



Edmonton Social Planning Council

**DISCUSSION PAPER**

**Creating Social and Health Equity:  
Adopting an Alberta Social  
Determinants of Health Framework**

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## 1. Introduction

Our view of what makes us healthy is evolving. There is mounting evidence that the contribution of medicine and health care is quite limited, and as a result, spending more on health care will not result in significant further improvements in the health of Albertans. On the other hand, there are strong and growing indications that other key factors, or determinants of health<sup>1</sup>, such as income and social environments, are the primary influencers on population health (Health Canada, 2004).

The challenge facing Alberta government decision makers is that most influences on the health of Albertans originate outside the health care system. Some experts estimate that the social and economic environments contribute to 50% of a population's health status (Chart 1), while the "illness care" system contributes only 25% (Canadian Institute for Advanced Research, Health Canada, 2002). The Alberta government will be unable to meet its health targets if it continues to allocate billions of dollars to a health care system that is unable to deliver the necessary health outcomes.

This paper envisions the adoption of an Alberta Social Determinants of Health (SDOH) Framework that will improve the health of individuals and all Albertans. The development of this framework is an important step leading to significant health care reform in Alberta. The adoption of this framework would represent an important shift in emphasis from an illness based health care system (characterized by a focus on acute care) to a wellness-based system that focuses on preventing illness and chronic disease by addressing the social determinants of health.

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<sup>1</sup> Different health organizations use the terms "determinants of health" (Health Canada) and "social determinants of health" (World Health Organization), yet typically, the terms include similar factors and have similar meanings. Others argue that the more appropriate terms are "societal determinants of health" or "socio-economic determinants of health". In this paper, the term "social determinants of health" is used.

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In some respects, this shift is not as dramatic as it may appear. The foundations for a SDOH Framework can be found in several Alberta government documents. For example, the Framework for a Healthy Alberta (2004) acknowledges the key influence of the determinants of health. Similarly, Alberta's 2004 Report on Comparable Health Indicators (2005) stated, "Our education, employment, income and physical environment influence our health as much or more than the quality and availability of health services". However, this shift would be a dramatic move from the status quo and would require strong political will to overcome the anticipated resistance.

Resistance to the adoption of the SDOH Framework and the resulting health care reforms would likely emerge from three sectors: 1) traditional health care providers; 2) the health care industry (i.e., medical suppliers); and 3) supporters of non-interventionist government. It is hoped that this resistance would diminish as our understanding of what makes us healthy evolves and as a result of the inclusive and collaborative approaches taken to implement the SDOH Framework.

### **1.1 Purpose of the Alberta SDOH Framework**

- Make continual progress in advancing the health of all Albertans through recognition of the important influence of the SDOH.
- Develop a greater understanding of the key influence of the SDOH among decision makers and Albertans.
- Develop an integrated, inclusive and multi-sectoral approach to addressing the SDOH in Alberta.
- Strengthen health promotion and population health activities across the health system, including strategies to address the SDOH in Alberta.
- Advance the concept of entitlement to basic social and economic rights based on the SDOH.

## 2. Social Determinants of Health

### Key Concepts Defined

The following are definitions of the key concepts in this paper:

**Social Determinants of Health** – The SDOH are “the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole” (Raphael 2004:1). They are “the conditions in which people live and work. They are the “causes behind the causes of ill-health”” (World Health Organization 2005:1). Finally, SDOH “refers to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action” (Krieger 2001:693).

**Population Health** – Population Health is a social and political concept aimed at improving health, prolonging life and enhancing quality of life among whole populations through health promotion, disease prevention and other forms of health intervention (Chronic Disease Prevention Alliance of Canada, 2002).

**Health Promotion** – According to the Ottawa Charter, health promotion is a process of enabling people to increase control over and to improve their health. It focuses on enhancing the capacities of individuals and communities to enable them to make healthy choices and to develop healthy and supportive environments (World Health Organization, 1998).

### 2.1 Canada behind in addressing the SDOH

A social determinants of health approach is not a completely new development as it has its roots in critical examinations of the causes of illness and disease that date from the mid-nineteenth century. Over the past 35 years, British researchers have studied the sources of health inequities among populations, which has contributed much to our understanding of the importance of social determinants of health. More recently, Canadian researchers played a leading role in developing the concepts of health promotion and population health, which helped to draw attention to the social determinants of health (Raphael, 2004).

Unfortunately, according to the Canadian Population Health Institute, Canada has fallen behind countries such as the United Kingdom and Sweden, and even some jurisdictions in the United States, in applying the population health knowledge base that has been largely developed in Canada (CPHI, 2003). Raphael (2004) notes his surprise at Canada's shortcomings in addressing the social determinants of health given the tremendous increase in our knowledge about how economic and social conditions determine health. He argues that for the most part, policy-makers, the media and the general public are badly informed about these issues.<sup>2</sup>

## **2.2 Why the SDOH Matter**

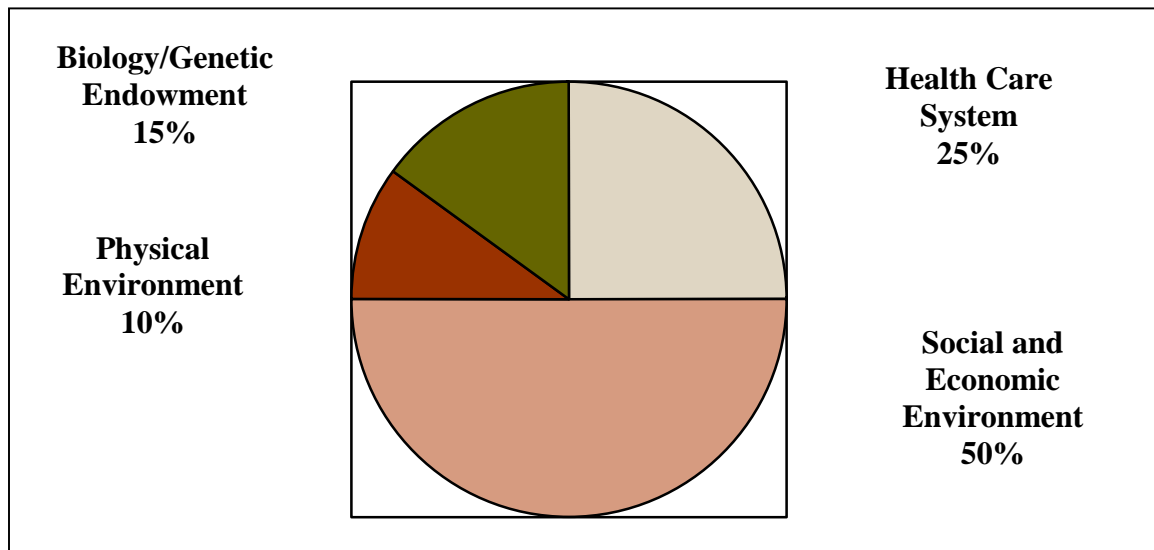
A wealth of evidence from Canada and other countries supports the concept that the socioeconomic circumstances of individuals and groups are equally or more important to health status than are medical care and personal health behaviours, such as smoking (Evans et al., 1994; Frank, 1995; Federal/Provincial/Territorial Advisory Committee on Population Health, 1999). The weight of evidence suggests that the SDOH 1) have a direct impact on the health of individuals and populations, 2) are the best predictors of individual and population health, 3) structure lifestyle choices, and 4) interact with each other to produce health (Raphael, 2003). In particular, disparities – the size of the gap or inequality in social and economic status between groups within a give population – greatly affect the health status of the whole. The larger the gap is, the lower the health status of the overall population (Wilkinson, 1996; Wilkinson and Marmot, 1998).

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<sup>2</sup> Results of a 2005 survey conducted by the Canadian Institute for Health Information showed that Canadians generally believed that making lifestyle changes could improve health to a much greater extent than could the social determinants of health. Media analysis in the survey showed that very few newspaper stories dealt with such determinants as housing, employment, and income distribution (Canadian Institute for Health Information, 2005).

As noted previously and shown in Chart 1, experts estimate that the social and economic environments contribute to 50% of a population’s health status, while the “illness care” system contributes only 25% (Canadian Institute for Advanced Research, Health Canada, 2002). Yet in the period 1997-00, regional health authorities in Alberta consistently spent only about 3% of their budgets on promotion, prevention and protection initiatives (Report of the Premier’s Council of Health Care, 2002).

**Chart 1– Estimated Impact of Determinants of Health on Health Status of the Population**



Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002.

Despite dramatic improvements in health in Canada, significant health inequalities among Canadians persist (Wilkins et. al., 2002). The existence of Medicare weakens the argument that these inequalities are due to a lack of access for some people to quality health care. The affects of differences in health behaviors (e.g., tobacco use, diet, and physical activity) do not explain the inequalities either. Studies from as early as the mid 1970s – and reinforced by many more studies since then – show that their impact on health is minor compared to the social determinants of health (Raphael, 2002).

### **2.3 Scientific Evidence Supporting the SDOH**

Even in the richest countries, people who are better off live several years longer and have fewer illnesses than the poor. The lifestyles and the conditions in which people live and work strongly influence their health and longevity. In essence, poorer conditions lead to poorer health. Medical care can prolong survival after some serious diseases, but the social and economic conditions that affect whether people become ill are more important for health gains in the population as a whole (WHO, 2005).

Income is a prime determinant of Canadians' premature years of life lost and premature mortality from a range of diseases (Raphael, 2004). Numerous studies show that income levels throughout life – during early childhood, adolescence, and adulthood are all independent predictors of who will develop and eventually die from disease (Smith, 2003). This suggests that the social determinants of health influence health at every stage of life, meaning they have an immediate influence as well as provide the basis for health or illness in subsequent stages (Raphael, 2004).

According to Shaw, Dorling and Smith (1999:216), “A body of evidence is now emerging which shows that health outcomes in adulthood reflect the accumulating influence of poor socio-economic circumstances throughout life. Adverse socio-economic conditions in early life can produce lasting increases in the risk of cardiovascular disease, respiratory illness, and some cancers later in life.”

In 2002, Statistics Canada examined the predictors of life expectancy, and the presence of fair or poor health among residents in 136 regions across Canada. The findings were consistent with most other research: behavioural risk factors (i.e., smoking, eating patterns, etc.) are weak predictors of health status compared to socio-economic

factors and demographic measures (Shields and Tremblay, 2002). The influence of the SDOH is especially strong in the case of chronic diseases such as heart disease and stroke,<sup>3</sup> diabetes, cancers, as well as injuries and infectious diseases (Raphael, 2004). The most recent data shows that in 1996, Canadians living within the poorest 20% of urban neighbourhoods were more likely to die from cardiovascular disease, cancer, diabetes, and respiratory diseases than other Canadians (Wilkins et al., 2002).

Raphael (2004) contends that both the rate and mortality from heart disease and stroke and adult-onset of diabetes are especially good examples of the importance of the social determinants of health. He argues that the emphasis on traditional adult risk factors (e.g., cholesterol, diet, physical activity, and tobacco use) is misguided given that these factors are poor predictors of heart disease, stroke and adult-onset diabetes rates among populations. Instead, the factors that do make a difference are living in poverty as children and adults, the stress associated with living in those conditions, and the adoption of health threatening behaviours as a way of coping with living in these circumstances. In fact, difficult living circumstances during childhood are especially good predictors of these diseases (Raphael, 2004).

There are several theories, but no definitive explanation, for the mechanisms and pathways by which the SDOH influence health and cause disease. It is clear that each SDOH factor is important on its own, but at the same time, the factors are inter-related and they interact in complex ways that are difficult to isolate. What is understood is that it is the combined influences of these factors that determine the health status of populations (Health Canada, 2002).

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<sup>3</sup> In May 2005 the Heart and Stroke Foundation of Ontario announced a \$1 million award competition for innovative research submissions that help to identify and better understand the social determinants of hypertension.



## 2.4 Policy Implications – the Swedish Model

Alberta has much to learn from the approaches of other countries in improving health by addressing the social determinants of health. In the late 1990s, Sweden launched a new and innovative public health strategy based on a social determinants model. Perhaps most tellingly, the strategy does not define its objectives in terms of morbidity or mortality figures. Instead, the social, economic and environmental determinants of health are used to develop national health objectives. The overall aim of the strategy is to “create social conditions which ensure good health for the entire population” (National Institute of Public Health 2003:3).

Equity in health is a central and explicit aim of Sweden’s public health policy. The strategy’s overarching aim is to alter the historic pattern of social stratification that produces health inequities. At the same time, the strategy focuses on intermediate level steps to address factors that particularly undermine the health of disadvantaged groups (ibid and World Health Organization, 2005).

### **Objectives of Sweden’s Public Health Policy**

1. Participation and influence in society
2. Economic and social security
3. Secure and favourable conditions during childhood and adolescence
4. Healthier working life
5. Healthy and safe environments and products
6. Health and medical care that more actively promotes good health
7. Effective protection against communicable diseases
8. Safe sexuality and good reproductive health
9. Increased physical activity
10. Good eating habits and safe food
11. Reduce use of tobacco and alcohol, a society free from illicit drugs and a reduction in the harmful effects of excessive gambling

Source: National Institute of Public Health, 2003

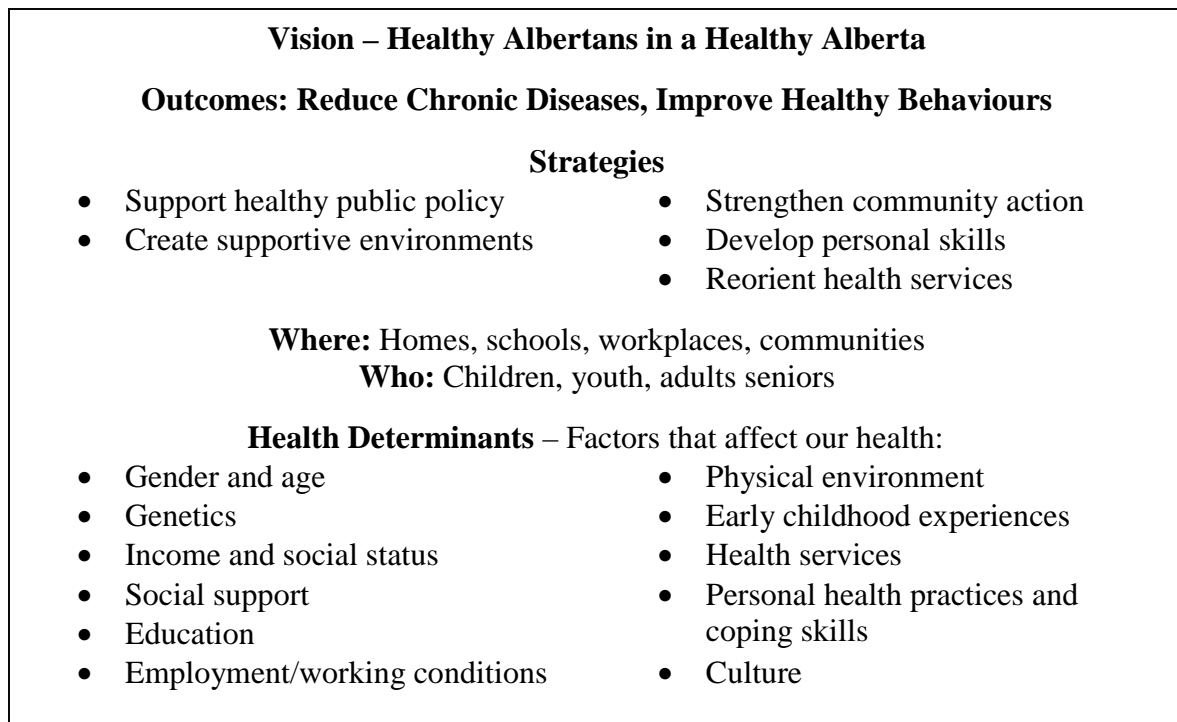
The first six objectives relate to structural factors while the last five are lifestyle choices which an individual can influence, but where the social environment plays a key role. Responsibility for meeting these objectives is shared among individuals, non-profit organizations, and local/regional/national governments, etc. “In essence, this approach seeks to strengthen conditions that improve health in society and that in turn improve the health of individuals, particularly among the most vulnerable groups” (ibid:25).

### 3. Alberta Social Determinants of Health Framework

#### 3.1 Healthy Alberta Framework to an SDOH Framework

The Framework for a Healthy Alberta (Alberta Health and Wellness, 2004) seen in Figure 1 incorporates the language of health promotion, population health and SDOH, but not the practice.

**Figure 1– Framework for a Healthy Alberta**



Source: Alberta Health and Wellness, 2004

The two outcomes in the framework – improve healthy behaviours and reduce chronic diseases<sup>4</sup> – reflect a bias towards improving health through changing behaviour and a reliance on the health care system. As has been shown earlier, the influence of these factors on the health of individuals and the whole population is minor compared to the social determinants of health. This bias is also reflected in the targets and government strategies in the framework. The focus is largely on public education programs, health care programs and services and incentives for individuals to make healthy choices. The framework offers little direction, for example, about the key role of the provincial government in adopting healthy public policies.

Even the praiseworthy commitment to primary health care reform in Alberta is couched in language about “giving Albertans the knowledge and skills to make healthy choices and stay as healthy as possible” (ibid:2). The point is not that there is no value in Albertans having the knowledge to make better and healthier lifestyle choices. Poor lifestyle choices clearly play an important role in the health of individuals and the population as a whole. However, individuals do not make these choices in a vacuum isolated from the broader socioeconomic environment, which the government can influence through the adoption of health public policies.

The framework’s emphasis on “healthier lifestyle choices” will not transform Albertans into “the healthiest population in the world”. In large part, achieving that goal requires moving from an emphasis on “healthier lifestyle choices” to the adoption of the healthy public policies (see page 16) that address the social determinants of health.

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<sup>4</sup> The Alberta Healthy Living Framework also focuses on chronic disease prevention and its areas of focus are healthy behaviours, i.e., healthy eating, active living and tobacco-free. However, it also advocates a population health and holistic approach that recognizes the key influence of the social determinants of health (Alberta Healthy Living Network, 2003).

### 3.2 SDOH as an Instrument of Health Reform

A number of background papers were prepared as part of the Report of the Premier’s Council on Health Care (Mazankowski Report) (2002), including a paper entitled *Is the balance right?* This balance referred to is the allocation of resources and the paper posed the question – do we spend too much time and health resources on acute care in hospitals to the detriment of funding actions that could make people healthier in the long run? As the paper notes, when people judge the performance of the health system, they typically look at the waiting times for surgeries, not at how healthy people are and what the system is doing to promote better health.

As was noted earlier, in the period 1997-00, regional health authorities in Alberta consistently spent only about 3% of their budgets on promotion, prevention and protection initiatives (ibid). Table 1 shows that from 1995 to 2000, health authorities allocated over 90% of their funding to facility-based acute care compared to less than 10% for promotion, prevention and protection services.

**Table 1 – Proportion of health authorities’ spending on facility-based acute care vs. spending on promotion, prevention and protection services**

	Actual 99-00	% of total	Actual 98-99	% of total	Actual 97-98	% of total	Actual 96-97	% of total	Actual 95-96	% of total
Facility based acute care	2130 m	91.9%	1959 m	91.7%	1774 m	91.3%	1594 m	91.5%	1528 m	92.4%
Promo., prev., prot. services	188 m	8.1%	178 m	8.3%	169 m	8.7%	148 m	8.5%	127 m	7.6%

Diagnostic and therapeutic services and other indirect expenditures (excluding research and education, amortization of facilities) have been allocated to acute care, continuing care, community and home based services, and promotion, prevention and protection services to derive at full cost.

Source: Report of the Premier’s Council on Health Care (Mazankowski Report) (2002)

The *Is the balance right?* paper suggests that the heavy emphasis on acute care may be short-sighted given that increasing acute care costs are driving up health care spending and raising concerns about whether Alberta can sustain the system. At the same time, little attention and funding is being allocated to services that could actually reduce illness and injury and reduce the longer term costs to the health system (ibid).

Shifting significant resources from acute care to health promotion/population health is an essential step in health care reform in Alberta. Going further and recognizing the SDOH as an important influence on health and allocating resources proportional to its influence would be ground-breaking health care reform in Canada.<sup>5</sup> This would require institutional change and administrative restructuring such as the merging of the ministries of health and social services (as Quebec has done) and formal processes for ministries to work together on “health” (i.e., health, education, human resources and employment, finance, community development, etc.). For example, at the service delivery level, the Income Support program (welfare) would be transformed into a comprehensive health program designed to improve the health status of Albertans with low incomes.

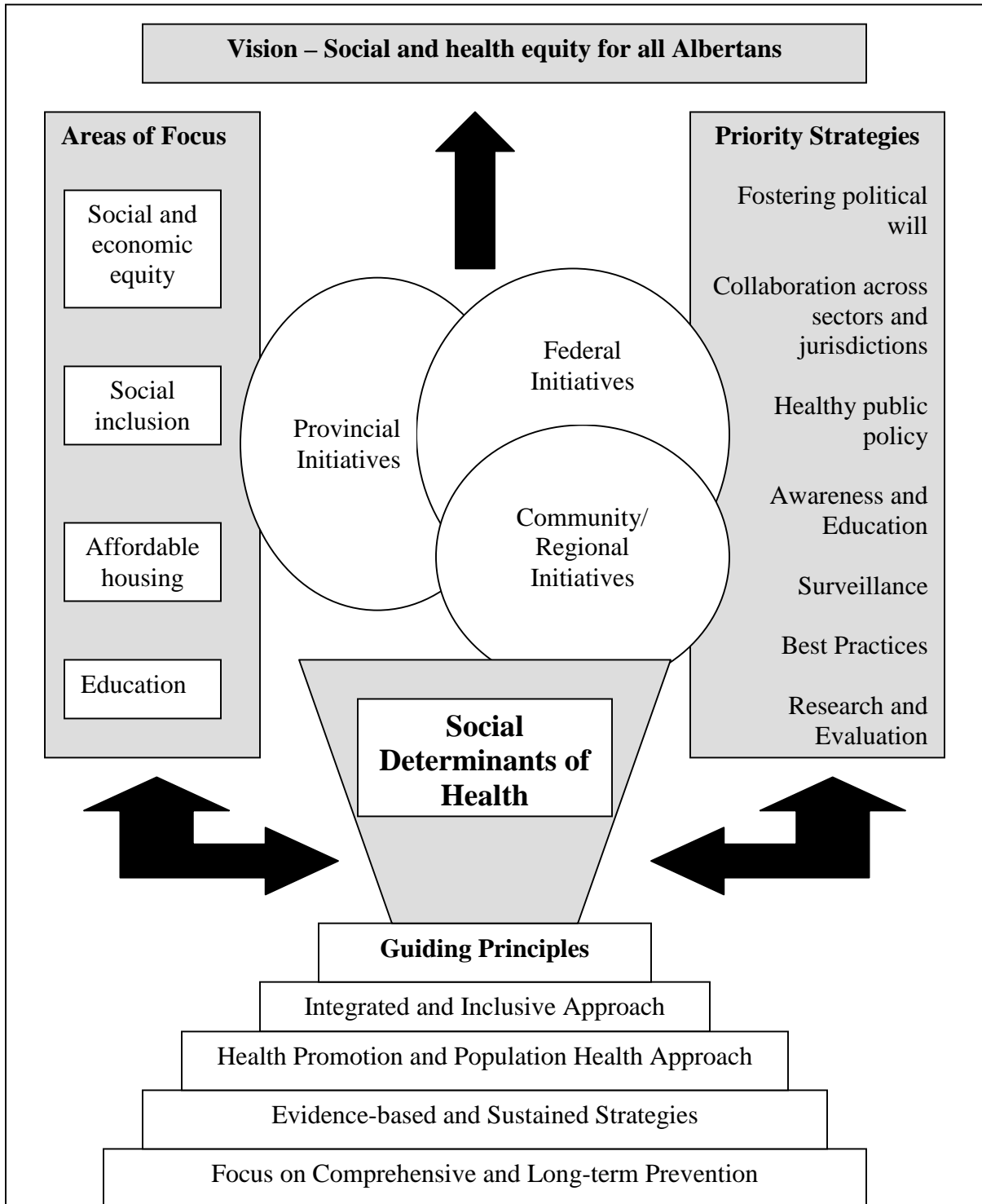
Over time, resources would gradually be shifted from the health care system (especially from acute care) into policies and programs that address the SDOH. This would not be a cost-saving measure, especially in the short run. In fact, there would be transitional costs associated with this shift. The envisioned improved health outcomes and reduced health costs may take a generation to realize. The transition phase from an “illness care” system into a health system that addresses the SDOH may be more costly, but over time, it would result in healthier and more prosperous Albertans.

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<sup>5</sup> More research needs to be done to better understand the required institutional change and administrative restructuring, as well as the most effective ways of shifting resources from acute care to a comprehensive and integrated health system that addresses the SDOH.

### 3.3 Alberta Social Determinants of Health Framework

Figure 2 – Alberta Social Determinants of Health Framework



The Alberta Social Determinants of Health Framework will help to direct the efforts of stakeholders in addressing the social determinants of health using an inclusive and collaborative approach. The primary areas of focus are four key areas of SDOH in Alberta – social and economic equity, social inclusion, affordable housing and education.<sup>6</sup> The priority strategies will help to guide efforts to make measurable progress in the areas of focus. Both the areas of focus and the priority strategies emerge from a fundamental commitment to improving the health of Albertans by addressing the social determinants of health. In turn, the efforts to address the social determinants of health are grounded in the four guiding principles of the framework.

### 3.4 Components of the Framework

**Vision** – “Social and health equity for all Albertans”

**Social Determinants of Health**<sup>7</sup> –

- Early life
- Education
- Employment/working conditions
- Food security
- Health services
- Housing
- Income/income distribution
- Social exclusion
- Social safety net
- Unemployment

(Raphael, 2004)

### Guiding Principles

- **Integrated and inclusive approach** – Multi-sectoral discussions, breaking down barriers between jurisdictions and ministries, supportive healthy public policy decisions, meaningful community participation, health care reform, close collaboration with non-government organizations, the private sector, etc.

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<sup>6</sup> These focus areas were selected based on the needs of Alberta. Inclusion and education are particularly important SDOH given the generally poor health status of the Aboriginal population in Alberta.

<sup>7</sup> The factors in various SDOH lists are quite consistent, particularly regarding the socioeconomic factors. However, Health Canada (2004) also includes such factors as culture, gender, personal health practices and coping skills, and biology and genetic endowment, which are not typically included. (See page 1) The World Health Organization (1998) determinants are: social [class health] gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transportation.

- **Health Promotion and Population Health approach** – Target the population as a whole, but focus attention on particularly vulnerable groups; integrate health promotion goals of building the capacities of individuals and communities to enable them to 1) increase control over and to improve their health, 2) make healthy choices and 3) develop healthy and supportive environments.
- **Evidence-based and sustained strategies** – Utilize the compelling SDOH evidence in adopting approaches and interventions; commit to sustaining the strategies over an extended period in order for them to be effective.
- **Comprehensive and long-term prevention** – Fundamental shift from an “illness care system” to a prevention system that reduces the occurrence of the SDOH risk factors, which would improve the health of individuals and all Albertans.

### 3.5 Priority Strategies

**Table 2– Summary of Alberta SDOH Framework Priority Strategies**

<b>1. Foster political will – Nurture a greater understanding of the key influence of the SDOH among decision makers leading to the adoption of the SDOH Framework</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Increase decision makers understanding of the key influence of the SDOH</li> <li>• Alberta Premier and Health Minister publicly recognize the key influence of the SDOH</li> <li>• Adoption of the SDOH Framework</li> <li>• Cross-ministry dialogue to develop collaborative strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Interactive presentations with media and decision makers, provincial party caucuses, municipal councils, etc.</li> <li>• Alberta Health and Wellness conducts an objective review of research on the SDOH and their applicability to Alberta</li> </ul>
<b>2. Awareness and Education – Increase awareness among Albertans of the important influence of the SDOH on health</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Province-wide dialogue about SDOH</li> <li>• Albertans and decision makers better understand the important influence of the SDOH on health</li> <li>• Decision makers lead the debate about increasing health budgets to cover transitional costs associated with SDOH and shifting current resources to SDOH</li> </ul>	<ul style="list-style-type: none"> <li>• Launch a social marketing campaign about the SDOH to coincide with adoption of the framework</li> <li>• Schools have cultural competence in addressing the SDOH in classrooms at all education levels</li> <li>• Decision makers develop funding options to cover SDOH costs</li> </ul>



<b>3. Collaboration across sectors and jurisdictions – Develop and strengthen genuine partnerships across sectors and government jurisdictions</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Strong, genuine partnerships and collaborations across sectors, ministries and jurisdictions; links with stakeholders inside/outside of health sector (i.e., education, social services, housing, community development, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Develop an inclusive/collaborative plan and process to address SDOH; external facilitator of the collaborative processes and plan development</li> <li>• Public commitment to process by ministries, governments, other parties</li> </ul>
<b>4. Healthy public policy<sup>8</sup> – Adopt healthy public policies that address health and equity in all areas of policy</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Recognition of the value of the public good and the role of governments in supporting the concept</li> <li>• Adoption of healthy public policies known to positively influence health and equity</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate public consultations on the role of government in a debt-free Alberta, especially the role of promoting the public good</li> <li>• Critically examine the healthy public policies adopted elsewhere (e.g., Sweden, Finland, Quebec etc.) and adapt for Alberta</li> </ul>
<b>5. Surveillance – Develop effective surveillance systems to generate and distribute information to support addressing the SDOH</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Identify and document current data available, data gaps and requirements related to addressing the SDOH in Alberta</li> <li>• Alberta surveillance system created to provide ongoing, timely and reliable information; used to facilitate the planning, implementation, evaluation of SDOH policies and programs</li> </ul>	<ul style="list-style-type: none"> <li>• Work with researchers and health professionals on identifying specific data requirements related to addressing the SDOH in Alberta</li> <li>• Collaborate with researchers and health professionals on developing a comprehensive surveillance system; fund and maintain the system</li> </ul>

<sup>8</sup> Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The goal is to create, maintain and protect the health of populations by addressing all the elements that are known to influence health (Alberta Healthy Living Framework, 2003).

<b>6. Best Practices – Establish a province-wide system that facilitates the sharing of evidence-based practices for policies and programs that address the SDOH</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Identify, and distribute information on, the best and most promising strategies, policies or practices related to addressing the SDOH in Alberta</li> <li>• Adopt the best and most promising strategies, policies or practices related to addressing the SDOH in Alberta</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate the development and distribution of information on the best and most promising practices related to addressing the SDOH in Alberta; when they are not available, convene a multi-disciplinary panel to identify the potentially most effective strategies, policies or practices</li> </ul>
<b>7. Research and Evaluation – Fund and collaborate on innovative research and evaluation initiatives that examine SDOH in Alberta; analyse and document Alberta’s progress in improving health by addressing the SDOH</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Practitioners, researchers and evaluators evaluate the SDOH in Alberta so that practice is based on current research and is evidence based</li> <li>• Research on the SDOH in Alberta meets the needs of the community</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate regular and productive interaction among professionals working on research and evaluation of the SDOH in Alberta</li> <li>• Feed the results back to Albertans</li> <li>• Facilitate access to/development of evaluation tools and expertise</li> <li>• Require provincially funded research on the SDOH to take a community-based approach</li> </ul>
<b>8. Transition Plan – Establish a transition plan to drive the process of change, oversee implementation of recommendations, and monitor the impact</b>	
<b>Intended Results</b>	<b>Actions</b>
<ul style="list-style-type: none"> <li>• Transition team composed of diverse stakeholders oversees and manages implementation of the SDOH Framework</li> <li>• Health professionals actively participate in the transition process</li> </ul>	<ul style="list-style-type: none"> <li>• Action plans and strategies developed for elements of Framework</li> <li>• Further study to develop an Alberta approach to implementation</li> <li>• Identify legal/practical barriers to implementation and develop solutions</li> </ul>

## **4. Recommendations**

1. Nurture a greater understanding of the key influence of the SDOH among decision makers leading to the adoption of the SDOH Framework.
2. Implement social marketing strategies to increase awareness among Albertans of the important influence of the SDOH on health.
3. Adopt legislation entitling Albertans to basic social and economic rights based on the SDOH.
4. Establish a multi-stakeholder team to develop a transition plan that will drive the process of change, oversee the implementation of recommendations, and monitor the impact of adopting the Alberta SDOH Framework.
5. Develop programs and adopt healthy public policies based on the SDOH to reduce socioeconomic and health inequities for individuals and all Albertans.
6. Target resources to address inequities in education (i.e., early childhood education, school readiness, cultural competence in schools, etc.) as a key SDOH for the next generation of Albertans.
7. Implement a timetable for gradually reallocating resources from the health care system (especially from acute care) to holistic policies and programs that address the SDOH.
8. Develop and strengthen genuine partnerships across sectors, ministries, the community and government jurisdictions to coordinate the adoption of policies and programs that address the SDOH.
9. Develop effective surveillance systems to generate and distribute information to support efforts to address the SDOH.
10. Establish a province-wide system that facilitates the sharing of evidence-based practices for policies and programs that address the SDOH.
11. Commit to developing research competence in the field by funding and collaborating on innovative research initiatives to enhance our understanding of the SDOH dynamics in Alberta.
12. Involve external stakeholders in conducting a comprehensive evaluation every four years of the progress being made in improving the health of Albertans through addressing the SDOH.

## **5. Implementation Plan**

The effective implementation of the Alberta SDOH Framework requires inclusive and collaborative approaches. This involves working across sectors and jurisdictions, both within government and between governments. These multi-sectoral collaborations will necessitate breaking down the barriers between jurisdictions and ministries, creating opportunities for meaningful community participation, enacting health care reform, and forming partnerships with non-government organizations, the private sector and others. In essence, it requires both a structural and philosophical shift that involves moving health policies and programs from the health silo and into an integrated, multi-sector framework.

### **5.1 Implementation Strategies**

The Alberta government will be responsible for facilitating integrated actions with diverse stakeholders to implement the SDOH Framework. Priority strategies will be clearly identified and articulated and expectations agreed to, in order to enable success for the individuals and organizations helping to implement the framework.

The following are proposed implementation strategies for the Framework:

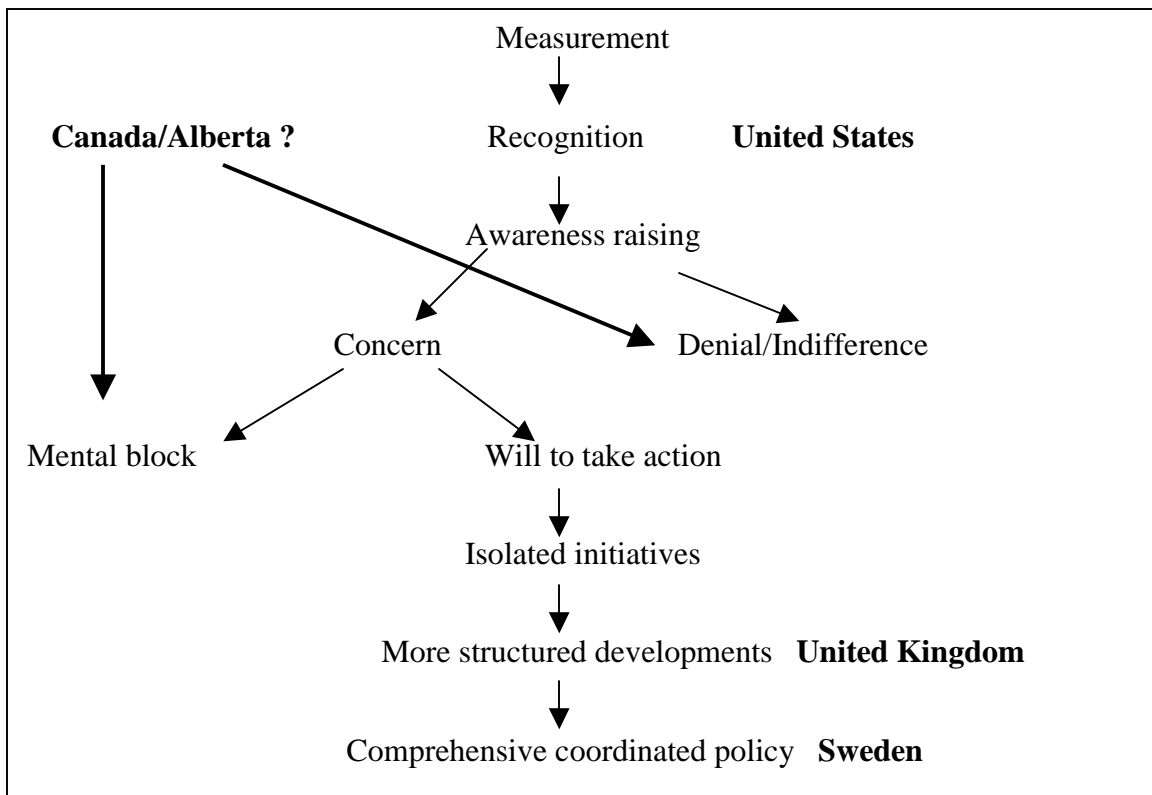
- The Alberta government will adopt the Alberta SDOH Framework.
- The Alberta government will facilitate the creation of a multi-stakeholder transition team, which will oversee the implementation of the SDOH Framework.
- The Alberta government will develop processes for cross-ministry collaboration and funding to address the priority strategies in the SDOH Framework.
- The Alberta government will develop action plans and facilitate efforts to achieve the priority strategies in the SDOH Framework.
- Individual and groups of stakeholders will develop their own action plans to align with the strategies and approaches outlined in the SDOH Framework.

- The Alberta government will develop an evaluation framework for the SDOH Framework in consultation with the multi-stakeholder transition team.

## 5.2 Implementation Barriers

Resistance to the adoption of the SDOH Framework and the resulting health care reforms will likely emerge from three sectors: 1) traditional health care providers; 2) the health care industry (i.e., medical suppliers); and 3) supporters of non-interventionist government. The former two sectors are influential forces in our society with a financial incentive to maintain the status quo. Those with a traditional view of government will bristle at what they perceive as a reframing of personal problems (such as poverty) as collective health concerns impacting the health of all Albertans.

**Figure 3 – Action on the Social Determinants of Health**



Source: Action spectrum on equalities in health (Whitehead 1998); Drawing on reality to influence public policy presentation at the Reality Check: Equity in a Debt-Free Alberta Conference (Raphael 2005); ESPC added specific Alberta emphasis.

As shown in Figure 3, Canada and Alberta recognize and raise awareness about the importance of the social determinants of health, but then denial/indifference and mental blocks undermine our will to take coordinated action. The Canadian public and media's lack of understanding about the key influence of the social determinants of health reinforces this inclination towards denial (Canadian Institute for Health Information, 2005). Alberta's political will and commitment to the Framework will be tested by the impulse to avoid the inherent conflict that typically accompanies major change.

Acting through a social determinants lens requires various ministries to coordinate policy making and implementation and have the patience to assess their effectiveness over long timelines (Raphael, 2003). But as Walt (1994) points out, the problems of policy coordination are exacerbated by intersectoral rivalry and territorial jealousy. As well, the emphasis on timely measurable outcomes can discourage the adoption of policies requiring long term outcomes.

Another barrier to taking action on the social determinants is what Arbour describes as "our very partial and hesitant embrace of economic, social and cultural rights in Canada" (LaFontaine-Balwin Lecture 2005:4). She challenges Canadians to consider whether our democratic process, legal system and our basic values explain the persistence of poverty and inequity in Canada. "Poverty and exclusion is too readily accepted by majorities as regrettably accidental, or natural or inevitable, rather than the outcome of conscious policy choices" (ibid:15). Arbour contends that Canada needs to evolve from a charitable model to a recognition of entitlement. "There will always be a place for charity, but charitable responses are not an effective, principled or sustainable substitute for enforceable human rights guarantees" (ibid:17).

## 6. Conclusion

This paper explores how the Alberta government can address the social determinants of health, which are the primary influencers on population health (Health Canada, 2004), through the adoption of this Alberta SDOH Framework. As noted earlier, the social and economic environments contribute a minimum of 50% of the population health status in Alberta, while the “illness care “ system contributes only 25% (Canadian Institute for Advanced Research, Health Canada, 2002). The Alberta government will be unable to meet its health targets if it continues to allocate billions of dollars to a health care system that is unable to deliver the necessary health outcomes.

The proposed adoption of the SDOH Framework presents both challenges and opportunities. Although the Framework is consistent with the literature cited and direction taken by other countries (i.e., the United Kingdom, Finland, Sweden, etc.), its adoption would be controversial. It would represent an important shift in emphasis from an illness based health care system (characterized by a focus on acute care) to a wellness-based system that focuses on preventing illness and chronic disease by addressing the social determinants of health. This shift would usher in significant health care reform in Alberta. However, opposition to the adoption of the Framework would be swift and unrelenting. Acknowledging the validity of this opposition while still remaining true to the course of reform will take strong political will. It requires both a commitment to change and sensitivity to the uncertainties that the change creates.

There are inherent political risks to this proposed strategy. Despite these risks, the adoption of the Alberta SDOH Framework is a justifiable and appropriate strategy to improve the health of individuals and all Albertans.

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