RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Speaking out for nursing. Speaking out for health.

Fairer Societies for Better Health Equity

A young woman who was interviewed for the Take Action Project to Address Women's Poverty and Violence against Women provides a perfect metaphor for understanding RNAO's commitment to action on the social determinants of health:

> She spoke of living in a low-income community bordering a very affluent neighbourhood. She described her community as a supportive one that facilitated strong connections between its members. She knew the neighbours in her community well. In her yard were trees, trees that never bore fruit. In front of her house was a fence that divided her community from the affluent neighbourhood. In her many years of living in the community she had never met anyone who lived beyond this fence, although the persons living there were as physically close as those living in her low-income neighbourhood. Each year the flowers blossomed on the trees on the other side of the fence and cherries grew. She told us that she often thought about the cherries growing on the other side of the fence as a metaphor for,
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> *"what's going on in our lives; they get to grow and prosper and be successful and live nice and we don't. And even though there is only a fence dividing us, there is such a disconnect."*
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> This disconnect is not simply a gulf in income, but reflects enormous social distancing between those who are socially regarded as worthy, and those who are not; those who we embrace as "us" and those who we dismiss as "them" (the other); between those who have access to the resources necessary to shape their lives and those who do not. Her metaphor of the cherry tree captures so vividly the challenges facing Ontario (or Canada, or the world for that matter); how do we tear down the fences that distance us from each other and how do we ensure that cherries grow in everyone's yard?[1]

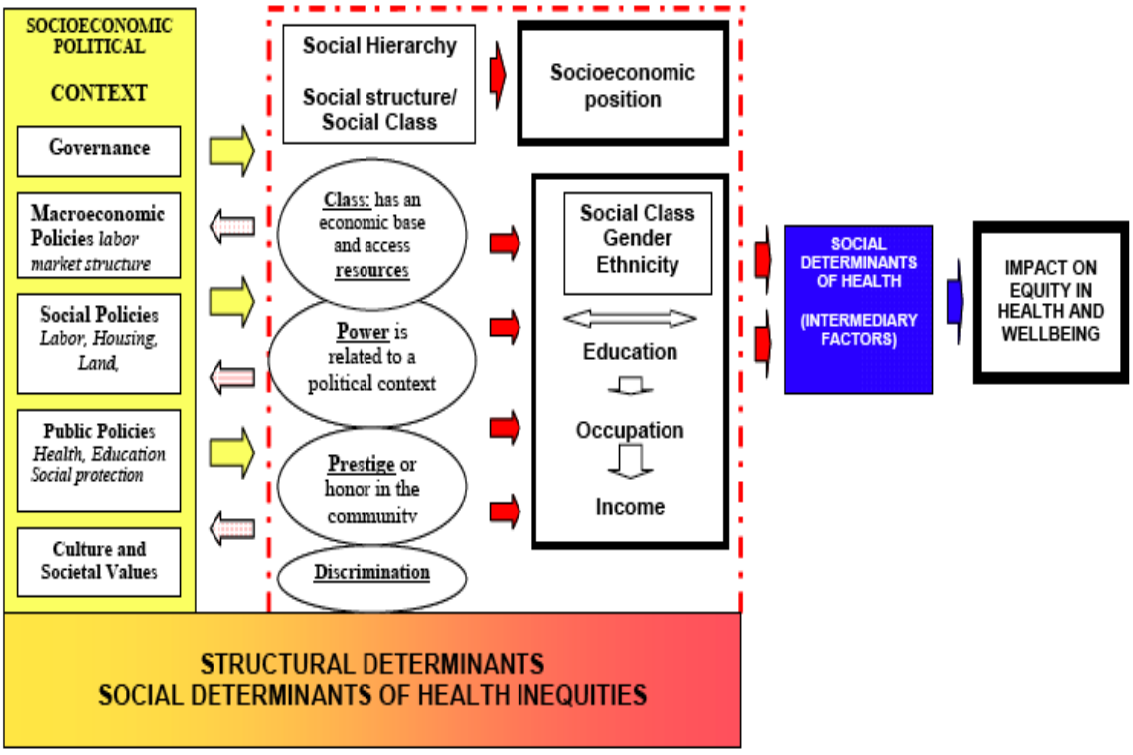
The evidence is incontrovertible: poverty makes people sick, gives a cumulative disadvantage across the life course, and causes premature death.[2] [3] [4] What is perhaps less discussed is that even when people are not materially deprived and have access to health services, there is still a stark health gradient that follows the social gradient.

In the first ground-breaking Whitehall study[5] of more than 10,000 male British civil servants over two decades, epidemiologist Michael Marmot and his colleagues found that the relative risk of age-adjusted mortality was four times higher when comparing top administrators with those at the lowest occupational grade doing manual labour. Those in the middle ranks had a 2.3 and 3.2 mortality risk difference that corresponded with their occupational grade compared with those at the highest rank.[6] Even when behavioural and biological factors such as smoking, blood pressure, and cholesterol were taken into consideration, there remained a powerful "something" that influences health related to hierarchy. Canadian economist Robert Evans describes this as "some underlying general causal process, correlated with hierarchy, which *expresses* itself through different diseases. But the particular diseases that carry people off may then simply be alternative pathways or mechanisms rather than 'causes' of illness and death, the essential factor is something else."[7] Marmot calls this "the status syndrome" as he directly links control that people are able to exert over their life circumstances, including work, social engagement and participation in society with health outcomes and longevity.[8]

These findings are congruent with the evidence that health inequities researchers, Richard Wilkinson and Kate Pickett, have brought together showing that more equal societies enable healthier individuals and stronger communities along a number of dimensions. In more unequal countries: more people suffer from mental illness; the use of illegal drugs is more common; infant mortality is higher; life expectancy is lower; more children are overweight; more adults are obese; math and literacy scores are lower; teenage birth rates are higher; homicide rates are higher; children experience more bullying; and more people are imprisoned. In more equal countries: levels of trust are higher; social mobility is higher; levels of innovation are higher; and they recycle a higher proportion of their waste.[9]

Health inequities are "health differences that are socially produced; systemic in their distribution across the population; and unfair."[10] The World Health Organization's Commission on the Social Determinants of Health invites us to move further upstream in our analysis of health inequities to the "'causes of the causes'— the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age—the social determinants of health."[11]

As the figure below suggests, the structural determinants of health generate or reinforce stratification and that defines socioeconomic position within a specific historical and political context:[12]

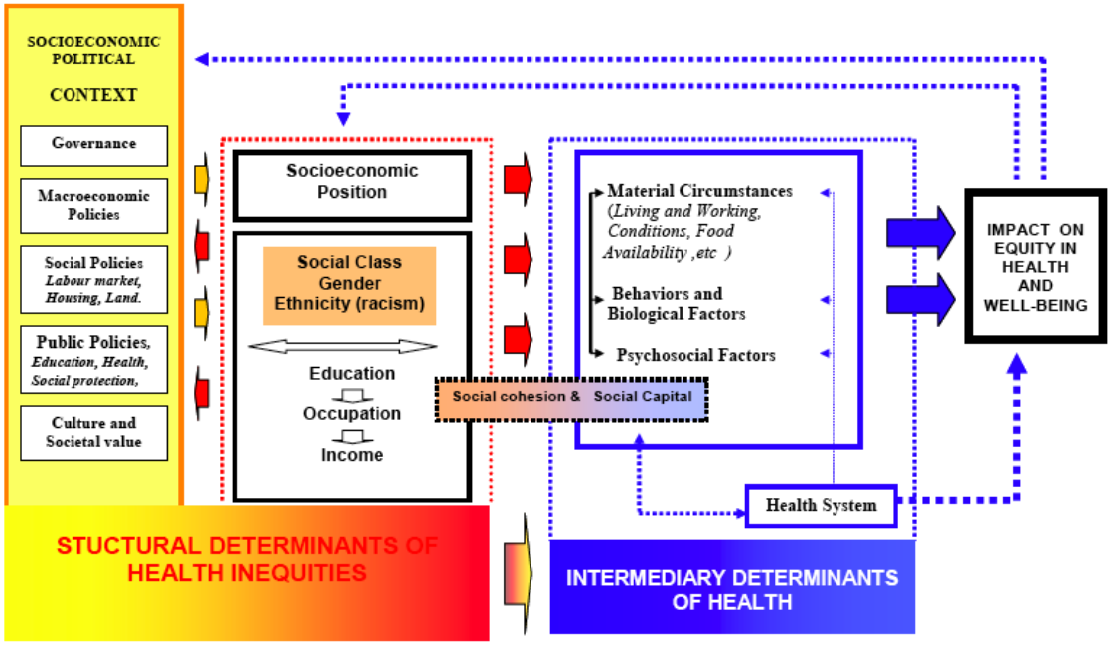


It is because of RNAO's commitment to health equity that it has been and continues to be imperative for the association to speak out on:

Selected Illustrations of RNAO's Action on Structural Determinants: Social Determinants of Health Inequities:

Governance	Strengthening democracy through vigorous engagement in political process through political platforms, submissions, civil society coalitions, education through public meetings, Action Alerts, demonstrations, aligning with voiceless and people with lived experience so they may be heard Submissions and action on accountability, transparency, erosion of data collection to make evidence-informed decisions Support rights of First Nations, Métis, and Inuit for self-determination
Macroeconomic Policies	Education and Action on Health Implications of Free Trade Agreements such as NAFTA, AIT, TILMA, OQCTA, CEUTA Municipal, Provincial and Federal Budget Submissions Spotlighting Redistributive Agenda of Market Forces that Would Privatize Health Services and Other Public Goods for Private Profit Advocacy for Progressive Tax System
Social Policies	Working with community partners on Ontario's Poverty Reduction Strategy, ongoing campaigns for food security, affordable housing, social assistance reform, increasing minimum wage and safeguarding vulnerable workers
Public Policies	Ongoing action to strengthen and protect health care system through nursing specific as well as broader system expertise, early learning and childcare, environmental protection, green energy, education, harm reduction including support for supervised injection services
Cultural and Societal Values	Explicit articulation of access to health and health care as human rights in platforms, submissions, Action Alerts Position Statements on Racism; Peace, Security, & Well-Being; Respecting Sexual Orientation & Gender Identity; Recruitment of Internationally Educated Nurses Supporting Nishnawbe Aski Nation (NAN) and other Aboriginal communities and political organizations in their advocacy goals Working against discrimination of people living in poverty and/or with mental health challenges with MHNIG and those with lived experience Highlighting root causes of violence linked to homophobia, biphobia, transphobia, racism, sexism, ablesim, colonialism, and ageism as well as supporting human rights legislation such as amending the Canadian and Ontario Human Rights Codes to include gender identity and gender expression, supporting safer schools by enabling Gay-Straight Alliances, and protecting access to health care for refugees

The complete version of the Commission on the Social Determinants of Health's Conceptual Framework shown below includes the intermediate determinants such as material circumstances, biological, behavioural health, and psychosocial factors as well as the health system that can mitigate or exacerbate the health impacts of the intermediate and structural factors.[13]



If we are to nurture hope where those metaphorical cherries grow in everyone's yard, we need to heed the call of the Commission on the Social Determinants of Health:

> Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health…. The time for action is now: not just because better health makes economic sense, but because it is right and just.

References

[1]Metropolitan Action Committee on Violence Against Women and Children and Woman Abuse Council of Toronto (2008). *"No Cherries Grow On Our Trees:" A Social Policy Research Paper for the Take Action Project, A Public Policy Initiative to Address Women's Poverty and Violence Against Women.* Toronto: Author, 5. http://metrac.org/resources/downloads/take.action.report.dec08.pdf
[2] Raphael, D. (2011). *Poverty in Canada: Implications for Health and Quality of Life.* Toronto: Canadian Scholars' Press, Inc.
[3] Seabrook, J. & Avison, W. (2012). Socioeconomic Status and Cumulative Disadvantage Processes across the Life Course: Implications for Health Outcomes. *Canadian Review of Sociology*. 49(1), 50-68.
[4] McIntosh, C., Fines, P., Wilkins, R., & Wolfson, M. (2009). Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001. *Health Reports*. 20 (4). http://www.statcan.gc.ca/pub/82-003-x/2009004/article/11019-eng.pdf
[5] More information about the first Whitehall study, set up in 1967, and subsequent studies, that included women, may be found at http://www.ucl.ac.uk/whitehallII/history
[6] Marmot, M., Rose, G., Shipley, M., & Hamilton, P. (1978). Employment Grade and Coronary Heart Disease in British Civil Servants. *Journal of Epidemiology and Community Health*, 32, 248.
[7] Evans, R. (1994). Introduction. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Aldine de Gruyter, 7.
[8] Marmot, M. (2004). *The Status Syndrome: How Social Standing Affects our Health and Longevity.* New York: Times Books.
[9] Wilkinson, R., & Pickett, K. (2010). *The Spirit Level: Why Equality is Better for Everyone*. London: Penguin Books.
[10] Commission on Social Determinants of Health (2007). *A Conceptual Framework for Action on the Social Determinants of Health*. Geneva: Author, 7. http://www.who.int/social_determinants/publications/commission/en/index.html
[11] Commission on the Social Determinants of Health (2007). *Interim Statement Achieving Health Equity: From Root Causes to Fair Outcomes.* Geneva: Author, iv.
[12] Ibid, 32-33.
[13] Ibid, 33-42.