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Article

"It's a tradition of naming injustice": An oral history of the social determinants of health – Canadian reflections, 1960s-present

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ABSTRACT

The 'social determinants of health' (SDOH) approach in Canada is widely acknowledged as having emerged through contributions such as the 1974 Lalonde Report or 1986 Ottawa Charter. Drawing on original oral histories, I consider this history through the reflections of past and present leaders in Canadian public health. Through this rich information, I identified three phases in the recent history of the SDOH, from a social awareness (1960s-1970s, when participants underwent training and gained exposure to social and health inequities), to a loose collection of theoretical and empirical concepts (1970s–1990s, when the evidence base on health inequities and the mechanisms behind them began to solidify), to a distinct research approach (2000s-present, when high profile events led to acceptance of the SDOH approach) that encompassed the spirit of its previous iterations. This paper will be of interest to health researchers and professionals, decision-makers, and trainees as they contemplate their own role in this ongoing history.

1. Introduction

Canada is widely credited for facilitating early developments in SDOH history through catalytic contributions such as the 1974 *Lalonde Report* (Lalonde, 1974; Canadian Public Health Association, 2008; Commission on the Social Determinants of Health, 2008; Raphael, 2009; Health Canada, 2014; Raphael, 2011; Raphael, 2008; Young, 2005; Canadian Public Health Association, 2014; Public Health Agency of Canada, 2014; Low & Theriault, 2008; Johnson et al., 2008; Sparks, 2009; Reutter & Eastlick Kushner, 2010; Loe, 2012; Hancock, 1985; Irwin & Scali, 2007; Green and Allegrante, 2011; Graham, 2004). Known formally as *A New Perspective on the Health of Canadians*, the report is credited as the first government document in the western world to draw attention to the determinants of health that lay outside of the health care system (Hancock, 1985; Lalonde, 1974). Some (Irwin & Scali, 2007) have suggested this report 'crystallized' SDOH into a global public health movement. However, a gap remains concerning how the Canadian context contributed to the development of the SDOH approach.

This history is drawn from in-depth interviews conducted with individuals who have held decision-maker, academic, and practitioner roles in Canadian public health. I supplement these oral histories with the analysis of archival materials from the Canadian Public Health Association, Library and Archives of Canada, academic literature, and government documents. In line with the conventions of socio-historical research using oral histories, I present my findings as a narrative, but include a detailed methodology section as a supplementary file.

2. Social awareness sparks a paradigm shift in public health

As a generation of future public health leaders underwent their training in medicine and social sciences during the 1960s-1980s, they gained exposure to social and health inequities. These early exposures coincided with a heightened period of social activism in Canada and were essential to bringing social justice back into public health at a time when medicine "was all about engineering and technology and science" (Hancock, 2016). Participants developed an internal commitment to act on the health and social inequities they observed, which helped to shape the ideas formative to the SDOH.

Ronald Labonté, Canada Research Chair in Globalization and Health Equity at the University of Ottawa, identified social change movements such as feminism, environmentalism, and political progressivism as having an important influence during the postwar period. As Labonté explained, his "generational cohort essentially came out of the more radicalized period of the '70s or '80s and then found themselves in positions [in public health… W]e brought all that movement knowledge and tried to muck about with what we could where we were, in terms of where we worked" (Labonté, 2015). Monique Bégin, for example, reflected on the influence of social change in her journey to becoming Canada's federal Minister of Health and Welfare. Bégin, a

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feminist sociologist, recalled that she had always understood that social change "was always about social issues, the reforms needed, and the cultural openings on the world" (Bégin, 2015). Bégin became the Minister of National Health and Welfare in 1977-9 and again in 1980-4 and during her last year in office she introduced the *Canada Health Act, 1984* that reduced barriers to medical care for Canadians through its principles of universality, portability, public administration, accessibility, and comprehensiveness (Canada Health Act, 1985).

2.1. International development and community development

In the context of decolonization, the Canadian International Development Agency (CIDA), which was established in 1968, and its affiliates supported a number of projects in the decades following the Second World War to strengthen community health services in the global south, in part by leveraging the experience of professionals and trainees from nursing, medicine, and community development (Glass, 2017; Dafoe, 2015). Gerald Dafoe, who worked as the Executive Officer of the Canadian Public Health Association (CPHA) from 1973 to 2003, recalled that how at one time, the CPHA worked simultaneously in 45 countries to "build strength in the community so they could delivery whatever program [their international partner country] felt was necessary" (Dafoe, 2015). In North America, physicians who came to be involved in the SDOH reflected on how concepts from international development were adapted and incorporated into their medical training, particularly through consciousness-raising and community development.

Medically-trained participants also made connections between health, inequities, and social justice through their clinical training experiences (Hancock, 2016; McIntyre, 2016; Butler-Jones, 2016). David Butler-Jones, who served as the first Chief Public Health Officer of Canada from 2004–2014 (Butler-Jones, 2008), recalled his experience working with a suicidal woman during his family medicine residency at Queen's University during the late 1970s (Butler-Jones, 2016). The woman, Butler-Jones explained, "was a single mom with few friends, little education, no family around, [and a] couple of little kids that she was trying to raise on welfare" (Butler-Jones, 2016). He credits this experience as leading him on a path oriented in prevention that addressed social influences on health, by considering the "things that matter and that go well beyond what clinical medicine and the field of treatment […] can do" (Butler-Jones, 2016). Around the same time, in 1982 Lynn McIntyre, a renowned poverty researcher and Professor Emerita, took a job as a staff physician in Sioux Lookout, Ontario. It was in this Indigenous community where she witnessed "the complex context health is created in" (McIntyre, 2016). She remembered working with a particularly troubled woman whose condition was contextualized only by the explanation that she had attended residential schools. At the time, McIntyre remarked, "nobody knew what that meant" (McIntyre, 2016) other than the fact that it had disrupted the community. Her patients also faced hardship from their community's lack of basic health needs, such as no running water, latrines, and inadequate housing (McIntyre, 2016). During her time with this community, she explained, she began to connect how the health conditions she treated "were really rooted in lots and lots and lots of community problems" (McIntyre, 2016).

Marie de Loyer, a retired public health nurse, professor, and founding member of the Loyer-DaSilva Chair in Public Health Nursing, recalled her job as a nurse in the emergency department of the Ottawa General Hospital in the late 1960s. "People came from the streets with various health issues and complex problems," de Loyer reflected, "They had very serious medical issues, but really to do anything helpful for them we had to be able to work with them from a community perspective […by making] a number of contacts with the social workers, and with the public health nurses out in the community" (de Loyer, 2016). The desire that de Loyer expressed, to reform conditions for those suffering from social and material disadvantage, seems to have materialized for many participants early in their careers. As Butler-Jones recounted from his medical training, "Very early on […] I was really interested in the 'so what do you do about it?' as opposed to just more documentation of the problems" (Butler-Jones, 2016).

2.2. Health promotion: a paradigm shift in public health

As discussed elsewhere (McKay, 2000; Lalonde, 2002), the *Lalonde Report* initially had limited impact in Canadian government and public health for offering ideas without concrete solutions. Outside of Canada, however, the report gained an international following, in part due to Ivan Illich's acknowledgement of the "courageous" report in the first pages of his 1976 book, *Medical Nemesis: The Expropriation of Health* (Illich, 1976). Throughout the 1970s and 1980s, the *Lalonde Report* gained a slow and steady following in Canadian public health as it circulated among health professionals, government departments, and policy makers. Over time, the new way of thinking proposed by Lalonde would come to be known as health promotion, which was later ratified in the *Ottawa Charter on Health Promotion* as "the process of enabling people to increase control over, and to improve their health" (World Health Organization, 1986).

For participants, the *Lalonde Report* synthesized several ideas that had been circulating on the root causes of illness. Trevor Hancock recollected his first encounter with the health field concept in early 1975, noting that it "in a sense, it confirmed and put in writing what I had already figured out in the back of my mind" (Hancock, 2016). For Lalonde himself, one of the main contributions to public health that he credited to the report was its "formal government integrated approach to health issues" (Lalonde, 2015). Lifestyle, Lalonde recalled, was adopted as a of the focus of the federal health department, because "it was not a matter of jurisdictional conflict with provincial governments. Nowhere in the Constitution does it say 'Lifestyle is a provincial or a federal matter.' Everybody can do something about this" (Lalonde, 2015).

Some of the ways that health promotion was taken up in public health came directly from government, such as its establishment of a Health Promotion Directorate in 1978 (Pederson & Rootman, 2017) or the Health Advocacy Unit that was established by the City of Toronto in 1979 and operated until 1982 (Hancock, 1984; MacDougall, 1990). Labonté described the Advocacy Unit as a "hot bed of activism," that represented that "there is a shift that's underway" (Labonté, 2015) as members of the public health community began to challenge the biomedical assumptions of disease causation.

Academic think tanks of the 1980s also brought attention to the non-medical determinants of health. The Canadian Institute for Advanced Research is one well-documented example. A lesser-known example is that of Paradigm Health, a futurist think tank that formed after the Health Advocacy Unit disbanded in Toronto. Suzanne Jackson, co-Director of the WHO Collaborating Centre in Health Promotion, remembered that the group did "future scenario work" and "causes of the causes work" (Jackson, 2016). At one point, Jackson reflected, Paradigm Health presented a report they had prepared for the Ontario Minister of Health, which outlined "three major components to any health strategy or approach. Those were: learning the art of being well, providing rescue services to all, and creating a supportive environment" (Jackson, 2016). According to Jackson, "some of the ideas from Paradigm Health were carried forward into the *Ottawa Charter* discussions" (Jackson, 2016).

Another predecessor to the *Ottawa Charter* was the 1984 conference in Toronto, "Beyond Health Care: From Public Health to Healthy Public Policy" (Hancock, 1984). At this conference, which was chaired by Hancock, over 200 delegates came together to consider the health impacts of economic and social policy, and to brainstorm new ways of developing "healthy public policy" (Hancock, 1984). This work continued two years later at the First International Conference on Health Promotion ("the Ottawa Charter conference"), which the present Chief

Executive Officer of the CPHA, Ian Culbert, described as a "sea change" in the history of the SDOH because it "set the stage" for SDOH work, and talked about the SDOH "without using that language" (Culbert, 2015).

A key figure in the history of health promotion is Ron Draper, a public servant who served as the inaugural Director General of the Health Promotion Directorate when it was established in 1978. Draper, who is widely credited by his colleagues as a "master thinker" (Edwards, 2015), was vital to the organization of the *Ottawa Charter* conference and "hugely important" (Hancock, 2016) in the development of health promotion. In fact, Marie de Loyer stated that, "In my view, Ron Draper really was the person who initiated [and] coined the concept of health promotion in the federal government and worked very determinedly for its acceptance" (de Loyer, 2016). Another "one of Ron's many great achievements," was convincing then Conservative Minister of Health, Jake Epp, the value of health promotion and "radical things like equity" (Hancock, 2016). Peggy Edwards, who worked for Draper's Directorate at the time, recalled hearing how Draper had booked a meeting with Epp where he "propose[d] to him that we write a policy document on health promotion" (Edwards, 2015). Ultimately, the outcome of this meeting was the development of the 1986 *Achieving Health For All: A Framework for Health Promotion.* Suzanne Jackson remembered how the *Epp Report* "was considered leading edge" and "really put the whole concept of healthy public policy, and citizen engagement, and 'social determinants of health' right in there" (Jackson, 2016). Hancock even posited that the *Epp Report*, which was published and distributed at the same time as the *Ottawa Charter*, "was basically a reframing of the ideas and principles of the *Ottawa Charter* in Canadian terms" (Hancock, 2016).

3. Fractures and tensions in public health, 1980s–1990s

Despite the enthusiasm and symbolic adoption of health promotion in federal government, for instance, by labelling programs under 'health promotion' (Edwards, 2015) as early as 1981, members of the public health community began to take issue with the way that health promotion had been implemented into practice across Canada. In some cases, critiques of health promotion arose from the practice base, among the same people who had expressed earlier enthusiasm. Ron Labonté and co-author Susan Penfold, a professor in child and adolescent psychiatry, critiqued health promotion for "ignor[ing] the social context which conditions attitudes and shapes behavior," such as the "pathogenic social structures" of poverty, sexual inequality, racism, occupational hazards, and environmental pollution in a 1981 manuscript (solicited by Ron Draper) (Labonte & Penfold, 1981).

One attempt at re-orienting health promotion towards recognizing the broader influences of health was the Healthy Cities Movement that aimed to change environments to support health promotion and disease prevention (Wadell, 1995). As Hancock recalled of Healthy Cities, "it made the principles of the Ottawa Charter concrete and took them out on the streets.[…] I mean, you can theorize all you like, but if you don't change what you do on the ground then does it really matter?" (Hancock, 2016)

Another competing intellectual framework to health promotion was population health. This approach aimed to move beyond health promotion's focus on individuals to address the "interrelated conditions and factors that influence the health of populations over the life course" (Public Health Agency of Canada, 2012). By and large, population health in Canada arose out of the Population Health program of the Canadian Institute for Advanced Research (CIAR), led by its founding president James (Fraser) Mustard in 1982 (Fraser Mustard Institute of Human Development, 2016). The CIAR was important in developing some of the SDOH's foundations, through its work interrogating the biology of "the determination of health" (Frank, 2016) and the "heterogeneities in health status," that is, why some population groups are healthier than others (Hertzman, 1994). Importantly, CIAR was essential in bringing together a number of important but disparate findings on social gradients of health that were crucial to the development of population health in Canada.

It was during the 1990s that population health began to "squeeze out" (Raphael, 2008) health promotion in public health at the national level; the new approach was taken up nationally by Health Canada as a major research theme and topic of policy reform which created a tension in public health that has been examined in depth elsewhere (Raphael, 2008; Coburn et al., 1996; Coburn et al., 2003; Poland, Coburn, Robertson, & Eakin, 1998; Raphael & Bryant, 2002; Robertson, 1998). This new tension emerged among those who supported health promotion, those who supported population health, and those who were critical of both approaches. Looking back on this period from a contemporary standpoint offers insight into how it contributed to the development of the SDOH. In the words of Labonté, "in many ways you can see social determinants of health as being where health promotion and population health battled it out with each other" (Labonté, 2015).

According to John Frank, during the 1990s those working at CIAR were not trying to influence policy, but influence policy they did. By the early 1990s, the population health approach had gained the support of government health departments at the federal and provincial levels (Hayes & Dunn, 1998). For example, the Canadian Institute for Health Information (established in 1994) included a Population Health Initiative in 1999 (Canadian Institute for Health Information, 2006), due largely to the influence of John Frank (Bégin, 2015). In 1996 Tariq Bhatti and Nancy Hamilton of Health Canada had attempted to overcome tensions and bridge population health and health promotion by illustrating how action on the determinants of health could be achieved through health promotion strategies in their Population Health Promotion model (Hamilton & Bhatti, 1996).

Perhaps somewhat predictably, alongside the period of theoretical and empirical advancements described above came a strong and at times urgent need to re-focus public health efforts on more pressing issues, such as communicable disease outbreaks (e.g., HIV/AIDS, SARS). Finding a balance between disease prevention, treatment, and health promotion is a challenge that has persisted throughout the history of the SDOH in Canadian history. Yet, as public health tackled its priorities and issues, they did so in ways that advanced the understanding of SDOH that was developing.

4. New commitments and the distillation of a research approach

By the early 2000s, the fractures in public health and the academic disciplines related to public health (e.g., population health) began to give way to the acceptance of the SDOH as a unifying, coherent approach. This acceptance is apparent through developments that took place in government, academia, and non-government organizations.

Several government initiatives helped promote the SDOH approach in Canada. In 1996, the Federal, Provincial, and Territorial Advisory Committee on Population Health prepared the *Report on the Health of Canadians* to advise the Conference of Deputy Ministers of Health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996). The report was also intended to communicate with the public about "the factors that influence their health" and to "serve as a tool to help policy makers, health workers, and the public measure Canada's progress in achieving better overall population health…" (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996) The report considered determinants of health, including income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996). Three years later, Health Canada published *Toward a Healthy Future: Second Report on the Health of Canadians* in 1999 (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). It was in this report

that the well-known story "Why is Jason in the Hospital?" was published. The "deceptively simple story," which was written by Peggy Edwards, "speaks to the complex set of factors or conditions that determine the level of health of every Canadian" (p.vii) (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). The story asks a simple question that challenges readers to consider the social and economic factors that have contributed to Jason being in the hospital, such as his neighbourhood and his parents' employment (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Another government initiative that helped solidify the SDOH approach to public health was the establishment of the Canadian Institutes of Health Research (CIHR) through an Act of Parliament in 2000 (Canadian Institutes of Health Research Act, 2000). One of the CIHR's 13 institutes was the Institute of Population and Public Health (IPPH). This event was significant in the history of the SDOH because IPPH explicitly addressed the SDOH in its mandate. The IPPH has been and continues to be essential to SDOH-related research in Canada. As one example, IPPH would later become a funder of Ron Labonté. and colleagues' transdisciplinary research network on globalization and health (Raphael, 2016; CIHR, 2012), which represents "a huge advanced in terms of creating this idea of an entire global system that creates inequities" (McIntyre, 2016).

4.1. The first university course on the SDOH

University courses helped to solidify a more coherent SDOH approach. Ron Labonté and Ann Robertson are credited as having developed and taught the first course on the SDOH in Canada in 1993/4 (Raphael & Bryant, 2015). Labonté, who at the time was working as an associate professor at the University of Toronto, recalled his difficulty in bringing the concept of the SDOH into his graduate-level Community Development course, which was radically different from the health education concepts that students were accustomed to (Robertson, 2015). As Labonté remembered, before 1993:

> there had been no concentrated effort to try to theoretically draw together social epidemiology and actually do a course that talked about these non-medical determinants of health, the risk conditions of people's lives (Labonté, 2015).

The syllabus that Labonté and Robertson developed for their course, which was listed as a sociology of health and illness course, stated that "the course is not so much about what the social determinants of health 'are' as it is about a critical analysis of competing discourses on [the causes of] health" (Robertson & Labonteé, 2001). It was novel in its bridging of health promotion, community development, and public health perspectives with critical social sciences.

Dennis Raphael, who is today one of Canada's most renowned SDOH researchers, "became aware of health and the social determinants of health" (Raphael & Bryant, 2015) through his interactions with Robertson and later began teaching a course in the social determinants of health at York University in 2002 (Raphael & Bryant, 2015). Both courses continue at these institutions, today (York University, 2017; Dalla Lana School of Public Health, 2017).

4.2. The Toronto Charter on the SDOH

The 2002 conference, "The Social Determinants of Health Across the Life-Span" was another important milestone in the evolution of the SDOH in Canada. The conference coincided with the tabling of Roy J. Romanow's final report of the *Commission on the Future of Health Care in Canada* in the House of Commons, which included recommendations to strengthen and ensure the sustainability of the health care system. At the conference, which was co-organized by Dennis Raphael, Ann Curry-Stevens, and David Langille, over 400 people came together to outline policy directions for action on the SDOH. As Raphael recalled:

> I thought when this conference was organized, [it] was going to be an opportunity to tell people about the social determinants of health. Four hundred people showed up and within an hour or two they were basically saying, 'We know about this stuff. We're here to find out what to do about it.' (Raphael & Bryant, 2015)

As Raphael's quote indicates, the public health community remained true in their past commitment to seek solutions to health and social inequities.

On the other hand, to some degree the practice of 'conscientizing' seemed to re-enter public health during in the 2000s, as it had during the 1970s-1980s. This time, however, consciousness-raising occurred on the SDOH without interrogating solutions. As Raphael recalled of the 1996 release of Richard Wilkinson's *Unhealthy Societies: The Afflictions of Inequality*, the public health community adopted the notion that "all you had to do was tell people about the determinants and suddenly good things would happen" (Raphael & Bryant, 2015). This idea, that raising awareness on the SDOH would bring change, is mirrored in an earlier critique of 'conscientization.'

An important outcome of the 2002 Across the Life-Span conference, which brought together academics, professionals, and government representatives, was the development of a *Toronto Charter for a Healthy Canada*, spearheaded by Michael Polanyi (Raphael & Bryant, 2015). Toba Bryant recalls that "early on Sunday morning [of the conference] they really knocked themselves out preparing that Charter" (Raphael & Bryant, 2015). The Charter helped to synthesize ongoing ideas about the SDOH that were circulating throughout public health's not-for-profit, government, and academic networks. As Bryant recalled, the Charter included a list of SDOH that "you can affect or shape through public policy" (Raphael & Bryant, 2015). Based on the evidence available at the time, the list consisted of ten determinants: early childhood development, education, employment and working conditions, food security, health care services, housing shortages, income and its equitable distribution, social exclusion, social safety nets, and unemployment and employment security (No author, 2002). As well, the list noted that women, persons of colour, and new Canadians would likely be more vulnerable to the health effects of these SDOH than others (No author, 2002). The Charter resolved that governments, public health and health care associations, and the media move forward the evidence base on the root causes of illness to improve policymaking (No author, 2002). An additional outcome of the conference and its Charter was the impetus that it provided Raphael to compile perspectives on the SDOH and publish a book on the topic, specific to the Canadian context, entitled *The Social Determinants of Health: Canadian Perspectives* (Raphael, 2004). The third edition of this book was published in 2016 (Raphael, 2016).

4.2.1. The WHO Commission on the Social Determinants of Health (WHO CSDH)

As interest in the SDOH has waxed and waned in Canada over time, events on the international stage have maintained momentum on this topic in Canadian public health. A key event, as mentioned earlier, was the 2005 to 2008 WHO CSD.

As John Frank recalled, the WHO CSDH "was cleverly framed to appeal to people's common sense. […] At the end of the day, it's a brilliant piece of work and it just brought all the ideas that he had been researching inside Whitehall into the mainstream" (Frank, 2016). Ian Culbert referred to the WHO CSDH as an "international movement" that "shone the light on [the SDOH] at the global level and got the media interested in it" (Culbert, 2015). Another participant, recalled how "the nomenclature of social determinants of health […] really took hold and gained prominence" after the WHO CSDH, and "built on much health inequalities work that had been going on by many scholars" (Anonymous, 2015). This participant, who was described earlier as involved in shaping the health research landscape of Canada through CIHR's early stages, recalled how the IPPH's second strategic plan,

Health Equity Matters framed the SDOH in an equity way instead of a disparities way, influenced by the work of the WHO CSDH (Anonymous, 2015). In their words, "health equity was in the water supply, essentially, meaning that it was a very prominent term in its use" (Anonymous, 2015).

The WHO CSDH has helped to unite the disparate approaches of public health, internationally, in its efforts to reduce health inequities and brought widespread attention to the SDOH approach (Lucyk, 2017), in public health and also in the public, generally.

4.3. Canadian public health commitment to the SDOH

Advocacy organizations, such as the Canadian Public Health Association (CPHA), have continued to be involved in the SDOH throughout their history and have recently organized their efforts to more directly address the SDOH. Lynn McIntyr, who also served as a former president of the CPHA during 2013–4, noted how CPHA has served as an important "forum for social reformers" and for social reform "to be legitimized as in the interest of health and the collective and that we always have to argue for the unpopular and the lack of common sense ideas" (McIntyre, 2016). Speaking on the history of the CPHA and its role in social reform and calling attention to the influence of the SDOH, she noted: "It's a tradition of naming injustice, of naming individuals as being unnecessarily vulnerable" (McIntyre, 2016). As Ian Culbert, the current Chief Executive Officer of the CPHA likewise noted:

> [T]he undercurrents have always been there, they're just getting better organized as far as what the evidence is and what some of the ideas for action could be or should be. So it's taking shape, almost as a movement you would say, but certainly for people, for supporters, it's become second nature to talk about equity, to talk about social justice, to talk about taking action or the causes of causes[. It] is second nature now. So you're no longer trying to convince the choir, as it were, you have a really well-organized group of supporters. It's: how do you become evangelical about it? How do you start converting non-believers? (Culbert, 2015)

Suzanne Jackson similarly reflected on the need to mobilize civilian action for the SDOH. She recalled the discussions and workshops she engaged in with a colleague from Ontario, Brian Hyndman, and how:

> he used to talk about that if we could figure out how to have a social movement about health promotion and the determinants of health and really engage the public in it, then we would be getting somewhere. But all it is, is a movement amongst the people who work in the field…

Perhaps, as Jackson mentioned, the SDOH's existence as a movement in public health is why it has not galvanized the general public as other movements, such as feminism or environmentalism (Jackson, 2016). However, Jackson's above quote suggests that the social awareness that was sparked among members of the public health community in earlier stages of this history has remained a shared attribute among those who work in SDOH.

5. Conclusions

The history of the SDOH has evolved from a social awareness, to a loose collection of theoretical and empirical concepts, to a research approach. This history developed alongside the overlapping histories of health promotion and population health, their many sub-disciplines that developed, and competing public health priorities. As evidenced throughout this paper, the SDOH – which can today be understood as a research approach – is not a linear nor single history. Indeed, many perspectives exist beyond the 17 represented here that were, by necessity, left out.

In ending this paper, I wish to leave readers with the sense of optimism instilled upon me by interview participants, as well as the many public health leaders who came before them, and after. It seems apt, therefore, in reflecting on the value and history of the SDOH approach that I end this paper with a series of quotes (Table 1) by voices from the past and the present of public health. I believe this speaks to the field's unending commitment to social justice and I invite readers to contemplate their own role and position in the ongoing history of the SDOH.

Table 1
Quotes on the SDOH from past and present public health voices.

On questioning power
"Those who have been more endowed with the talent of health, wealth, and knowledge are but stewards, who must make use of their opportunities for the common good (Atherton, 1911)."
– William Henry Atherton (1867-1950), 1911
Secretary, City Improvement League of Montreal
"[T]he other thing to always remember in this work is that public health or health promotion, to do its job, should be questioning power and equality and questioning the way things are (Hancock, 2016)."
– Dr. Trevor Hancock, 2016
"It's about perspective. I just hope that at whatever level people are working at, you have a little nagging voice like me, who is sitting at the table and saying, 'Let's look at the life circumstances of this group.' Or, 'Let's look at where they live,' you know? Before we fund a program (Edwards, 2015).""
– Peggy Edwards, 2015
On a Common Purpose
"Let us never reach the stage when we cannot abandon something when shown that it is wrong or that it can be improved upon. We should not hesitate a moment when convinced that the time has come for a change. […] Time passes. Life is short. Men come and go. Possibly it is too much to hope for that the individual contribution of any one of us to the cause will be sufficient to be noticeable; but taken in the aggregate, if we carry on, play the game, give the best that is in us, may […it] may cause future generations to adjudge that our labour has not been in vain (Douglas, 1930)."
– Alexander J. Douglas (1874–1940), 1930
Winnipeg Medical Officer of Health
[Referring to past public health conventions in the 1980s]. "It was just an important time to come together and to feel the unity and the purpose of a group who were invested in public health. I mean necessarily we were self-selecting, but very unifying. Because you get a spreading effect, you get people sort of infecting other people with their enthusiasm for what can be accomplished in the group who want to move things along (Mills, 2016)."
– Karen Mills, 2016
On Working across Disciplines on the Social Determinants of Health
"The modern tendency in medicine is to recognize more and more the importance of social conditions in disease, with the result that there is a closer relation between the general practitioner and the social worker. Social service has now its recognized place in most well appointed hospitals (Porter, 1926)."
– George Dana Porter (1870–1963), 1926
President of the Canadian Public Health Association
"I think we're trying to start to get together, but we also have to be respectful in health, at least, that there are many sectors who have been at this for a lot longer than we have, and we've got to be respectful of the hard work that they've put into trying to keep communities healthy with very limited resources. And so it's a struggle, I would say. So health has to add its voice, but in a respectful way, and also know when to get out of the way (Anonymous, 2015)."
– Interview participant (anonymous), 2015

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