Oppression: A Social Determinant of Health

“Social injustice is killing people on a grand scale”

(World Health Organization, 2010)

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Today’s presentation: Focusing on “Building an Equitable World: Where do we start?”

• The social determinants of health (SDH)
• Intersections: the SDH, the isms and geography
• Dominant ways of thinking about the SDH
• Oppression and the structural/systemic determinants of health
• Justice: What can we be doing?

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The Social Determinants of Health

“Economic and racial inequality are not abstract concepts, [they] hospitalize and kill even more people than cigarettes. The wages and benefits we're paid, the neighborhoods we live in, the schools we attend, our access to resources and even our tax policies are health issues every bit as critical as diet, smoking and exercise...
...The unequal distribution of these social conditions - and their health consequences - are not natural or inevitable. They are the result of choices that we as a community, as states, and as a nation have made, and can make differently. Other nations already have, and they live longer, healthier lives as a result.”

(Larry Adelman, Executive Producer, UNNATURAL CAUSES, March 2008)
“All diseases have two causes: One pathological, the other political”

Rudolf Virchow
(1821-1902)
The Social Determinants of Health: When research, practice, education and policy are political

- early childhood development
- employment and working conditions
- income and its equitable distribution
- food security
- health care services
- housing shortages
- education
- social exclusion
- social safety nets

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Three core areas of Social Determinants of Health (SDH) and how they “intersect”

1. The SDH as described by Raphael, WHO

2. The ‘isms’ as SDH (racism, sexism, ageism, heterosexism...)

3. Geography as a SDH
SOCIAL DETERMINANTS OF HEALTH (SDH)
- early childhood development
- employment and working conditions
- income and its equitable distribution
- food security
- health care services
- housing shortages
- education
- social exclusion
- social safety nets

IDENTITY as a SDH (the "isms")
- immigrant status
- social class
- gender
- race
- ethnicity
- culture
- age
- (dis)ability
- sexual orientation
- spirituality
- ...

GEOGRAPHY as a SDH
- rural, remote, fly-in
- East, West, North, South
- segregation and ghettoization
- unfair geographic access to public services
- lack of public transportation (or funds)
- environmental patterns: pollution dispersion, toxin location...

Intersections of SDH

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POVERTY AND POLLUTION MAP

Toronto Neighbourhoods with Poverty Rates at or above the National Average of 11.8 Per Cent and Air Releases of Toxic Pollutants over 100,000 Kilograms

Legend
- High Poverty and Pollution
- Below High Poverty and Pollution Threshold
- National Pollutant Release Inventory Facility
- Principal Roads

* From industrial sources reporting toxic air pollutants to the National Pollutant Release Inventory; national poverty rate based on economic families.
Dominant ways of knowing and thinking about SDH

- Quantitative
- Epidemiological
- Apolitical
- Mass media (Raphael)
- Individualistic

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An example of the power of discourse: Healthy lifestyle tips for health

- Don't smoke. If you can, stop. If you can't, cut down.
- Follow a balanced diet with plenty of fruit and vegetables.
- Keep physically active.
- Manage stress by, for example, talking things through and making time to relax.
- If you drink alcohol, do so in moderation.
- Cover up in the sun, and protect children from sunburn.
- Practice safer sex
- Take up cancer screening opportunities.
- Be safe on the roads: follow the Highway Code.
- Learn the First Aid ABC: airways, breathing, circulation.

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OR....

(Source: Center for Social Justice, 2011)

• Don't be poor. If you can, stop. If you can't, try not to be poor for long.

• Don't have poor parents.

• Own a car.

• Don't work in a stressful, low paid manual job.

• Don't live in damp, low quality housing.

• Be able to afford to go on a holiday and sunbathe.

• Practice not losing your job and don't become unemployed.

• Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.

• Don't live next to a busy major road or near a polluting factory.

• Learn how to fill in the complex housing benefit/shelter application forms before you become homeless and destitute.
Another example: Infant mortality in Canada

“As a result of the alarming drop in Canada’s ranking, the Society of Obstetrics and Gynecologists of Canada Executive Vice President Andre Lalonde requested an urgent meeting with Health Minister Leona Aglukkaq to craft a national birthing strategy... Lalonde estimates a national birthing plan would cost $43.5 million spread over five years.

The plan would include accurate data gathering, focus on maternity patient safety, the implementation of national benchmarks, and the creation of a model of sustainable maternity and newborn care.” (Priest, Globe and Mail, 2010, p. 1)
but...

the causes of infant mortality in ‘rich’ countries have been found to be:

• racism-related stress and socioeconomic hardship (Giscombe & Lobel, 2005)

• high prevalence of low income among women who experience serious hardships during pregnancy (Braveman et al., 2010)

• high poverty rates and lack of access to a socialized health care system, as is the case on the United States (Tillet, 2010)

• significant correlation of high poverty rates with infant mortality rates among minority and white mothers in the US (Simms, Simms, & Bruce, 2007)

• significant correlation among poverty level, racial composition of geographic areas, and infant mortality rates (Eudy, 2009)

• high correlation of inequality and child relative poverty with infant mortality rates in rich societies (Pickett & Wilkinson, 2007).
Figure 3: New England Journal of Panic-Inducing Gobbledygook.
So, where/how do inequities in SDH get created and sustained over time?

The structural causes of SDH inequities:

They are called structural because “they are part of the political, economic, and social structure of society and of the culture that informs them” (Navarro, 2007. p. 2).

Oppression: How is it at the core of SDH inequities?
1. Biased information leads to stereotyping

Stereotyping: An often negative exaggerated belief, fixed image, or distorted idea held by persons, groups, political/economic decision makers— is embedded in, and reinforced by, oppressive power relations.

2. Prejudice

A way of thinking based on stereotypes— is embedded in, and reinforced by, oppressive power relations.

3. Discrimination

Action or inaction based on prejudice— made possible/condoned implicitly or explicitly by oppressive power relations.

4. Oppression

Discrimination backed up by systemic power relations (e.g. government, education, legal, and health system policies; multi-national corporations)

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Oppression-Related Stress

• People Under Threat: Health Outcomes and Oppression

• Reframing “vulnerable ” or “at-risk” people, families, communities, populations as “People under Threat”
Spiritual and psychological stress (i.e. impact of chronic worry about lack of money for adequate food, shelter; experiences of violence, racism, colonialism, homophobia, misogyny…)

Physical and physiological stress (i.e. physical and physiological impact of damp housing, food insecurity, heat insecurity; impact of spiritual and psychological distress on the body’s SAM-HYPAC adrenal systems …)

Chronic mental health problems (i.e. traumatic stress, depression, anxiety …)

Dominant diagnostic and treatment frame: DSM IV-TR, ICD (i.e. one-size-fits-all; gender, race, social class neutral; often operates as a mechanism for sustaining oppression)

Pathologizing the mental health consequences of oppression (i.e. psychotropic overmedication; denial of colonialism as a root of traumatic stress …)

Physical and mental health outcomes of oppression-related stress

OPPRESSION (mental health)

OPPRESSION (physical health)

Physical and physiological stress (i.e. physical and physiological impact of damp housing, food insecurity, heat insecurity; impact of spiritual and psychological distress on the body’s SAM-HYPAC adrenal systems …)

Chronic physical and mental health problems (i.e. cardiovascular disease, asthma, diabetes, depression, anxiety, obesity …)

Dominant diagnostic and treatment frame: Conventional biomedicine (i.e. focus is on symptom treatment; health policy is generally designed with scant attention to the causes-of-causes of ill health—the political economy of health)

Inscribing oppression on the body (i.e. chronic pain, early death, social murder …)
More on the Structural/Systemic Context

Sustaining oppression over time and over geographies: Oppression is borne out in public policy (e.g. health social, economic policy) around the globe...

What are some of the ways that oppression is tethered to public policy?
Health and Social Problems are Worse in More Unequal Countries

Index of:
- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility

Child low-income (family) rates in OECD countries based on market sources and disposable income: late 1990s and early 2000s

Source: Adapted from Corak, M. (Canadian Population Health Initiative, 2007).
Table 1: The Child Poverty League

<table>
<thead>
<tr>
<th>Country</th>
<th>Per cent of children living below national poverty lines</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>2.4</td>
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<tr>
<td>Finland</td>
<td>2.8</td>
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<tr>
<td>Norway</td>
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<td>Sweden</td>
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<tr>
<td>Switzerland</td>
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<tr>
<td>Czech Republic</td>
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<td>France</td>
<td>7.5</td>
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<td>Belgium</td>
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<td>Hungary</td>
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<td>Luxembourg</td>
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<td>Netherlands</td>
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<td>Germany</td>
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<td>Austria</td>
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<td>Greece</td>
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<td>Poland</td>
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<td>Spain</td>
<td>13.3</td>
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<td>Japan</td>
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<tr>
<td>Australia</td>
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<tr>
<td>Canada</td>
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<tr>
<td>UK</td>
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<td>Portugal</td>
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<td>New Zealand</td>
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<td>Italy</td>
<td>16.6</td>
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<tr>
<td>USA</td>
<td>21.9</td>
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<tr>
<td>Mexico</td>
<td>27.7</td>
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</tbody>
</table>

The bars show the percentage of children living in ‘relative’ poverty, defined as households with income below 50 per cent of the national median income (details of the calculations and years to which data refer are given on page 32).
Socio-Economic Status & Cognitive Development

Average incomes for families, two persons or more, in constant dollars (adjusted for inflation), Canada, 1996-2005

Income Gains at the Top Dwarf Those of Low- and Middle-Income Households


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Global Distribution of Income

The richest fifth receives 82.7% of total world income.

-11.7% of income

2.3% of income

1.9% of income

Poorest
1.4% of income

Each horizontal band represents an equal fifth of the world's people.

The poorest fifth receives 1.4% of total world income.

Source: Werner, 2001: Address to the Global Assembly on Human Rights and Health
Odds of Escaping Child Poverty vs ‘Left’ Cabinet Share

What can we be doing?

First..

If you're not outraged, you're not paying attention.

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What can we be doing?

- Educate ourselves, our families, our colleagues about public policy and the **politics** of SDH inequities
- Continue to **politicize** practice
- Re-orient public services for **critical** social justice...more than lip service...

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What might re-orientation look like?

Example: Chronic disease prevention

Ontario Public Health Association (2010):

Health Promotion:
Working with government and stakeholders to build community capacity to speak out for healthy policies and supportive environments that address health issues.

Example:
Training parents in planning, shopping and preparing food; walking school bus; legislation requiring restaurants to post nutritional content on menus.

Systemic/structural/justice approach: (McGibbon & Hallstrom, In Press)

Health Promotion:
Developing policy-entrenched mechanisms to provide the material and social conditions to increase political action capacities of citizens (e.g. eradication of poverty and unemployment).

Example:
Creating a robust national network of federally funded community health centers that follow the principles of the Alma Ata Declaration to mobilize parents for social action to decrease child health inequities.

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Participatory Democracy

...translating democracy to practice, education, policy-making, research...

- Taking sides
- Acting in solidarity
- Taking risks
- Developing political literacy
- Listening to dissenting voices

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Participatory Democracy

...how to translate to practice, education, policy-making, research?

• Taking sides
• Acting in solidarity
• Taking risks
• Developing political literacy
• Listening to dissenting voices

• Educating for social change
• Questioning the status-quo
• Exposing the power of language
  (UK, 2008)

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...and, according to Raphael (2008)...

Carrying out the action areas of the Ottawa Charter would be a good beginning 😊...

• build healthy public policy  
• create supportive environments for health  
• strengthen community action for health  
• develop personal skills  
• and re-orient health services

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More resources...
Unnatural Causes...is inequality making us sick?

“We hope that UNNATURAL CAUSES and its companion tools, like this ACTION TOOLKIT, will help you tackle health inequities by bringing into view how economic justice, racial equality and caring communities may be the best medicines of all.”

Larry Adelman
Executive Producer
December 2007
Go to the **Policies of Exclusion, Poverty and Health** website

(over 30 thousand visits so far)

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Policies of Exclusion, Poverty and Health:
Stories from the front
Crystal Ocean, 2007
ICN Equity and Access Toolkit
May, 2011
“Capitalism: A Love Story examines the impact of corporate dominance on the everyday lives of Americans (and by default, the rest of the world)…” (Film Jacket)
“...nor have economists, whom we might expect to focus attention on such a dramatic trend, expressed much concern about widening inequality. For the most part, economists concern themselves about efficiency and growth.

In fact, some of them argue that wide inequality is a necessary, if not inevitable, consequence of a growing economy... whether to distribute wealth more equally, or what might be gained by doing do, is a topic all but ignored by today’s economic researchers.”

(Preface, The Spirit Level, 2009)
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