

Ryan Meili

A
Healthy
Society

How a Focus on Health
Can Revive
Canadian Democracy

UPDATED AND EXPANDED EDITION



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The author will donate
a portion of the proceeds from this book's sales
to Upstream and SWITCH.



Upstream is a movement to create a
healthy society through evidence-based, people centred ideas.
It seeks to reframe the public discourse around addressing
the social determinants of health.



SWITCH, the Student Wellness Initiative
Toward Community Health clinic, augments the training
of future professionals while improving the health, education,
and skills of people from Saskatoon's core communities.

Praise for *A Healthy Society, Updated and Expanded Edition*

“What do you get when an empathetic physician combines stories, concern for his community, and analysis? This special book. Ryan Meili goes from patient to society, and from social and political forces to the patient. If this book’s insights were put into practice, we would get a healthy society indeed.”

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“Meili speaks from experience, from the heart, and with passion for achieving social justice. His political insight in how to achieve prosperity for all citizens and society is creative and revolutionary.”

– LOUISE SIMARD, former Saskatchewan minister of health and minister responsible for the status of women

“Understanding health means understanding society. Ryan Meili is a physician who understands both. This book is passionate, very readable, and gives the whole system a major push toward a better future.”

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– YANN MARTEL, author of *The Life of Pi*, winner of the Man Booker Prize

“Dr. Meili’s focus on health and its social determinants to drive social and political change is powerful. This book is written with clarity, centred on stories, and informed by years of experience as a family doctor and public policy reformer. Canadians would do well to heed its call to action to deepen our democracy through a focus on health.”

– DANYAAL RAZA, chair of Canadian Doctors for Medicare

“It is a huge privilege to be allowed into people’s individual stories as a family doctor, to come face to face with their most private fears and challenges. To do so while seeing the bigger picture, learning what can be generalized from each story, is the finest way to honour one’s patients. The first edition of *A Healthy Society* brought upstream thinking to the mainstream, showing Canadians how a health lens could help us tackle our greatest challenges. The combination of story, evidence, and vision for the future in this latest edition is what we need to chart a path to a healthier Canada.”

– DANIELLE MARTIN, author of *Better Now: Six Big Ideas to Improve Health Care for All Canadians*

“A vivid portrait of the adverse effects of current public policy directions upon the health of Canadians ... this volume is more timely than ever.”

– DENNIS RAPHAEL, professor of health policy and management at York University and editor of *Social Determinants of Health: Canadian Perspectives*

“Collected in this book are stories most Canadians don’t get to hear – stories that show that Canada can, and must, be a more compassionate country. *A Healthy Society* should be required reading for those tasked with crafting policy in this country, those pushing for a more caring Canada, and those interested in evidence-based decision-making.”

– MAX FINEDAY, executive director of Canadian Roots Exchange

Praise for the First Edition

“We know it in our hearts: poor health is intimately linked to poverty, abuse, and lack of social services. Yet in all these areas, Canada is marching steadily backward. In *A Healthy Society*, Ryan Meili, a practising doctor who knows this first hand, sounds a clarion call to all Canadians. We will not have a healthy society until we put social justice and universal social security for all back at the top of our political agenda.”

– MAUDE BARLOW, honorary chairperson, Council of Canadians

“Dr. Meili makes a powerful argument: better health is a central narrative of our lives, our society, and our democratic institutions; so what’s stopping us from walking the talk? A doctor’s analytic eye diagnoses the problem: too much focus on treatment, not enough on preventing what makes us sick; too much focus on spurring economic development, not enough on taking care of what we’ve got.”

– ARMINE YALNIZYAN, economist and media commentator

“A very personal and passionate account from a doctor on the front lines of health care, this book should be required reading for every decision-maker in Canada.”

– GREG MARCHILDON, Ontario Research Chair in Health Policy and System Design

“*A Healthy Society* is an eloquent cry from the heart and a rational appeal to the mind. With meticulous research, dramatic personal histories, and precise analysis, Dr. Meili shows why our wealthy society is far from a healthy one. He illustrates how social status affects physical well-being and suggests steps necessary to create a culture that’s democratic not only in the electoral sense but also in providing for the health of its members.”

– GABOR MATÉ, author of *In the Realm of Hungry Ghosts: Close Encounters with Addiction*

“Combining powerful analysis and compelling stories, Dr. Meili inspires us to engage in new politics to build a healthier, more equal society. May he continue to bring us together around bold ideas for change.”

– NIKLAŠTON, member of Parliament for Churchill–Keewatinookiwasi

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1

A HEALTHY SOCIETY

The development of a 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.

– Commission on Social Determinants of Health,
*Closing the Gap in a Generation*¹

Buying Smokes for My Patients

Maxine just turned twenty, but she walks like she's ninety-one. I suppose that's because she's closer to death than most ninety-one-year-olds. You'd walk slowly, too, if that's what lay ahead. She's been on the street since she was thirteen, hooked on IV cocaine and morphine for nearly as long, but she's had HIV for only two years, three at the most. For some reason, like many of the growing number of people in Saskatchewan who are infected with HIV, she is a "rapid progresser." This means that her infection didn't take years to progress to the immune suppression of AIDS. It happened very quickly. There are a few theories as to why this occurs: different genetic capacity to respond, unique strains of the virus, or simply poor underlying health. The truth is, we don't quite know why. What we do know is that she's in really bad shape – what

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many doctors would call, in back rooms and unprofessional asides, a train wreck.

When I first met Maxine, she came in with florid thrush, a rip-roaring pneumonia, and a prescription for prophylactic antibiotics that she never intended to fill. I instantly recalled the hospital in Mozambique, where caring for young men and women who arrived emaciated and scared, fast approaching the end of their lives, was a daily occurrence. Maxine's is the worst case of AIDS I've seen walking a Canadian street. I told her she was sick enough to go into hospital, but she had just been discharged for the umpteenth time. She wouldn't say much, just told me she wanted antibiotics and nutritional supplements. The last thing she wanted was to go back into the hospital.

Three months later, the word on the street is that Maxine wants help. She's getting weaker and sicker, and finally recognizes she's in trouble. She comes into the clinic and falls asleep on the exam table. She is deathly thin, and under my stethoscope her lungs sound like a rubber boot being pulled from the mud. I call the infectious disease service and internal medicine at Royal University Hospital. They know her well; she's done this before. She gets sick enough to need help, is admitted, gets a bit better, hates the hospital, misses the drugs, and bolts. Reluctantly, they agree to give her another try.

That was a Friday, and I was out of town for the weekend. When I arrived to see her on Monday morning, the internal medicine team was about to discharge her. Her CD4 count, a measure of the immune cells that defend against infection, is 4. It should be at least 400. The HIV viral load tells us how active the virus is in her system. More than 100,000 is considered too much; hers is 3 million. However, her pneumonia has improved, she's not ready for the anti-retroviral medications that must be taken every day to avoid increasing resistance, and she is no longer sick enough that she needs to be on the acute ward. She doesn't make it easy to help her, either. She swears at the nurses, refuses to take pills or have blood work. When the security guard assigned to keep her in line takes her for walks, she bums cigarettes, hides them in her gown, and smokes them on the ward. She takes as much time and attention as the rest of the patients on her ward combined, and the nurses and medical staff are exasperated.

Despite her misbehaviour, she tells me she wants to stay. I visit twice a day, sitting on the edge of her bed and talking with her about the future. She says she wants to get on methadone and off the streets. She wants to take the anti-retroviral medications to start her immune system working again. She is refusing to leave the hospital. The idea that, as health care providers, we might have security guards escort this young girl who is dying of AIDS to the street is against all we stand for.

So we don't. After a long discussion with the medical team, we agree to try a little longer. Give her a week and see how she does. Because, despite the frustrations of bed shortages, extra workload, and chances that are cachectically slim, we know these are the moments that define us as a profession. Even when the odds are long, we cannot walk away from someone who is so clearly suffering. So we'll try for another week. Get the methadone doc to see her, get psychiatry involved, and social work, and nutrition, and anyone else we can think of; make our boundaries clear and try once more.

We know the hospital is no place for Maxine. But the system has no better place. Most drug rehab programs won't take people on methadone; none of them will take someone who needs to start it. The waiting list to get into a program can be several months and requires people with numerous social and economic barriers to jump through multiple hoops that seem designed to keep them out. So in the gap between wanting to kick the drugs and having the personal and social capacity to do so, they're dumped back on the streets to start from scratch.

On the second or third night of this experiment in patience, I go up to see Maxine. The nurses are frustrated; she's still sneaking smokes into her room. She constantly demands that security take her for walks. She fights meds and blood work. But she's still there. She's taking her methadone. She tells me again she wants to stay; she wants to get better. The nurses think that maybe if she had her own cigarettes, they could help her set a schedule for when to have one and help her stay out of the trouble she finds when she leaves the hospital. Maybe if they print off more of the crossword puzzles she likes, she'll keep busy. In many ways she is older than her twenty years. In others, she's truly a child.

The next morning I go in to see her. I've got a couple of books of crossword puzzles and a pack of Player's Light. I never thought I'd buy

a pack of smokes for a patient, but in this case “first do no harm” takes a back seat to the immediate fight for her life. I go up to her room to deliver my gifts and talk with her. She’s gone. The night before, she got frustrated, left the hospital, scored some drugs, shot up, and showed up in emergency in bad shape. The line was crossed and she is no longer welcome in the hospital. She can come to see me at the clinic the next week – we’ll always see her – but the glimmer of hope is significantly dulled.

The last time I saw her, just before I stopped working at the clinic she trusts, she was repeatedly wearing out her welcome at the brief detox centre near the clinic. I told her I hoped she’d at least come in and take her medications and see the other doctors there. She said goodbye, and thank you, and gave me a heartbreakingly innocent hug.

The cigarettes stayed in my freezer for a long time. I thought maybe the next time I was invited to a sweat lodge ceremony, I’d bring them as my offering of tobacco and say a prayer for Maxine. It turned out I didn’t get the chance – at least not while she was still alive. A few weeks after I left the clinic to work in rural Saskatchewan, a car hit her, shattering her pelvis. While in hospital she contracted pneumonia again, and this time she couldn’t recover from it. She died just before her twenty-second birthday.

It’s easy to get fixated on the pathology of Maxine’s story, to think that it’s about viral invasion, fractured bones, and infected lungs. These physical details, however, are distractions from the real disease. They are symptoms of what Stu Skinner, a Saskatoon infectious disease physician who specializes in HIV, refers to as the “End Stage of Poverty.” Maxine’s life was hard from the beginning. She grew up in an environment of poverty, dysfunction, and abuse. Her mother had spent most of her own childhood in a residential school; she hadn’t seen what it was like to be a parent and wasn’t very good at it. Maxine never knew her father. Instead, she knew the attentions of various boyfriends and extended family members who abused her physically, sexually, and emotionally throughout her childhood. She had a baby before she reached Grade 9 and never returned to finish high school. In many ways she never got a chance to be a child, and at the same time never matured to be an adult.

Such a broken life, such an inherently tragic existence, provokes serious questions about our society: questions about the prevention and treatment of disease, about poverty and services for vulnerable people, about education, and about justice. What often escapes our attention when we consider the tragic story of one individual is how intimately it is connected to all of us, to the collective decision-making process that is electoral politics. It is politics that decide whether young women like Maxine live or die. Ultimately, our political choices are to blame for the large number of people who slip through the cracks.

There is strong evidence that our current political choices aren't working for everyone. In Canada and around the world, the health of the poorest people is far worse than that of the richest, and new evidence suggests that we all suffer as a result. If we are to address the fundamental unfairness of this situation, we need to rethink not just how we do health care, but how we make decisions as a society.

Economic growth and advances in health care have improved human longevity, health status, and quality of life all over the world. Yet there are many people, in both poor countries and rich ones, who do not experience the benefits of this progress. Canada is one of the wealthiest nations on the planet, but the gap between the rich and the poor is widening, and rates of child poverty and homelessness are rising. Despite Canada's self-image as a welcoming and equal place, Indigenous people, immigrants, and women continue to suffer more illness than the rest of the population. The cost of post-secondary education has become unaffordable for many. Epidemics of drug abuse, diabetes, obesity, HIV/AIDS, and other diseases closely related to poverty result in lost lives and wounded communities. Meanwhile, human actions are harming the wider environment that supports life; this, in turn, harms humans. These problems are fundamentally political, but those who object to the current state of affairs, who suggest that there must be a better way of organizing ourselves for the benefit of all, are dismissed as naïve and ignorant of economic realities.

None of this is news. Most people are well aware of the situation, and many are moved to action. Their overall response, however, is fragmented, confused, and ineffective. The question before us is how can we

move beyond this impasse? How can we organize ourselves to make wise decisions that will benefit everyone?

Politics and public discourse, the field that should be responding to such pressing societal concerns, flounders instead from crisis to crisis. Parties and public figures bounce around the political and social spectrum in reaction to events or public opinion. The key issues of the day are decided more by the news cycle than by any rational understanding of priorities. Ideas are presented by extreme opposite views in debate rather than in a search for common ground. Political reporting is dominated by scandal to the exclusion of substance, and as a result, we are unable to focus on real issues. The agenda of governments seems to be either hidden or absent. From day to day, the top stories change from an international conflict to a far-off natural disaster, from the rising or falling loonie to a record lottery jackpot, with no discernible pattern of progress or failure. In this fragmented experience of history and the present, we all have a hard time recognizing what is really happening, what a government has done, or what it ought to do.

The problem is not a failure to understand the extent of our difficulties; it is the lack of a focus, of an organizing principle for change. An undeclared objective will not be realized; we must state our goals clearly if we wish to reach them. In the absence of a societal project that advances the well-being of all, it is only natural that groups will use politics cynically for their own gains and that people will find it difficult to decipher the mixed and ever-changing signals. Without clear common goals, we have increasing polarity and discord. If we are to make anything of this mess, we must find something we agree on and work toward it. We need a clear objective that will inspire people from diverse circumstances to work together for a greater good.

Windows and Frames

The roots of our most significant health problems are not clinical: they are social, political. This means that the solutions must be political as well. Public opinion determines, as it should in a democracy, what solutions are available. But what determines public opinion?

At any given moment, there is a range of acceptable and desirable ideas, with others lying outside the realm of possibility. This is sometimes referred to as Overton's Window – the policy options that politicians can safely discuss without being considered too radical to be elected.² The window changes over time, with marriage between same-sex couples being a recent example of something that was unthinkable only a few decades ago but is now widely accepted.³

Like all windows, that of political possibility is delimited and determined by its frame. As George Lakoff, author of *Don't Think of an Elephant!*, famously notes, "all politics is moral."⁴ Much more than a cold, rational analysis of arguments and statistics, frames are the moral lenses we use to decide what policies and politicians to support. They refer to our deep understanding of issues and, though not solely about language, can be greatly influenced by the way in which an issue is described or discussed. Language choice determines which moral frame is activated and – depending on people's underlying values – which policy they are likely to support.

The terms of debate, and the window of possibilities, are defined by the active frame. Imagine you have a friend who is paranoid of the coming zombie apocalypse. He tells you of the many steps he's taken to protect his house from attacks. You don't believe in zombies, but in arguing with him, you highlight the weaknesses of his defences, explaining that the undead will merely come in through his garage or that he'll never get to the shotguns under the bed in time. By accepting his framing, you've lost the argument from the beginning.

Now, that's a bit of a silly example, but we are constantly dealing with frames that, despite being countered repeatedly with arguments and evidence, continue to rise from the grave. We see economic growth presented as the most important political objective, rather than a necessary means to the greater end of improving our lives. We see framing that all taxes are a burden and any tax cut a relief, rather than talking about taxation as an essential tool for funding social investment. Frames of austerity in a time of abundance, of the private sector as the sole source of efficiency and innovation, of the poor being to blame for their own circumstances, all of these limit our ability to think differently about

the problems before us and to seek the most creative means of addressing them.

The way to move the window is not to argue with the existing frames, it's to put forward a new one, to allow ourselves to focus on what really matters. What I propose is that we already have that new frame, that people have already chosen the focus. It is simply a matter of recognizing, understanding, articulating, and acting upon it. The focus is health: the health of individuals, the health of communities, the health of democratic institutions.

People care about health. It's part of our assumed common ground, a truly shared value that transcends class, colour, and political ideology. We greet people by asking how they are, asking about their well-being. The conversations that follow are replete with references to health. We speak of healthy relationships, healthy attitudes, healthy economies, and healthy appetites. We toast each other's health. If you ask expectant parents whether they're having a boy or a girl, the answer is inevitably, "We don't care, as long as they're healthy." When neighbours and friends are ill, we go out of our way to help them. If people fall on hard times, a common encouragement is, "At least you have your health." These familiar expressions reflect our unconscious preoccupation with our common vulnerabilities, hopes, and fears: we know, deeply, that good health – physical, mental, and social – is a necessary condition for the full enjoyment of life.

This focus on health is reflected in public life as well, particularly in the heated political debates around health care and health spending. Health care and health are very different things, but health care is the policy area most obviously linked to health, and the attention given to it is an identifiable surrogate for this deeper preoccupation. With rare exceptions, health care is the number-one issue of importance in Canadian polling, an unusual constant in the tumultuous sea of public opinion. Polls taken during federal elections since the mid-1990s have consistently ranked health care as the issue of greatest importance to voters, more so than employment, debt, taxation, and the environment.⁵ Accordingly, health care takes up the largest portion of provincial budgets. Many people have complained about this, asserting that an inordinate focus on health takes away from other important areas such

as education, justice, and infrastructure. In a way they're right – our focus on health care at the expense of other key aspects of public life is disproportionate. But the problem is not that we care too much about health: it's that we are doing so in an incomplete and reactive fashion.

The reality is that health is already 100 percent of the budget. If we understood that, we would make better choices. Decisions in and across all ministries – education, environment, finance, justice, and so on – all influence health outcomes. There are opportunities in every sector of government to improve health and prevent illness. Our approach tends to be palliative rather than preventative; we focus too much on what to do when our health fails, not on how to ensure that we thrive and stay healthy. If we truly want a healthy society, we need to build a political movement with health as its focus.

So Urban It's Rural

To explore the idea of health as a focus for public discourse, I'll start with an example, one that hits very close to home for me. I live in Saskatoon, a city of nearly a quarter million people on the Canadian prairie. My house is in a neighbourhood called Riversdale, a few blocks west of the South Saskatchewan River. Riversdale is one of five core neighbourhoods that make up this part of town, often referred to simply as the west side. Some people are surprised that a small urban centre such as Saskatoon should have an inner city, but it certainly does, with all its accompanying charms and difficulties. My neighbours keep an eye on the house when I'm away, and in summer they share fresh carrots and zucchini from their gardens. Strangers lean over the hedge to chat when I'm out raking leaves. People greet me with "Hi, Doc" when we pass on the street. I often say it's so urban it's rural.

Though the isolation of the core neighbourhoods amid the city's doughnut development (with peripheral suburbs and big box stores pulling social and economic activity away from the centre) has conferred upon them some small-town charms, their problems are decidedly urban. These neighbourhoods have the lowest per capita income in Saskatoon. They have a reputation for petty and violent crime, and are an active marketplace for illicit drugs and prostitution. They are also plagued by

a significant deficit in services, including frequent shortages of quality housing, access to good nutrition (there has been no real grocery store in the area for years), health services, and more. As a result, the health of their residents is the worst in the city.

The fate of Station 20 West is typical of the way in which these communities have been treated. In the spring of 2007, the Saskatchewan government dedicated \$8 million to this innovative project, a collaboration between community groups in the core neighbourhoods, with the goal of addressing service gaps and creating economic opportunities. Community-based organizations such as CHEP Good Food and Quint, a housing co-op based in the five neighbourhoods, joined with the Saskatoon Community Clinic, the University of Saskatchewan, and the Saskatoon Health Region to design this unique response. The name, Station 20 West, played off its location, literally just on the wrong side of the tracks crossing 20th Street, the core's main drag. Billed as the "Engine of Urban Renewal," it featured a wide variety of services and community development initiatives in one convenient location.

Station 20 West was to be situated next to fifty-six new affordable housing units and a branch of the public library. It was to include a dental outreach clinic, a community health clinic, a student-run after-hours clinic, offices for the aforementioned community-based organizations and others (including Heifer International and the Elizabeth Fry Society), a university outreach education centre, and a member-owned co-op grocery store called the Good Food Junction. These were all to be housed in a building that would set a standard for environmentally responsible development, with the highest level of LEED (Leadership in Energy and Environmental Design) certification.

At least, that was the plan. In the November 2007 provincial election, the governing New Democratic Party (NDP) was defeated by the Saskatchewan Party. In March 2008, the new government informed Station 20 West board members that the dedicated funds were being rescinded. Just months before starting construction, the project's future seemed extremely dim. The new government's ill-considered decision to withdraw its funding shocked the people of Saskatoon, triggering a firestorm of criticism and a groundswell of support for the project. In April 2008, in one of the largest demonstrations that Saskatchewan had

seen in decades, over 2,500 people from across the city took to the streets to proclaim their support for Station 20 West. Despite this show of support, funding was not reinstated, and the organizers had to start from scratch.

At the time, I was a family physician in the clinic that was slated to relocate to Station 20 West. While working on the west side as a student, a resident in family medicine, and later as a practising family doctor, I had become quite excited about the potential of this project and was deeply disappointed when its funding was cancelled.

Clinical work in underserved areas offers many joys: the sense of community, the easy humour and relaxed attitude of many patients, and for me a sense of purpose, as I am often able to connect with people in real need and offer them meaningful support. When I was first planning to study medicine, I had a naïve notion that what doctors did was make friends all day. Patients come in, you hear their stories, help as best you can, and make a connection. After a decade of practise, with time in northern Saskatchewan and all over the rural areas of the province, rural Mozambique, and inner-city Saskatoon, that's exactly how it feels. The questions we're asked aren't easy, and people aren't always pleased with the answers, but all-in-all that's exactly what the job is: making friends all day.

As such, it's extremely rewarding, but it's also very frustrating. I want the best for my patients, my friends, but every day I see patients whose problems are not merely physical. They're political. They stem from a lack of safe or appropriate housing, a lack of education, or simply from not having enough money to afford the basic necessities of life. People don't get sick when they come into the clinic or show up at the hospital; their problems can't be solved there, either. They get sick in their real lives: at home, at school, at work, and at play.

Healthy, Wealthy, and Why

The notion that health and illness are determined by life circumstances is not new, and in recent years it has become a staple of health theory and teaching. In one of the first lectures of medical school, students are asked to name the greatest factors that decide whether someone will be

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healthy or ill. They commonly mention lifestyle choices, such as the so-called holy trinity of diet, exercise, and smoking cessation.⁶ Some talk about access to health services, and others cite genetics or culture. After this discussion, the students are shown a list of health determinants such as this one from the Canadian Institute for Health Information. In order of impact, the twelve factors that make the biggest difference in people's health are

- ▶ income status
- ▶ education
- ▶ social support networks
- ▶ employment and working conditions
- ▶ early childhood development
- ▶ physical environment
- ▶ personal health practices and coping skills
- ▶ biological and genetic factors
- ▶ health services
- ▶ gender
- ▶ culture
- ▶ mass media technology (i.e., TV viewing and physical inactivity).⁷

Invariably, this list comes as something of a surprise to students. As aspiring doctors, they think they are getting into the business of making people healthy. Then they see that the services offered by the health professions barely crack the top ten.

The lesson to be drawn from the list of determinants, and the one that is stressed to students, is that the most important factors that determine health are social, and the most effective solutions are political. Health services have much less effect on ultimate health outcomes than social determinants such as income and education, housing and nutrition. Gender, culture, and biology, the more immutable of the determinants, also figure near the bottom. What the students learn is that, though they may indeed have the power to heal, they cannot act alone. The response to illness is not limited to one profession or sector: it must be societal.

The question, then, is where does it make the most sense to focus our political efforts? In other words, which determinants of health are most directly affected by public policy? There are many lists of social determinants of health in Canada, but the most commonly used cites them as income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety net, health services, Aboriginal status, gender, race, and disability.⁸ As you can see, these are all areas where public policy can change a person's situation or experience to either improve or worsen health. If optimal health is the desired destination, this list is the road map of where to invest to reach that goal.

When we address inadequate housing, when we stop gender discrimination and racism, when we ensure that people have work that is safe and fair, and that our children receive the care and attention they need to grow, we can dramatically improve health outcomes. So what's holding us back?

An Unhealthy Imbalance

The list of social determinants rings true to me and to others who work with the people of Saskatoon's west side. Most of our patients are First Nations or Métis. We also see many refugees and other newcomers. They face challenges in accessing child care and education. Unemployment, poverty, and dependence on an inadequate social safety net are endemic, particularly for women. Housing is expensive and often crowded or unsafe. Health care services are limited and difficult to access. Violence, racism, sexual exploitation, and substance abuse are only a few of the many symptoms of ongoing poverty and social exclusion. The list goes on, and the result is ill health.

The effects of the social determinants on health are readily apparent to those who live and work in underserved communities. They are also supported by studies such as "Health Disparity by Neighbourhood Income," a 2006 article in the *Canadian Journal of Public Health*.⁹ This study compared the health of the six lowest-income neighbourhoods in Saskatoon (according to Statistics Canada) with the same health indicators

in the rest of the city. The findings were startling. People in the core were four times more likely to have diabetes, four to seven times more likely to get a sexually transmitted illness, and fifteen times more likely to have hepatitis C. Those in the core also experienced significantly higher rates of injury, mental illness, and coronary artery disease.

When the six poorest neighbourhoods were compared with the city's six most affluent areas, the contrast was greater still. People who lived in the core were fifteen times more likely to contract a sexually transmitted infection, fifteen times more likely to attempt suicide, thirty-five times more likely to get hepatitis C, and thirteen times more likely to have type 2 diabetes than those who lived in the suburbs. Children in the core were half as likely to have received their vaccinations. With all these increased risks, a core neighbourhood resident was 2.5 times more likely to die in any given year. The infant mortality rate was three times higher in the lowest-income neighbourhoods than in the more affluent ones.

To get a sense of income ratios, the average family income in the six core neighbourhoods was approximately \$30,000 per year, in the rest of Saskatoon it was over \$60,000, and in the wealthiest areas it was just under \$100,000.¹⁰ Forty-four percent of families in the core live below the low-income cut-off line, compared with less than 4 percent among their high-income counterparts. People from the wealthier neighbourhoods are more than five times as likely to have progressed past Grade 9 or to have current employment. This landmark study revealed the huge disparities in health in Saskatoon and the obvious correlation to the social determinants.

Since that time, many other studies across Canada and around the world have demonstrated similar results. For example, if you live in the North End of Winnipeg, you're likely to die sixteen years earlier than other residents in the city.¹¹ In Hamilton, the Code Red project showed a difference in life expectancy of twenty-one years between the wealthiest and poorest neighbourhoods.¹²

A 2016 update of the Saskatoon study, led by Dr. Cory Neudorf, compared health outcomes to levels of income across Saskatchewan.¹³ One of the most striking findings was how much inequality had increased in

recent years. Between 2001 and 2011, income had gone up by seven dollars for the highest 20 percent of earners for every dollar it had risen for those in the lowest 20 percent. In that same period, housing and food prices jumped considerably, meaning that the basics of life were less affordable. As the income gap widened, so did the outcome gap. The lowest-earning group saw a steady increase in mortality rates, with 50 percent more deaths in 2009 as compared to 2001.

Saskatchewan has a reputation for seeking equality, particularly with regard to health. It was the first province to institute what would eventually become Medicare, a national health insurance program designed to ensure that all Canadians would receive care based on need rather than ability to pay. It is also a reasonably well-off province in one of the wealthiest and supposedly most advanced countries of the world. The discordance between perception and the reality of the drastic imbalance in health has been a shocking embarrassment for Saskatchewan. It is, paradoxically, not particularly surprising. We know, and have known for a long time, that poverty is the greatest contributor to ill health. What is new about these studies is the way in which they quantify our assumptions, showing in simple and clear data that the effect is much larger than most people would have predicted or any could possibly justify. And the implications are obvious, though politically inconvenient: one, poverty and inequality kill; two, governments that stand idly by are complicit in every avoidable illness and premature death.

Waking Up Democracy

This embarrassment and shock could serve as a wake-up call. It could help to refocus our political discourse on the real work of a democracy. Our job, as people who govern ourselves, is to strive to do so in a way that is fair and good, that allows everyone to participate fully and enjoy wisely the good things given to us by providence. A functioning democracy is one in which the government, to the best of its ability, carries out the will of the people and takes seriously its responsibility to serve the best interests of all citizens. This democratic governance requires a number of things, key among them being that people are sufficiently

informed to articulate their real needs, sufficiently empowered to present them as demands that can't be ignored, and sufficiently organized to see the process through to fruition. To put it another way, a democratic society requires a shared notion of what is good and a willingness to find a way to reach it. This does not imply that everyone would agree on all points and would work together in constant harmony. Democracy is the messy, argumentative, painstaking art of navigating a common course among conflicting priorities; if it isn't, we can be sure that some voices aren't being heard. Or, as one colleague in the world of HIV advocacy said to me, "If your coalition is comfortable, it's not broad enough." Having some shared framework, some set of guiding principles to steer the course, helps these differing priorities to be weighed by all in terms of what is best for all.

I mentioned earlier the importance we give, in private and in public, to human health. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹⁴ We all want health for ourselves and our family. The role of government in a democracy is to work with the people to produce what they want and need. What better goal for a society than to ensure that everyone enjoys true health – a state of complete physical, mental, and social well-being? And what better measure of the success of a government, and the society it represents, than the health of the people?

If we as a society address the social determinants of health – economy, education, the environment, and more – people will enjoy fuller, healthier lives. This much is clear: the road map of the social determinants can guide us to that shining shared goal of health for all. If we are transparent in our intentions, decisive in our actions, and honest in our evaluation of the results, we will also foster a common purpose that deepens community, builds solidarity, and rejuvenates democracy. In short, we will have found a means to move beyond our fragmented, haphazard approach to governance to one that works.

Yet some will object to such an approach. Change is hard, especially if it comes with a cost. If people doubt that they will benefit from it, they will be resistant. Any reasonable approach to building a healthy society,

especially one informed by social accountability or social justice, means that improving conditions among the poorest residents must be a top priority. The foundation of a healthy society must be built among those who find themselves at the bottom. We need to move beyond a focus on equality to one that stresses equity, from treating people as if they are exactly the same regardless of their circumstances to responding to their real needs in order to achieve the best possible outcome. It is by using an equity approach and directing our resources to the most marginalized that addressing the determinants of health will have the greatest impact: for those who are directly affected and, perhaps paradoxically or counter-intuitively, for everyone in society.

There are many people who see the world through compassionate eyes, who are motivated by a sense of social justice and who act altruistically to improve the world. However, many of us don't follow suit; perhaps we don't enjoy the luxury of doing so. We look first to the needs of our family, to a little more enjoyment of our own existence. We are guided by rational self-interest, and we support the politicians who share our world view, who offer us a little more money in our pockets or protection from the forces that threaten our peace and security. What we fail to recognize is that it is in the best interests of everyone, even those at the top, to improve the health of all.

Helping Some Helps Us All

Addressing the social determinants of health doesn't just help those who are most in need; it helps everyone, regardless of social position. This is why the concept is so important: everyone benefits. This approach can be used to reach across divisions of class, race, geography, or political affiliation. The poverty and ill health of some affect us all. Poverty is a drag on the economy. When people live in poverty, they are unable to participate fully in public life and the marketplace, and cannot contribute to the common account through taxes. They are also more likely to require health services, fall into the prison system, or need social assistance. People who lack decent housing or access to education are less able to participate in the economy as customers, workers, or innovators. As

their health suffers, the costs are borne by taxpayers. Our jails are not filled with hardened criminals (at least, not when they go in); the vast majority of crimes against property and people stem from poverty. Our safety, prosperity, and satisfaction with society are decreased by gross inequality.

In *The Spirit Level: Why More Equal Societies Almost Always Do Better*, epidemiologists Richard Wilkinson and Kate Pickett present compelling evidence that the degree to which resources are unequally distributed has a significant impact on the health of everyone.¹⁵ Countries with higher levels of equality, such as Japan or the Scandinavian nations, have much better health outcomes overall than countries with higher levels of inequality, such as the United States or Britain. Although the ill effects of inequality are greater for those at the bottom of the social ladder, the impact is not limited to the poorest few. Health outcomes follow a gradient of wealth: the working poor have worse health than the middle class, whose health is not as good as that of higher-earning professionals, and so on up the social and economic scale. But even the wealthiest people in an unequal society are less healthy than they would be in a more equal one. Whether it is the stress of constant competition and jockeying for position, the threat of personal ruin, or the burden of a large, marginalized population on public services and the social fabric, there is something about the experience of living in a society with a vast gap between rich and poor that damages everyone's health, resulting in more mental and physical illness, shorter lives, greater levels of obesity, and higher infant mortality. Less equal societies suffer more of the social problems that lead to negative health effects, experiencing higher levels of violence, imprisonment, illiteracy, and teen pregnancy.

Living in a more egalitarian country, on the other hand, benefits the health of everyone, from the least advantaged to the most successful. The editors of the *British Medical Journal* grasped the significance of these findings: "The big idea is that what matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly that wealth is distributed. The more equally wealth is distributed, the better the health of that society."¹⁶

Any serious attempt to address health disparities must therefore involve a plan to address not just poverty, but wealth disparity as well.

This is not an easy idea to sell, especially not in countries that have a strong systemic commitment to inequality. But if, as the Commission on Social Determinants of Health's *Closing the Gap* report asserts, ill health is caused by the inequitable distribution of power, money, and resources,¹⁷ any serious attempt to address health inequities must involve a plan to distribute resources more fairly.

The common response to stories of people living in poverty is that they are poor because of their own bad choices. Individuals who succeed in life possess the drive, determination, and skills to get ahead; they make wise decisions. If we look back at Maxine, there's no denying that she didn't make the wisest of decisions. The question is, could she have done differently?

To choose well, one needs to have had the chance – through good role models, through childhood development, through access to the basic necessities of life – to have developed some real wisdom. Maxine didn't choose the life she was born into, and that life didn't equip her to make better choices than she did. In fact – through poverty, abuse, lack of education, discrimination, and social exclusion – it worked against her at every step. It's hard to imagine anyone succeeding in her circumstances. Although we can't create a system that can force people to make wise choices, we can work toward one where more people have the opportunity to do so. By making the social determinants of health a primary driver of public policy, we can develop a society in which more people have the chance to succeed and to live better lives as a result. We can create the conditions that allow for good choices.

Providing everyone the opportunity to improve their lives, to escape poverty and experience the fullness of health, is not just the right thing to do, but also the smart thing to do. It is a delightful coincidence that our future well-being depends not on our selfishness but on our generosity, our sense of justice. The growing gap between rich and poor impoverishes us all, diminishing the quality of life for rich and poor alike. We in Canada consider ourselves a developed country, but to allow the gulf between rich and poor to expand is to become less developed.

The dream of a truly healthy society offers us a shared goal with the power to reach across the differences that separate us. It allows us to connect with our neighbours in recognition of our common vulnerability

and our common desire to lead full and healthy lives. By systematically addressing the determinants of health and continually measuring our success, we can do both what is right and what is smart. We can chart a path of meaningful progress. We can improve the health of people and of the political system at the same time.