politics of sickness," in Conrad and Kern (eds.) **The Sociology of Health and Illness: Critical Perspectives** (3rd edition), New York: St. Martin's Press.

Hall, E. (1991) "Gender, work control and stress: a theoretical discussion and an empirical test," in Johnson and Johansson (eds.) **The Psychosocial Work Environment: Work Organization, Democratization and Health** Amityville: Baywood Publishing.

Lawless, S., Kippax, S. and Crawford, J. (1996) Dirty, Diseased and Undeserving: The Positioning of HIV Positive Women. **Social Science and Medicine** 43(9): 1371-1377.

Popay, J., Bartley, M. and Owen, C. (1993) Gender inequalities in health ... **Social Science and Medicine** 36(1): 21-32.

Riessman, C. (1983) Women and medicalization: a new perspective. **Social Policy** Summer: 3-18.

Saltonstall, R. (1993) Healthy bodies, social bodies: men's and women's concepts and practices of health in everyday life. **Social Science and Medicine** 36(1): 7-14.

Sawicki, J. (1991) "Disciplining Mothers: Feminism and the New Reproductive Technologies", Chapter 4 in **Disciplining Foucault: Feminism, Power, and the Body**. New York: Routledge.

Stacey, M. and Olesen, V. (1993) Introduction **Social Science and Medicine** 36(1): 1-5.

CLASS 11: Race/ethnicity as a determinant of health
(3/28)
<u>Required Readings:</u>
Annandale, E. (1998) " 'Race', Ethnicity and Health Status" in **The Sociology of Health &**

Medicine: A Critical Introduction. Cambridge, UK: Polity Press.

Smaje, C. (1996) The Ethnic Patterning of Health: New Directions for Theory and Research. **Sociology of Health and Illness** (18)2: 139-171.

Lillie-Blanton, M. & Laveist, T. (1996) Race/Ethnicity, The Social Environment, and Health. **Social Science and Medicine** 43(1): 83-91.

Anderson, J., Blue, C. and Lau, A. (1991) Women's perspectives on chronic illness: ethnicity, ideology and restructuring of life. **Social Science and Medicine** 33(2): 101-13.

Recommended Readings:
Adelson, N. (1998) Health beliefs and the politics of Cree well-being. **Health** 2(1):5-22.

Caldwell, J. (1993) Health transition: the cultural, social and behavioural determinants of health in the third world. **Social Science and Medicine** 36(2): 125-35.

City of Toronto (1989) **The Native Canadian Community in Toronto** Toronto: Department of Public Health.

Fabrega, H. (1980) **Disease and Social Behaviour** Cambridge: MIT Press. Chapter 8, "Ladino theories of disease"

Geronimus, A. (1996) Black/White Differences in the Relationship of Maternal Age to Birthweight: A Population-based Test of the Weathering Hypothesis. **Social Science and Medicine** 42(4): 589-597.

McCord, C. and Freeman, H.P. (1994) "Excess Mortality in Harlem," in Conrad and Kern (eds.) **The Sociology of Health and Illness: Critical Perspectives** (4th edition), New York: St. Martin's Press.

Morse, J., Young, D. and Swartz, L. (1991) Cree Indian healing practices and western health care: a comparative analysis. **Social Science and Medicine** 32(12): 1361-66.

O'Neill, J. (1989) The cultural and political context of patient dissatisfaction in cross-cultural clinical encounters: a Canadian Inuit study. **Medical Anthropology Quarterly** 3(4): 325-44.

Pappas, G. Elucidating the relationships between race, socioeconomic status and health. **American Journal of Public Health** 84(6): 892-893.

Report of Scott Bain Health Panel (1989) **From here to there: steps along the way**. Achieving Health For All in the Sioux Lookout Zone

Shah, C. and Farkas, C. (1985) The health of Indians in Canadian cities: a challenge to the health care system. **Canadian Medical Asssociation Journal** 133(1):859-63.

Williams, D.R. & Collins, C. (1995) US Socioeconomic and Racial Differences in Health: Patterns

and Explanations. **Annual Review of Sociology** 21: 349-86.

Wise, P.H. and Pursley, D.M. (1992) Infant Morality as a Social Mirror. **The New England Journal of Medicine** 326(23): 1558-1559.

Young, T.K. (1987) "The health of Indians in Northwestern Ontario: A historical perspective," in Coburn etal (eds.) **Health and Canadian Society** (2nd edition) Toronto: Fitzhenry and Whiteside.

CLASS 12: Class as a determinant of health
(4/4)
<u>Required Readings:</u>
Annandale, E. (1998) "Class Structure, Inequalities and Health" in **The Sociology of Health & Medicine: A Critical Introduction**. Cambridge, UK: Polity Press.

Scambler, G. and Higgs, P. (1999) Stratification, Class and Health: Class Relations and Health Inequalities in High Modernity. **Sociology** 33(2): 275-296.

Calnan, M. and Williams, S. (1991) Style of life and the salience of health. **Sociology of Health and Illness** 13(4): 506-29.

Balshem, M. (1991) Cancer, control, and causality: talking about cancer in a working-class community. **American Ethnologist** 18(1): 152-172.

<u>Recommended Readings:</u>
Backett, K. (1992) Taboos and excesses: lay health moralities in middle class families. **Sociology of Health and Illness** 14(2):255-74.

Cobb, S. (1974) "Role responsibility: the differentiation of a concept," in McLean (ed.) **Occupational Stress** Springfield: Charles Thomas.

Frankenhauser, M. (1991) "A biopsychosocial approach to work life issues," in Johnson and Johansson (eds.) **The Psychosocial Work Environment: Work Organization, Democratization and Health** Amityville: Baywood Publishing.

French, J. (1974) "Person role fit," in McLean (ed.) **Occupational Stress** Springfield: Charles Thomas.

Hall, W. (1986) Social Class and Survival on the *S.S.Titanic*. **Social Science and Medicine** 22(6): 687-690.

Hart, N. (1985) **The Sociology of Health and Illness**, London: Causeway Books; Chapter 4.

Jones, I. and Cameron, D. (1984) Social class analysis: an embarrassment to epidemiology. **Community Medicine** 6:37-46.

Karasek, R. (1991) "The political implications of psychosocial work redesign: a model of the psychosocial class structure," in Johnson and Johansson (eds.) **The Psychosocial Work Environment: Work Organization, Democratization and Health** Amityville: Baywood.

Labonte, R, (1988) Stress articles and letters in **At the Centre** 11(2) and 11(4).

Pill, R. (1991) "Issues in lifestyle and health: lay meanings of health and health behaviour," in Badura and Kickbush (eds.) **Health Promotion Research: Towards a New Social Epidemiology**, WHO Regional Publication Europe No.37.

Williams D. and House J. (1991) "Stress, social support, control and coping," in Badura and Kickbush (eds.) **Health Promotion Research: Towards a New Social Epidemiology**, WHO Regional Publication Europe No.37.

CLASS 13: Policy as a determinant of health
(4/11)
<u>Required Readings</u>
Tesh, S. (1988) "Individualism and Science" in **Hidden Arguments: Political Ideology and Disease Prevention Policy**. New Brunswick, NJ: Routledge.

Szreter, S. (1988) The importance of social intervention in Britain's mortality decline. **Society for Social History of Medicine** 1(1): 1-41.

Navarro, V. and Shi, L. (2001) The political context of social inequalities and health. **Social Science and Medicine** 52: 481-491.

<u>Recommended Readings</u>
Aggleton, P. (1990) **Health**. London: Routledge; Chapter 6.

Blume, S. (198) Explanation and social policy: "the" problem of social inequalities in health. **Journal of Social Policy** 11(1): 7-32.

Epstein, H. (1998) Life & Death on the Social Ladder. **The New York Review**, July 16.

Fitzpatrick, R. (1987) "Political science and health policy," in Scambler (ed.) **Sociological Theory and Medical Sociology**, New York: Methuen.

Mhatre S. and Deber R. (1992) From equitable access to health care to equitable access to health ... **International Journal of Health Services** 22(4): 645-67.

McInlay, J. (1993) The promotion of health through planned sociopolitical change. **Social Science and Medicine** 36(2): 109-117.

Pallan, P. and Foster, L. (1994) "Integrating health determinants into policy: Barriers and prospects," Chapter 8 in **The Determinants of Population Health: A Critical Assessment** ed. by

Hayes, Foster and Foster. University of Victoria: Western Geographical Series 29.

Premier's Council on Health, Well-being and Social Justice (1994) **Wealth and Health: Health and Wealth** Toronto: Queen's Printer.

NOTE: I regard the following paper as one of the most important Public Health papers ever published. At some point in your career, you should read it:

Ratcliffe, J. (1978) Social Justice and the Demographic Transition: Lessons from India's Kerala State. **International Journal of Health Services** 8(1): 123-144.

4/18   Final Paper due

Appendix L: Permission to include syllabus for first course on the social determinants of health in this dissertation

From: Ann Robertson ████████████████████
Subject: Re: Invitation to participate in History of the SDOH project
Date: May 24, 2017 at 7:36:28 AM MDT
To: Kelsey Lucyk <klucyk@ucalgary.ca>

Dear Kelsey,

Congratulations on completing your doctoral dissertation! I am sorry that I was not able to participate in your interviews last year but am pleased to hear that your research went well.

██

You are very welcome to reproduce the 2001 Syllabus for Social Determinants of Health that I developed. While some may claim "ownership" of such things, I am a great believer in the notion of the "intellectual commons". But, thank you for asking.

All the best as you continue on your scholarly journey.

Ann

Sent from my iPad

On May 23, 2017, at 2:39 PM, Kelsey Lucyk <klucyk@ucalgary.ca> wrote:

Dear Ann,

I hope this message finds you well and perhaps in an easier time than when we last connected in May 2016.

As you may recall, I had been conducting interviews with individuals important to the history of the social determinants of health approach in Canada. I have spoken with many of your friends and colleagues, have written up the results, and am happy to report that I am now nearly finished my dissertation!

The reason I am writing is to request permission to reproduce a syllabus for your 5105S class that you taught in 2001, the first of its kind in Canada. You had shared this syllabus with me when we first connected in 2015. This syllabus has certainly been a useful and interesting resource as I have mapped out the history of the SDOH.

I reference the syllabus in one of the papers of my dissertation. My History supervisor (Frank Stahnisch) noticed this and thought that readers would be

380

interested in seeing the syllabus for themselves. **I am therefore writing to request your permission to reproduce the syllabus as an Appendix in my dissertation, and to include it as a supplementary file to my oral history paper once I have prepared it for submission to a peer-reviewed journal.**

The paper where I reference your syllabus is entitled "It's a tradition of naming injustice": An oral history of the social determinants of health — Canadian reflections, 1960s-present. My dissertation is titled, *A History of the Social Determinants of Health in Canada through the Lens of the Canadian Public Health Association, 1910-2010: Implications for Present and Future Population Health in Canada.*

The details of where my thesis will be published are as follows:
1. I will withhold my thesis from publication for 3-5 years following my defence (June 2017).
2. Once the hold has been lifted, the Faculty of Graduate Studies at the University of Calgary will publish my thesis on their online repository, the Vault (theses.ucalgary.ca)
3. My thesis may also be reproduced by the Library and Archives of Canada for archiving and to make accessible to the public. (More details available upon request).
4. During the withhold period described in item 1, I will submit the manuscripts from my dissertation to peer-reviewed journals for publication. Any article (and supplementary files) accepted to these journals will be subject to the copyright agreement of the journal.

Many thanks for your consideration and please let me know if you have any questions.

All the best,

Kelsey

381