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# Systems Approach Workbook

## Socioeconomic Determinants of Health

April 2014

### ***Who should read this brief?***

- Leaders and decision makers, such as regional directors and program managers, in substance use and related fields such as mental health.
- Service providers and others working with or within the substance use system.

### ***How are the socioeconomic determinants of health relevant to the Systems Approach?***

- This brief is part of the Systems Approach Workbook, which is intended to assist those using the *Systems Approach to Substance Use in Canada* report as a guiding framework for improving the accessibility, quality and range of services and supports for substance use in Canada.
- This brief will help you understand the influence of the socioeconomic determinants of health on the development and treatment of substance abuse and other health problems, and improve the service response along the full continuum of care from health promotion and prevention to recovery and continuing care.
- Taking a systems approach that takes into consideration the socioeconomic determinants of health can transform public policy and healthcare service delivery, ultimately helping to reduce the burden of substance abuse.

# Systems Approach Workbook

## Socioeconomic Determinants of Health

This document was published by the Canadian Centre on Substance Abuse (CCSA).

Suggested citation: Canadian Centre on Substance Abuse. (2014). *Systems Approach Workbook: Socioeconomic determinants of health*. Ottawa, ON: Author.

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Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

This document can also be downloaded as a PDF at [www.ccsa.ca](http://www.ccsa.ca).

Ce document est également disponible en français sous le titre :

*Manuel d'Approche systémique : Déterminants socioéconomiques de la santé*

ISBN 978-1-77178-128-2



# Table of Contents

Introduction .....	1
What are the Socioeconomic Determinants of Health? .....	2
Mental Health, Addictions and the Socioeconomic Determinants of Health .....	6
A Comprehensive Treatment Approach .....	7
Health Inequities and the Health Gradient .....	9
Current Trends in Inequity .....	9
Canada in an International Context .....	9
A Possible Solution: Community-based Primary Healthcare System .....	10
Conclusion .....	12
References .....	13



## Introduction

The social, cultural and economic forces that affect people's health are diverse and powerful, and often lie beyond any individual's control. These forces, which include the conditions in which individuals and families live, learn, work and play, are collectively referred to as the socioeconomic determinants of health. Paying closer attention to them has important implications for social policy and planning in many service and support systems.

*A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy* (the Systems Approach report) recognizes that “a comprehensive, holistic and integrated approach is needed to address risks and harms. The continuum of services and supports includes not only ‘treatment’ but also a much broader spectrum, both upstream and downstream, provided collaboratively by multiple sectors” (2008, p. 9).

Giving greater attention to the socioeconomic determinants of health can provide a common perspective to recognizing the complex causes of health problems within substance abuse and mental health treatment and primary care, and across other sectors and organizations. The following case study illustrates the complexity of health and social issues that face many Canadians with substance abuse problems and the issues that need to be addressed to achieve improved client outcomes.

### Case Study: Introducing Carmen

Carmen is a young single mother with two preschool-aged children. She lives in a large Canadian city and has no family close by. She and the father of her children separated before her second child was born; he has not had contact with her since nor has he provided any financial support. Although Carmen has worked a variety of part-time jobs over the past two years (when such jobs were available), she has had to rely upon welfare the rest of the time. She has a hard time finding reliable childcare that she can afford and is frequently concerned about the stability of her housing situation.

Carmen had periods of heavy drug use as a teenager and spent some time in treatment centres, as well as foster care. Feeling isolated and overwhelmed by her situation, she recently started drinking more heavily and using marijuana nearly every day. A neighbour who was worried about Carmen's children made a report to Child Protection Services. A worker came to assess the family's situation and develop a plan with Carmen that will ensure the safety of her children. However, Carmen fears they will be taken from her and put in the care of the ministry.

The economic burden of the harms associated with substance abuse in Canada has been estimated at \$40 billion per year (Rehm et al., 2006). Caseloads in large service systems such as corrections and child welfare are significantly affected by the high rates of addiction and mental health problems in their client populations (Correctional Service Canada, 2009; Public Health Agency of Canada, 2011).

These problems are both brought on and aggravated by adverse social, cultural and economic influences. However, when these influences are positive — adequate income and employment; access to healthy food, good housing and effective health care; support for parents; social belonging and openness to cultural differences — they can act as protective factors for individuals, families and communities, and urgent, more expensive, specialized services are not required as often as they would be otherwise (Mikkonen & Raphael, 2010). Substance use and mental health problems are also less frequent, less severe and more effectively treated (Herie & Skinner, 2013).

This guide provides a brief overview of the recent thinking about the socioeconomic determinants of health and how they provide common collaborative ground for the delivery of services and supports within the substance abuse, mental health and other systems that serve common clients.



# What Are the Socioeconomic Determinants of Health?

Good health is sometimes seen as simply being without disease or not having a medical condition. From this perspective, infections, injuries or organ failures are understood as the cause of most medical problems. Medical models therefore have an individual focus, diagnosing each patient's symptoms and prescribing specific treatments.

The reality, however, is much more complex: health, illness, disease and disability are outcomes of a number of social, cultural and economic factors that operate and interact at both the individual and population levels. These include income, housing, food security, early childhood development, education, health care, employment, the social and physical environment, culture, health behaviours, genetics and gender.<sup>1</sup>

This section provides a brief description of each factor and its relationship to substance use.

## Other Resources

The **System Mapping** module provides templates with space to consider if and how the socioeconomic determinants of health are or should be reflected in system evaluation and planning.

## Income, Housing and Food Security

Health status improves with each step a person takes up the income and social hierarchy. An adequate income is necessary to provide beneficial living conditions such as secure housing, clothing, transportation and a sufficient amount of healthy food. The healthiest populations are those that are prosperous and have an equitable distribution of wealth.

Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be as simple as poor living conditions. But the effect occurs across the entire socioeconomic spectrum. Research has shown that the degree of control people have over their life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in less stress and more control (Millar, 2013; Wilkinson, 2005) and the biological pathways explaining how this happens are becoming better understood. A number of studies have found that limited options and poor coping skills for dealing with stress increase one's vulnerability to a range of diseases through pathways involving the body's immune and hormonal systems.

Poverty creates particular problems in this regard. Children from low-income families often go to school hungry, which affects their ability to learn, so they often underperform and are less likely to graduate from high school. Children with the risk factors associated with poverty (e.g., hunger, inadequate clothing, poor housing) are also more likely to be involved in aggressive and delinquent activities, be street-involved, and use alcohol and other substances (Raphael, 2008). Furthermore, low-income families often cannot afford the time or money to provide recreational activities for their children, such as outdoor or organized sports, which act as protective factors.

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<sup>1</sup> See Mikkonen & Raphael, 2010: <http://www.thecanadianfacts.org>.



Children from low-income families are therefore at risk for poorer health, substance abuse, stress, mental health problems and poor school performance, as well as the associated issues of early pregnancy, criminal activity and unemployment – all of which can lead to a repeated cycle of poverty and poor health for the next generation.

### **Early Child Development**

Evidence of the effects of early experiences on brain development, school readiness and health in later life has established early child development as a powerful determinant of health. Experiences from conception to age six have the most important influence on brain development of any time in a person's life. Positive stimulation early in life improves learning, behaviour and health into adulthood. Investments in early childhood development and care can therefore yield a large return in cognitive and behavioural development. Infants and children who are neglected or abused are at higher risk for injuries and death, as well as a number of behavioural, social and cognitive problems later in life, such as street involvement, crime and substance use. Conversely, a safe environment and nurturing relationships are strong protective factors.

### **Education and Literacy**

Health status improves with the level of education. Effective education for children and lifelong learning for adults are key contributors to health and prosperity, equipping people for work and providing a sense of control over life circumstances. Education increases opportunities for job and income security, and it improves people's ability to access and understand information to help keep them healthy.

Canadians with low literacy skills are more likely to be unemployed and poor, suffer poorer health and die earlier than Canadians with high levels of literacy. In comparison, people with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than those with low levels of education. They also tend to smoke less, be more physically active and have access to healthier foods.

### **Healthcare Services**

Healthcare services designed to maintain and promote health, prevent disease, and restore health and function are essential to the health of the broader population. Healthcare services for substance abuse include prevention and education (e.g., increased family cohesion), early identification (e.g., screening and brief intervention by primary care physicians), harm reduction (e.g., needle exchange programs), specialized treatment (e.g., community and residential programs) and acute care (e.g., hospital inpatient care). Access to services for co-existent illnesses such as mental illness, diabetes, heart disease, stroke, arthritis and cancer is also needed. To best meet client needs, substance abuse, primary health care and other services should work collaboratively and address the socioeconomic determinants of health. A community-based primary healthcare system provides an excellent foundation for these collaborations and is well positioned to promote the Tiered Model's guiding concept of "every door is the right door."

### **Employment and Working Conditions**

Employment has a significant effect on physical, mental and social health. Meaningful work provides not only money but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to the health of both the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems such as depression, alcoholism, substance abuse and



suicide. Negative conditions at work (both physical and psychosocial) can also have a profound effect on a person's health and emotional well-being.

### **Social Support Networks and Social Environments**

Support from families, friends and communities is associated with better health. Such social support is important in helping people solve problems and deal with adversity, as well as in maintaining a sense of control over life circumstances (Wilkinson, 2005). The caring and respect that occurs in social relationships and the resulting sense of satisfaction and well-being act as a buffer against health problems.

The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in institutions such as faith-based organizations, voluntary organizations and clubs, and informal giving practices that people create to share resources and build attachments with others.

Social stability, recognition of diversity, safety, good working relationships and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health, including the use of addictive substances. A strong tradition of peer networks can also provide safe, supportive environments. These networks often provide support during and following specialized treatment for substance use.

### **Physical Environments**

The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

In the built environment, factors related to housing, indoor air quality, and the design of our communities, recreation facilities and transportation systems can significantly influence our physical and psychological well-being. Adequate housing is critically important for our well-being, particularly among individuals and families with low incomes and chronic conditions such as mental illness, substance abuse and addictions.

### **Health Behaviours**

Health behaviours include smoking, alcohol and substance use, diet and physical activity. There is wide recognition that behavioural “choices” are heavily influenced by the socioeconomic determinants of health. For example, a family with an inadequate income will find it difficult to provide a proper amount of healthy food to its children. Substance abuse and smoking are often a form of self-medication for coping with stress or mental illness. Problematic health behaviours such as alcohol and drug use are particularly high among those experiencing negative determinants in other areas – young men who are poor, unemployed and without family supports, for example.

### **Genetics**

Genetic make-up creates an inherited predisposition to a wide range of individual responses that affect health status. Genetic endowment frequently interacts with environmental factors and conditions for development that can affect one's health positively in terms of protective factors (e.g., parental attachment, secure housing) or negatively in terms of risk factors (e.g., trauma, poverty).



## Gender

Gender refers to the roles, personality traits, attitudes, behaviours, values, and relative power and influence society ascribes to the two sexes on a differential basis. Health issues can be a function of gender-based social status or roles. For example, men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. While women live longer than men, they are more likely to suffer depression, stress overload (often owing to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence.

## Culture

Some people face additional health risks because of an environment largely determined by dominant cultural values that contribute to conditions such as marginalization, racism, stigmatization, the effects of colonization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services.

Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were twice as high as those of the general Canadian population, and the prevalence of major chronic diseases such as diabetes, heart problems, cancer, hypertension and arthritis is significantly higher in Aboriginal communities and appears to be increasing.

The 1996–1997 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian-born peers, even though far more of the former lived in low-income households. The study suggested “poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty’s blows; the hopelessness of majority-culture poverty accentuates its potency.”

### Other Resources

The socioeconomic determinants of health speak to the complexity that service providers and system planners must respond to in order to improve client outcomes. The **Systems Thinking and Complexity** brief provides a guide to understanding and working with complexity.

Although there is general acknowledgement that social, cultural and economic factors do impact health status, there is often a limited appreciation for how profound that impact actually is. Commentary in the media, in public policy discussions and amongst average Canadians often appears to be based on the assumption that lifestyle choices and access to the healthcare system are the primary drivers of good health. Canadians understand that good nutrition, exercise, moderate alcohol use and abstaining from illegal drugs and tobacco – actions that relate to healthy lifestyle choices – are important for good health. However, they often fail to recognize that factors such as adequate income, educational achievement, good jobs, healthy food and early childhood support are considerably more important for improving health (Mikkonen & Raphael, 2010). There is also an interactive effect, where many aspects of a healthy lifestyle are more achievable when positive socioeconomic determinants (e.g. employment, food security, good housing, social inclusion) are in place. In a sense, lifestyle choices themselves are socially determined.





## Mental Health, Addictions and the Socioeconomic Determinants of Health

It has been estimated that good health is caused 15 percent by genetics, 25 percent by health care and 60 percent by the remaining socioeconomic determinants of health (i.e., income, food, shelter, education, work, and the physical and social environments). (Keon, 2009).

Genetics and developmental factors partially explain why some people are more vulnerable to certain diseases. When their circumstances are positive, some individuals never experience the health problems they might have otherwise. A supportive environment is especially helpful in preventing and reducing the severity of mental health and substance abuse problems. A negative environment makes them more likely to occur and to be more serious when they do occur. Mental health and addiction problems can quickly prevent people from responding effectively to the many tasks and challenges of life. In time, repeated failure and escalating symptoms can come together to create a vicious downward spiral (Raphael, 2009).

There is strong evidence for this pattern. In a study of 15 Canadian cities, people whose neighbourhoods were low on a socioeconomic index were 3.4 times more likely to be hospitalized for substance abuse disorders than people from neighbourhoods rated high on the same index. In the case of mental health conditions (including substance abuse), the hospitalization rate was 2.3 times higher for the low socioeconomic neighbourhoods (Canadian Institute for Health Information, 2009). Substance abuse clinicians see this connection repeatedly: people who become addicted to substances lose hope of meeting their needs in healthy ways, often turning to alcohol or drugs to get short-term relief from the pain of isolation and repeated failure (Alexander, 2008). The patterns reinforce each other negatively until, eventually, it is no longer clear which came first.

Table 1 (Raphael, 2009) provides examples of possible adverse states and mental health and substance use effects that connect back to each of the socioeconomic determinants of health.

**Table 1. Adverse Health Effects of the Socioeconomic Determinants of Health**

Determinant	Adverse State	Examples of Adverse Health Effects
Aboriginal status	Marginalization, exclusion, poverty	Addictions, lower life expectancy
Early life	Poverty and deprivation	Blunted coping skills
Education	Lower achievement	Learned helplessness
Working conditions	High demands, low control	Workplace stress
Food security	Food insecurity and hunger	Guilt, shame
Gender	Lack of gender equity for women	Dependency
Healthcare services	Lack of access or economic resources	Lack of treatment
Housing	Housing insecurity, homelessness	Stress, anxiety
Income	Low income and poverty	Lack of control, stress, depression, anxiety, hopelessness, more disease, earlier death
Social safety net	Lack of responsive services	Isolation
Social exclusion	Lack of participation	Alienation, anomie, discrimination, racism, violence
Employment	No paid income, job insecurity, lack of meaning and identity	Hopelessness



# A Comprehensive Treatment Approach

The perspective on treatment that incorporates the socioeconomic determinants of health emphasizes that basic life circumstances have a major impact on health. In many organizations we see participants, customers, clients, members and employees who have substance abuse or mental health problems. In our own social and family circles we also have people who are struggling with these conditions. Many of these individuals and groups have not received supports or early intervention services as soon as desirable or ideal. The resulting social and economic costs for communities and for society as a whole are great (Rehm et al., 2006; Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008).

Positive socioeconomic determinants protect against substance abuse and mental health conditions that might otherwise emerge. Comprehensive supports integrated into substance use services are also remedial: clients have a critical need for these same things before, during and after treatment. The connections between specialized substance use and other services and supports across the spectrum of socioeconomic determinants need to be reliable and strong to provide a truly comprehensive treatment approach (National Treatment Strategy Working Group, 2008).

### Other Resources

Examples of resources available to support the system-level collaborations needed to span substance use services and the socioeconomic determinants of health include CCSA's **Systems Approach Workbook** and Ontario's [Integration Resources](#) project.

The case study of Carmen from the introduction continues below, with a description of the responses that would be available to her if a socioeconomic determinants of health approach were to guide the actions of planners, managers and health service providers in her community.

## Applying the Socioeconomic Determinants of Health to Carmen

In her discussion with the child protection caseworker, Carmen agrees her drinking and drug use is affecting her children's safety. She very much wants to keep her children, and the caseworker believes Carmen can provide adequate care when she is not using substances. They agree that Carmen needs to quit drinking and using drugs—and that she will need some help to do that.

Typical Approach	Socioeconomic Determinants of Health Approach
<p>The caseworker gives Carmen the name of an agency she can call. She says there might be a waiting list, so she expects Carmen to follow up with the agency as soon as possible and definitely before her next visit. However, the agency is a couple of kilometres away from Carmen's apartment and the bus connections are not very good.</p> <p>When the caseworker finds that there is not much food in the house, Carmen says she will get a cheque the next day and promises to shop for groceries instead of using the money for drugs or alcohol. The worker then gets another call and has to leave. She says she will visit early the following week.</p>	<p>The caseworker commits to putting Carmen in touch with coordinated local mental health and addictions services. The caseworker understands that Carmen has little support of any kind and that she may not be getting all the income benefits for which she is eligible, and that her housing arrangement is very poor. The caseworker's agency has a working relationship with a multi-service agency in the community that could probably help Carmen in several areas. The caseworker calls the agency from Carmen's apartment and a support worker from the agency agrees to come to see Carmen early that afternoon.</p> <p>Marie, the support worker, is not at all threatening and Carmen likes her from the beginning. They talk about her children and how proud she is of them, some of the TV shows she likes, and her other interests. Marie tells her about several housing developments her agency runs that have on-site child care, good playground areas and preschools inside the complexes. (At a future meeting, Marie will show Carmen what the agency's apartments are like to see if she might like to live there.) She also tells Carmen that the agency runs a number of support groups, including substance abuse groups. Marie says there is an addiction group meeting in a couple of days and offers Carmen bus tickets to get there. Her children can be looked after while she attends the group. Carmen agrees to the plan.</p> <p>Marie also has contacts with the local public health unit and arranges for a nutritionist to contact Carmen to coach her on how to provide a healthy diet for her children and identify where the "best buys" are in her neighbourhood. She also mentions that her</p>



<p>As the worker leaves, Carmen feels discouraged and overwhelmed. She wonders if she'll be able to do what she needs to do to keep her children. She has no one to call.</p>	<p>agency has job skills groups, parenting groups, high school upgrading classes and good connections with some local employers, if Carmen is interested in part-time work. Finally, she gives Carmen her number, telling her to call any time over the next few days if she has questions.</p> <p>When Marie leaves, Carmen feels hopeful that she might meet some new, positive friends and finally be able to start building a better life for her family.</p>
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The causal and protective factors that determine health outcomes are the same factors that influence demand for other human services (e.g., education, employment supports, correctional systems, child protection services, income support). As a result, every service system and the clients it serves will benefit from a strong, coordinated social, economic and cultural support system that allows easy access for anyone who needs it. The Systems Approach recognizes these multiple influences and overlapping outcomes, and calls on substance abuse leaders and service providers to work with partners in other organizations to make sure all determinants are being addressed. Successful outcomes for clients and society depend upon this collaboration.

The guiding concepts outlined in the Systems Approach are meant to facilitate the complex connections between the many supports and services providers offer, and the wide range of activities and programs from which people can benefit. Systems should operate in ways that have a practical, positive impact on consumers of services. These concepts apply across tiers in substance abuse service systems and, more importantly, across the range of service systems that work with common clients. They apply by sharing care, referring individuals to services that address the many determinants of health, and providing practical support during transitions between tiers and systems.

Each of the System Approach's guiding concepts can affect responses and outcomes for clients across the various socioeconomic determinants of health. Making these concepts real for people like Carmen and her family is a significant system-level challenge, but doing so will provide the most effective approach.

### Carmen and the Systems Approach Guiding Concepts

**No wrong door.** A child protection complaint becomes the "right door" for Carmen because it opens a pathway not only to substance abuse treatment, but also to a better apartment, job training and child care.

**Availability and accessibility.** Access to services was made easy by the offer of transportation assistance and immediate entry into the support group. The group sessions are led by a person who can quickly facilitate referral to day treatment or residential treatment, if needed, and can assist with good child-care arrangements.

**Matching.** The child protection caseworker and support worker incorporate brief screening questions into their interviews and offer an appropriate referral to a group. The addictions group facilitator will refine the assessment of Carmen's needs during initial sessions.

**Choice and eligibility.** Marie will keep in touch with Carmen to ensure she understands and takes advantage of the agency's other services at a pace that works best for her. She will check with Carmen about how the addiction group is going and connect her with other services when she is ready for them. Marie will also be the main source for the child protection caseworker to monitor the safety of Carmen's children. Marie acts as a navigator, advocate, coordinator and integrator for Carmen.

**Flexibility.** The attitude of the service providers, which they communicate to Carmen repeatedly, is that the plan belongs to her and it needs to fit what she needs, wants and feels ready to commit to. Nobody has the exact same plan or schedule.

**Responsiveness.** Carmen has many challenges and can only focus on a few things at a time. Marie will be the main person who keeps in touch with Carmen, talking with her about how things are working out and helping her to decide what she wants to do and when she wants to do it. The roles are clear: to Carmen, Marie seems like a thoughtful coach who wants what is best for her and encourages her to get it.

**Collaboration.** The service and support system that is available to Carmen was developed over time by the sustained leadership and effort of a number of organizations that continue to fund and support various parts of the coordinated system. These organizations have developed protocols and expectations for their staff that allow for ongoing service planning and effective case planning with their clients.



## Health Inequities and the Health Gradient

The present reality in many communities across Canada is that health care and community services are fragmented, unorganized and disconnected. The result is that clients seeking care for substance use, mental health or chronic illness often have trouble getting to see a family doctor or mental health or addictions professional. When they are seen in an emergency room or hospital ward, there is often a lack of communication with primary care staff upon discharge, meaning continuity of service is lost. And if a patient has complex needs beyond clinical care (e.g., income, social support, housing, food, clothing, training, employment), there is no connection with community agencies that could help.

Social and economic disparities affect the health of populations, communities and the people who live in them. The World Health Organization Commission on the Social Determinants of Health (2008) stated that:

- Where systemic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity.
- Health inequities are caused by the unequal distribution of power, income, goods and services.
- This form of social injustice is killing people on a grand scale.

There are wide inequities in health in Canada. The life expectancy of wealthy Canadians is seven years longer than low-income Canadians, while Aboriginal people live 12 years less than non-Aboriginal Canadians. Between adjacent neighbourhoods in many major Canadian cities there is a difference of 10 years or more in life expectancy, reflecting the fact that disadvantaged neighbourhoods have high concentrations of poverty, homelessness and chronic health conditions such as substance abuse, addictions and mental health problems (Mikkonen & Raphael, 2010).

Across the socioeconomic gradient – from the more affluent to the relatively disadvantaged and the poor – the socioeconomic determinants of health exert their effects so that at every step down the scale the prevalence of health issues such as substance abuse, disease and early death increases.

### Current Trends in Inequity

The 2013 Campaign 2000 report shows that family and child poverty continues to exist at an unacceptably high rate, and that socioeconomic inequities are increasing across the country (Campaign 2000, 2013). In addition, recent studies conducted in British Columbia and the United States show that life expectancy for economically disadvantaged groups is actually decreasing, but continues to increase among the wealthy (Health Officers Council of British Columbia, 2013; Meara, 2008). These growing health inequities in turn are being caused by the increasing concentrations of income and wealth at the very top end of society (i.e., the “one percent”).

### Canada in an International Context

Canada has been a world leader in advancing the international discussion of health promotion (Collins & Hayes, 2007). Yet, in objective terms, the disparities between groups of Canadians are worsening and our population health indicators do not compare well with other countries.

**Early childhood.** Canada spends less than one-fifth as much on early childhood education as the highest-spending developed countries (Mikkonen & Raphael, 2010).



**Child poverty.** The percentage of Canadian children living in poverty has remained at about 15 percent for more than 20 years (Campaign 2000, 2013).

**Income gap.** The gap between highest and lowest household earnings is widening faster in Canada than in most other developed countries (Organisation for Economic Co-operation and Development, 2009).

**Aboriginal Canadians.** The Canadian Aboriginal population ranks far lower on life expectancy, education level and economic well-being than the rest of Canadians (Loppie Reading & Wien, 2009; Mikkonen and Raphael, 2010).

## **A Possible Solution: Community-based Primary Healthcare System**

One possible approach to reducing the inequities described above is a community-based primary healthcare system (CBPHC) (Millar, 2012). The “triple aim” vision driving the transformation toward a CBPHC approach has now been adopted by the Council of the Federation and all provinces:

1. Improve population health and reduce health inequities.
2. Improve the patient experience and the quality of care.
3. Reduce healthcare expenditures.

The system-level, collaborative and cross-sectoral nature of the CBPHC system is complementary to the approach promoted in the Systems Approach report. Some key features of CBPHC include (Millar, 2012):

- A CBPHC organization serves a defined (usually geographic) population, ideally in the 100,000–500,000 population range. This population will usually be in a large neighbourhood, a municipality or a cluster of municipalities. In some cases, it could share boundaries with a regional health authority.
- A CBPHC organization provides primary prevention, clinical care, home care, residential care, and mental health and addictions services through to palliative and end-of-life care. Health services specific to substance abuse include prevention, harm reduction and acute care, needle exchange programs, safe injection sites, detox, rehabilitation, methadone maintenance, primary care, specialist care and hospital care. Services for co-existent illness such as mental illness, diabetes, heart disease, stroke, arthritis and cancer are also included. The socioeconomic determinants of health are addressed through appropriate allocation of resources and direct linkages to community services, and through partners and advocacy.
- Services are delivered through a collaborative network of providers that include primary care providers (e.g., physicians, pharmacists, nurse practitioners, mental health and addictions professionals) linked to specialist and hospital care, as well as to community services such as income supports, social housing, food services, police, education, training and employment.
- CBPHC is supported by appropriately linked electronic data and telehealth systems, quality improvement programs, appropriate financial incentives and a community engagement mechanism. This mechanism enables performance reporting to the community, as well as a means of listening to the concerns of patients and citizens.



A CBPHC organization can address the socioeconomic determinants of health in several ways:

- Direct linkages to community services for individual patients. As illustrated by the case study of Carmen, linkages can be made on behalf of a patient to provide such supports as income supplementation, social housing, transportation, access to healthy food, child care, job training and employment.
- A CBPHC organization can also allocate resources so that those most in need of healthcare services (particularly mental health and addiction services) are given a priority.
- It can be a powerful voice to advocate for poverty and inequity reduction policies such as subsidized daycare, social housing, living wages for workers, food security and higher child benefits for poor families.



## Conclusion

The socioeconomic determinants of health operate in complex, interactive environments—and the effects they produce are often not apparent for a number of years. As a result, causal relationships are more difficult to establish, return on investments seem quite far in the future, and corresponding policies and initiatives don't compete well with other, more immediate spending and funding for healthcare service priorities.

Yet the evidence shows that a failure to address the social, economic and cultural factors that could prevent serious substance abuse and mental health conditions—and a failure to effectively address these same issues for people already experiencing substance abuse and mental health conditions—inevitably leads to escalating social and economic costs. Many developed countries, including Canada, are facing this challenge.

Two national strategies, *A Systems Approach to Substance Use in Canada* (National Treatment Strategy Working Group, 2008) and *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012), emphasize the need to work across all tiers, sectors and service systems to address socioeconomic determinants of health. The five strategies listed below do the same but at the provincial level:

- *Come Together: Report & Recommendations of the Mental Health and Addictions Strategy Advisory Committee* (Government of Nova Scotia, 2012);
- *Creating Connections: Alberta's Addiction and Mental Health Strategy* (Government of Alberta, 2011);
- *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (Government of British Columbia, 2010);
- *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (Government of Ontario, 2011); and
- *The Action Plan for Mental Health in New Brunswick, 2011–18* (Government of New Brunswick, 2011).

By taking a systems approach to the socioeconomic determinants of health and developing a CBPHC system, the substance abuse and mental health challenges we face can be successfully addressed and the health of Canadians improved.

The principles of coordinated care and networking that are highlighted under a CBPHC system are also foundational to the comprehensive continuum of care presented in the Systems Approach report. The Tiered Model of services and supports, and the guiding concepts on which it is based, illustrate the collaboration that needs to take place at all levels in order to better meet the needs of Canadians with substance use problems.



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