OUTLINE OF DEFINITION, PRIORITIES AND ACTIVITIES
HEALTH OVER THE LIFE COURSE THEMATIC CLUSTER

Beatriz Alvarado
Amélie Quesnel-Vallée

Definition
Despite decades of universal health insurance coverage, most developed countries are still faced with glaring health inequalities that are not reducible to lifestyle and health behaviours, and that bear a strong relationship with many social determinants (Buckley et al., 2006a, 2006b; Trovato and Heyen, 2006; Trovato and Lalu, forthcoming). This situation has been deemed of such concern to researchers and policymakers alike that limiting these inequalities has been put at the forefront of the agenda of many governing bodies. Social inequalities in health are generated by the accumulation of vulnerabilities and risks that begin at conception and that may be compounded or mitigated by the intervening life experiences (Robine et al., 2006). These inequalities are also thought to be the product of multigenerational processes that combine genetic and social risks (Quesnel-Vallée 2004; Quesnel-Vallée and Taylor 2006; Wu, Penning, and Schimmmele, 2005; Wu and Schimmmele, 2005). Research in a lifecourse framework can inform social policies that would mitigate the downward spiral of these processes of cumulative disadvantage (Bourque and Quesnel-Vallée 2006; Keating, et al., 2006).

Research priorities
There is a constant interaction between health and social determinants via both health selection and social causation over the life course. Therefore, the research priorities of the cluster should be oriented towards integrating both directions - from health to social dynamics (health selection), and from social dynamics to health (social causation) - and providing the best evidence to propose and implement social and health policies. The selection of research priorities should be consistent with: 1) health needs of Canadian populations (see for instance social determinants in www.phac-aspc.gc.ca), and 2) global health concerns (i.e. recommendations from the WHO Commission on Social Determinants of Health -CSDH). Following such principles will lead us to certain areas of research as follows:

Early child development and education: this includes child survival, physical and nutritional development, and social, emotional, language and cognitive development. This area of research is the top priority of the policy agenda of the CSDH and the Public Health Agency of Canada. Current programs that aim to protect early childhood education and health do not cover the needs of 65% to 85% of the Canadian’s family. Quality in children’s education and care is an issue and funding has decreased since 2001. Data on infants and youths are available in Canada and may facilitate comparative studies, and translation of evidence into policy recommendations. In this area, it will be important to ask: 1) To what extent does health status early in life influence individuals’ chance of social mobility in early adulthood (educational attainment)? 2) To what extent
does health status early in life influence labour force participation of parents and family functioning? Similarly important is to provide evidence on direct policy questions such as: 3) How do social policies aimed at protecting families with young children affect children’s survival and development? 4) How can policies that assist parents in balancing work and family time protect children’s development and survival?

Youth’s health and social capital: Youth’s health is shaped by many social conditions (urbanization, global markets, health systems), and this is manifested by their high vulnerability to unhealthy behavior, violence, unintentional injuries, obesity, and mental health problems. Schools are a good place to start interventions that reduce those vulnerabilities. Canada has achieved good standards of public education, but at the same time there appears to be inequalities among health of the students distinguished by socioeconomic, ethno-cultural, and gender differences. Further research evidence may be needed on 1) the impact of adolescent health behaviors such as smoking, binge drinking, and physical inactivity on human capital development and labor force participation in early adulthood; 2) on how poor mental health in adolescence and young adulthood affect human capital development and family formation; and 3) on the effectiveness of interventions such as school policies on health and social outcomes (educational success). This is one area where collaborations between thematic clusters may be particularly fruitful, notably with the lifelong learning and literacy cluster.

Employment and health: This aspect includes all types of working conditions: financial security, social status, personal development, social relations, physical and psychosocial hazards. This is especially important in the Canadian context, since employment has important interaction with gender, immigration, and race/ethnicity. Some data reveal that workers' compensation practices -which were designed to address physical trauma in a world of manual, blue-collar, male work- have not changed since 2000. Soft tissue injuries, such as repetitive strain injuries affecting female clerical and service workers, are under-reported and under-compensated. The types of questions for which we may need evidence are: 1) What effects do health shocks (e.g., onset of new chronic conditions) in adulthood have on income and labour force participation in Canada? Are those effects different for women and men? Are those effects different for immigrants, non immigrants or first nations people? 2) What are the gender-specific conditions and health linkages in Canadian work places? Regarding policy initiatives, 3) we may want to know what the most effective working policies are in regard to reducing job hazards or increasing quality of life among unemployed Canadians.

Social protection and health: According to the CSDH, social protection can cover a broad range of services and benefits, including basic income security, entitlements to non-income transfers such as food and other basic needs, services such as health care and education, and labour protection and benefits such as maternity leave, paid leave, and childcare. As examples, in the resource-dependent regions of Canada unemployment is higher and long periods of unemployment are more frequent, and available jobs are often precarious and poorly paid, which leads to lower benefits. Women in Canada are more likely than men to be unemployed and underemployed, and to face job insecurity. Evidence may be needed on: 1) how health conditions influence the access to social and
income security at different stages of the lifecourse? 2) What are the health conditions that impact more negatively the social and living conditions of families and older populations, specially in resource-dependent areas of Canada?; and regarding research priorities in terms of interventions: 3) What are the interventions that may help women to balance work and family, and how they are translate in better health outcomes? What are the effects of universal health coverage on the health of populations?

Social exclusion and health: As proposed by Public Health Agency of Canada-PHAC, “social exclusion refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources. These inequalities arise out of discrimination related to race, class, gender, disability, sexual orientation, immigrant status and religion”. Some examples of social exclusion in Canada are: 1) many new immigrants work in unsafe conditions, most workers from racialized groups have no standard benefits such as sick leave, disability insurance, pension or maternity leave; 2) members of minority groups often face institutionalized racism in the health care system, which is characterized by language barriers, stereotypical views held by some health professionals, lack of cultural sensitivity, barriers to access and utilization, and inadequate funding for community health services. It will be important that the cluster finds answers to the following questions: 1) What are the programs and policies available to reduce social exclusion of immigrants in Canada? 2) What are the health conditions that put some social groups (homosexuals, single parents, immigrant women, first nations people) at risk for social exclusion; 3) How social exclusion from social activities affect the mental health of older persons; 4) What activities are effective to increase social participation of the elderly in the society? This is again an area where collaboration with other thematic committees will prove essential.

Activities proposed
In spite of the need for policies that address health and its social determinants, “the bulk of actions for health promotion and the reduction of disparities in Canada has been directed at the level of the individual”, and the reports on failure to reduce inequities are increasing. It is unclear why policy makers appear to have difficulties in integrating upstream policies (i.e. policies acting on social determinants) within health promotion activities in Canada (perhaps due to the current socio-political context of Canadian society?). Little guidance is available (nationally and internationally) to help policy-makers and practitioners integrate these two levels of action so as to act upon the full range of social determinants of health. Therefore, we belief that the activities of the cluster should be oriented in creating the best evidence, the tools and techniques that would help to integrate the life course framework into policy and program design.

For that purpose, the main goals and the activities proposed of cluster of life course and health will be:
Goal 1. To provide the best evidence available from local, regional and national levels policies that respond to needs within the five above mentioned priorities:

1) Generate activities aiming to identify data (local, regional, national and international) that describe the status of health disparities and that can help monitor changes, identify populations at risk, and evaluate policies. The first step may include the creation of a repertoire of all possible local and national agencies that manage health data and include it in the website of the cluster. This activity may be complemented with visits to Statistics Canada, and seminars that bring researchers, statistics consultants and epidemiologists together with the purpose of detecting information gaps on health and social stratifiers: education, employment, social protection, social integration, gender, race/ethnicity and immigration status (details on requirements to monitor social determinants could be discussed in those seminars). In addition, we could plan workshops on how to present data, how to transmit information to the public and decision makers, how to make reports on statistics on health and social factors effective and well understood. This could be done in collaboration with the Quebec Interuniversity Center for Social Statistics, a Statistics Canada RDC, and researchers from across Canada could be invited to participate. The Cluster could provide funding for their travel expenses on a competitive basis, along the lines of many summer schools (see the ICPSR Summer School http://www.icpsr.umich.edu/sumprog/ or the Rand Summer Institute http://www.rand.org/labor/aging/rsi/).

2) There are established research networks that are trying to synthesize the evidence on strategies that reduce disparities in health using a similar approach to that used by Evidence-Based Medicine. Some European and Canadian Initiatives are creating databases of health and social good practices (DETERMINE; Cochrane Health Equity field, CAMPBELL collaboration). We could invite coordinators of those networks to seminars or workshops to find common needs and create collaboration. We will explore the possibility of creating web links to those best practices databases in our web page. If necessary, we can follow the “best practice” approach to identify existing projects, programs or policies that address any of the five research priorities and extract information on impact, effectiveness and cost-effectiveness. Our main interest will be in evaluating the impact of such programs or policies on reduction of inequities and vulnerabilities with the life course priorities in mind.

3) Promote pilot projects or synthesis projects among students and researchers in social and medical sciences which would have as a main goal the integration of evidence about interventions that address the five priority areas. Such interventions may have a macrosocial perspective (evaluation and comparison of national policies) or a local perspective (regional programs), and could include systematic reviews, cost-effectiveness analysis, or qualitative synthesis, and could be focused on vulnerable groups (sexual workers, immigrants, unemployment families, people living with disabilities). To achieve this, workshops to train researchers, students and decision makers on quantitative and qualitative approaches to evidence synthesis could be planned. The experience from the EPPI center on synthesis of policies (Evidence for Policy and Practice Information coordinating center-UK) and the CAMPBELL collaboration could be very valuable in this activity.
Goal 2. Promote pilot projects for the implementation of innovative approaches to address life course and health priorities.

1) The first action is the creation of research networks to establish criteria for innovative approaches in terms of implementation and evaluation of social and health programs and policies. This may include the organization of forums or seminars as part of the educational curriculum for students of social sciences, public health and epidemiology.

2) A second action is to promote (lobby for), at the level of national and regional agencies, funding for projects that explore innovative approaches to life course and health. This may include encouraging the use of data from Canadian surveys (again through summer schools or workshops for instance) and to financially support researchers in the diffusion of results.

3) Once innovative approaches have been established, it will be important to request the support of research-funding agencies in Canada for grant opportunities that specifically fund projects on implementation and evaluation of such innovative approaches to respond to the research priorities (pilot projects or catalyst grants).

Goal 3. Design and implement awareness raising and capacity building activities

1) Elaborate policy maker consultation projects (possibly as the DETERMINE project). This consultation will generate insight into what information policy and decision makers will need with respect to the life course social determinants of health, what their current awareness is, and their preparedness and capacity to address life course priorities in their policy sector. It will include consultations with national politicians, senior advisors, government official or regional politician, or a local decision maker/politician. The PWFC initiative is already providing a good platform for this goal.

2) Promote pilot projects that seek to better understand the policy making process in Canada. There are different theoretical frameworks to address this issue. We would like to create forums of discussion on what could be the more relevant framework to carry out this initiative, and involve researchers and decision makers in reaching such decision. Students, public health practitioners, and researchers would be invited to present projects and diffuse results in conferences or through the media.

Web pages of interest to this cluster:

Public Health Agency of Canada

DETERMINE project
http://www.health-inequalities.eu/

Commission on social determinants of health