Summary for FIRST TEST: chapters 1,4,12,13

CHAPTER 1: Imaging Health Problems as Social Issues

The Social Context of Health and Illness

- Our personal experience of illness means that we tend to view it in an individualistic way
- Health and illness are also social experiences. For example suicide even though it is an individual committing, it occurs within a social context
- Life Expectancy (LE) in the least developed countries is significantly lower than that in industrially developed and comparatively wealthy countries like Canada, Australia and USA
- The living conditions of the country in which you live can be a significant influence on your chances of enjoying a long and healthy life
- The longer immigrants live in their new country, the more their health mirrors that of the local population. This is called the Healthy Immigrant Effect
- LE figures are crude indicators of population health and actually mask significant health inequalities among social groups within a country. For example, In Canada those in the lowest socio-economic group have the highest rates of illness and premature death and have higher rates of illness-related behaviours such as smoking.
- Health sociology concerns the study of such social patterns of health and illness
- Social, economic, cultural and political features of society influence why some groups of people get sicker and die sooner than others

The History of the Social Origins of Illness: Social Medicine and Public Health

- Public Health: policies, programs and services designed to keep citizens healthy and to improve the quality of life
- Links between disease and poor living and working conditions is an outcome of capitalist exploitation
- Epidemiology: the statistical study of patterns of disease in the population
- Social environment played a significant role in the spread of disease

The Social Origins of Health and Illness in Canada

- Social Determinants of Health: social and economic environments in which people live that determine their health. For example: housing, education, working conditions, social class, gender
- Edwin Chadwick was a key figure in the development of the first Public Health Act in 1848 based on his ‘sanitary idea’ that disease could be prevented through improved waste disposal and sewerage systems

The Rise of the Biomedical Model

- Specific Etiology: the idea that there is a specific cause or origin for each specific disease
- The central idea was that specific micro-organisms caused disease by entering the human body through air, water, food, and insect bites
- The biomedical model is based on the assumption that each disease or ailment has a specific cause that physically affects the human body in a uniform and predictable way
- The model involves a mechanical view of the body as a machine made up of interrelated parts, such as skeleton and circulatory system
- The role of a doctor in this sense is like a body mechanic, identifying and repairing the broken parts
- 'Body as a machine' metaphor represented a significant turning point away from religious notions toward a secular view of the human body
- This model caused people to endorse a belief in the separation of body and soul
- Cartesian Dualism: belief that mind and body are separate entities

The Limits of the Biomedical Model

- Features of the Biomedical Model that are subject to criticism can be grouped under the following terms:

1. The Fallacy of Specific Etiology
2. Objectification and Medical Scientism
3. Reductionism and Biological Determination
4. Interventionist Bias
5. Victim Blaming

The Fallacy of Specific Etiology

- The idea of a specific cause for a specific disease
- Disease causation is more complex than biomedical model implies and is likely to involve multiple factors, such as physical condition, nutrition, stress

Objectification and Medical Scientism

- Patients may become objectified as 'diseased bodies' or 'cases' rather than treated as unique individuals with particular needs
- Patients thoughts, feelings and subjective experiences of illness are considered 'unscientific' and are mostly dismissed

Reductionism

- Belief that illnesses can be explained and treated by reducing them to biological and pathological factors

Biological Determination

- An unproven belief that individual and group behaviour and social status is an inevitable result of biology

Victim Blaming

- The process whereby social inequality is explained in terms of individuals being solely responsible for what happens to them in relation to the choices they make and their assumed psychological, cultural, and/or biological inferiority

Rediscovering the Social Origins of Health and Illness

- Major reasons for the increase in LE were not due to medical treatments, but, rather, to rising living standards, particularly improved nutrition which increased peoples resistance to infectious disease
- New threats to health: personal behaviour, as evidenced through smoking, alcohol consumption, drug taking, diet and lack of exercise

Lifestyle and Risk: From Risk-Taking to Risk-Imposing Factors

- By solely targeting risk-taking individual, there is a tendency to victim blaming by ignoring the social determinants that give rise to risk taking in the first place, such as stressful work environments, the marketing efforts of corporation, and peer group pressure
- Individuals are told to control stress by: exercising, more sleep and eating healthier
- Socio-demographic factors, such as unemployment rate, Aboriginal status, minority status, income, poverty and education are in fact better predictors of health status
- Biopsychosocial Model: multifactorial model of illness that takes into account the biological, psychological and social factors implicated in a patients condition
- Ecological Model: an understanding of health determinants must consider the interaction of social, economic, geographic and environmental factors
- Social Model of Health: focuses on social determinants of health, such as social production, distribution and construction of health and illness and the social organization of health care. It directs attention to the prevention of illness through community of participation and social reforms that address living and working conditions
- The biomedical model focuses on the level of the individual for the cause and cure of disease by attempting to address pathology and/or modify behaviour, assuming individuals are solely responsible for their health
- The Social Model on the other hand assumes health status and health-realted behaviour

- While the Biomedical Model concentrates on treating disease and risk-taking among individuals, the Social Model focuses on societal factors that are risk-imposing or illness-inducing and in particular highlights the health inequalities suffered by different social groups based on class, gender, ethnicity, race and occupation
- A Social Model approach logically implies that any attempts to improve the overall health of the community need to address material conditions, such as poverty, employment opportunities, working conditions and cultural differences
- A critical political economy approach goes a step further in that it considers how forces such as globalization and neo-liberalism affect the way societies are organized

Three Main Dimensions of the Social Model of Health

1. The Societal Production and Distribution of Health and Illness
   - Many illnesses that individuals suffer from are socially produced, they are an outcome of peoples material and living conditions
   - For example, illnesses arising from environmental contaminants, unhealthy workplaces are beyond an individuals control and need to be addressed at a societal level
2. The Social Construction of Health and Illness
   - How definitions of health and illness can vary among cultures and change over time, what is considered a disease in one culture or time period may be considered normal and healthy elsewhere and at other times
   - Homosexuality was once considered a psychiatric disorder
   - Cultural beliefs, social practices and social institutions shape or construct the ways in which health and illness are understood and experienced
3. The Social Organization and Health Care
   - The way particular society organizes funds, and utilizes its health services
   - Unequal relationships between the health professions can prevent the efficient use of health resources and the optimal delivery of health care to patients

How Can Sociology Help? Using a Sociological Imagination

- The social structure is a product of human action and interaction
- Social Structure: the recurring patterns of social interaction through which people are related to each other
- Social institutions such as the media, health care, government and education are formal structures within society that are set up to address identified social needs
- Social groups form as a result of the way that these social institutions are structured
- We exercise agency in our daily lives and in doing so can influence the way society is structured

- Agency: the ability of people, individually and collectively, to influence their own and the society in which they live

The Sociological Imagination: A Template for Doing Sociological Analysis

- Sociological Imagination: sociological approach to analyzing issues
- Thinking sociologically is making a link between ‘private troubles‘ and ‘public issues’
- Example: A sociological analysis of why manual labourers have a shorter LE would examine how and why the work done by manual labourers affects their health by investigating the following four interrelated parts:
- The Sociological Imagination can be viewed as consisting of four interrelated parts:
  1. Historical Factors: to understand why manual workplaces are so dangerous
  2. Cultural Factors: cultural value of individual responsibility and belief systems
  3. Structural Factors: the way work is organized, the role of managerial authority, the rights of workers, the role of the state

  Critical Factors: alternatives to the status quo like increasing effectiveness of occupational health and safety legislation

- To understand the complexity of health and illness we need to move beyond Biomedical approaches and incorporate a Social Model of health

CHAPTER 12: Medicine, Medical Dominance, and Public Health

The Origins of Scientific Medicine

- Early societies attributed sickness to spiritual or supernatural causes, such as evil spirits, direct intervention by gods, or the work of a sorcerer
- They also develop certain skills such as using herbal remedies and setting broken bones
- People with disabilities were viewed as sinners or as the offspring of parents who had sinned
- Barber Surgeons: learned their skills in apprenticeship, performed surgeries, managed open wounds and repaired broken bones
- One of the most important medical advancements in the 17th century was in physiology and William Harvey's experimental proof that blood is conserved and then circulated through the body by the heart
- Specific diseases could be traced to specific pathology in individual organs, hence developed the anatomical concept of disease
- Auenbrugger discovered that he could detect fluid in the lungs by tapping on the chest
- Edward Jenner discovered that persons inoculated with cowpox developed immunity to smallpox
- Rene Laennec invited stethoscope
- Cell Theory: diseases begin when there are changes in a healthy cell; treatment; therefore requires restoring the cell to its normal state
- Germ Theory: micro-organisms (germs) were responsible for infectious diseases in humans and animals and for their transmission among them
- Surgery became safer with the development of both anesthesia and antiseptics
- Joseph Lister discovered that infection was caused by airborne bacteria by applying carbolic acid to the wound, dressings, and surgical instruments which sterilized them, infection could be prevented
- Ultra sound imaging, CT scans, MRIs, endoscopes, heart-lung machines, kidney-dialysis machines, antibiotics, cortisone, and drugs to treat mental illness are all examples of 20th century medicine

Biomedicine/Scientific Medicine

- Biomedicine: the conventional approach to medicine
- Biomedicine, often referred to as allopathic medicine or conventional medicine is considered to be the scientific approach for treating disease and illness

1. The Determinants of Illness Are Primarily Biological

- Mind and body are separate
- Each disease has a specific cause that can be diagnosed by specific medical tests

2. **Biomedical Uses the Engineering Model of the Body**
- Since each disease is thought to be caused by a specific germ, diagnosis and treatment is limited to specific causes and specific parts

3. **Health Care Is Primarily about Curing Illness or Disability**
- Patients are treated as cases rather than as unique individuals who may have a range of specific physical and emotional needs
- Focusing on acute care makes it possible to ignore the effects of social determinants of health, such as unemployment, poverty, and racism, on health or the importance of public health in preventing disease and illness

4. **Medicine Is Scientific**
- There is an assumption that all patients with the same illness will have the same symptoms or will have the same pattern of disease development
- For moral reasons some doctors refuse to prescribe birth control pills or make referrals for abortion
- Women and men can have very different symptoms of impending heart attacks
- Treatments appropriate for one may not be for the other

5. **The Doctor Is the Authority and Expert**
- Allopathic doctors today are considered the ‘master labellers’ of illness
- The ones who have the power to decide what is considered an illness, what the appropriate treatment is, as well as who provides the treatment

The Ascendancy of Medical Dominance
- Medical Dominance: the power of the medical profession in terms of its control over its own work, over the work of other health workers and over health resource allocation, health policy, and the way that hospitals are run
- Medicine was, still is, the most powerful profession in the health system
- Some specific ways where medical power is evident include:
  - Only doctors can formally diagnose disease and sign birth and death certificates, and they have significant control over access to non-medical benefits such as sick leaves, workers’ compensation, and early retirement due to health reasons
  - Doctors’ control of diagnoses and treatment means that they effectively have administrative authority over other health professions
  - Doctors can control access to a range of therapies through the requirement of a doctors referral before other health professions can treat a patient
  - Doctors retain the right to set professional standards about treatment, which can affect hospital expenditures and the work of other health-care workers
  - Doctors control the educational curriculum, as well as the examination and licensing of future doctors

The Emergence of Medical Dominance in Canada

- Most people did not consult a doctor when they were sick in the 19th century but, visited the more affordable spiritual healers and midwives
- Not until the 20th century that hospitals became a place for most medical and surgical procedures
- Prior to that, hospitals were seen as places for the chronically ill, the poor and the dying
- People viewed hospitals as dangerous places with poor hygienic practices and unqualified practitioners
- Those who were middle class or wealthy were treated at home or in doctors office
- Canadian Medical Association was formed in 1867
- To gain dominance, physicians needed to restrict the activities of other health occupations such as pharmacists, homeopaths and eclectics
- Pharmacists eventually agreed to stop prescribing on the condition that doctors stopped dispensing medications
- Doctors gained exclusive control over pregnancy and childbirth and midwifery was relegated to isolated and northern regions of the country
- Medical hegemony was secured through its control of licensing and medial education and the subordination of other health care professionals under the authority of doctors, and by limiting the work of other health workers and restricting competition by denying legitimacy to alternative health practitioners

Challenges to Medical Dominance

The Emergence of the Welfare State

- Welfare State: a system whereby the government assumes primary responsibility for the welfare of its citizens through programs designed to protect and promote the economic and social well-being of its citizens through programs designed to protect and promote the economic and social well-being of its citizens
- Medicare: Canada's universal health-care program, funded and administered by federal, provincial and territorial governments

The Professionalization of Other Occupations

- Social Determinants of Health: refers to the social and economic environments in which people live and which determine their health. (Housing, job security, working conditions, income, education, gender, social class)
- Women's Health Movement: organizations of woman that addressed issues ranging from birth control to poverty.
- This movement has played an important role in legitimating midwifery as a desirable alternative to physician-managed pregnancy and childbirth

Conflicts within Medicine

- Academic and research physicians whose attitudes, interests, and goals differ from general practitioners and specialists

Demystification of Medicine

- Iatrogenesis: any adverse outcome or harm as a result of medical treatment
- Media exposes of medical fraud and negligence have made the public increasingly aware of the potentially damaging effects of medical treatment, referred to as iatrogenesis
- Various forms of scientific dis-honesty have been exposed over the years, in the form of biased medical research, pharmaceutical freud and medial technology freud

The Face of Medicine Today

- Primary Health Care: both the point of first contact with the health-care system and a philosophy of delivery of that care
- Patriarchal: a system of power through which males dominate households
- Women in Canada were not allowed to study medicine until the late 19th century
- In 2008, women accounted for more than half of new general practitioners and close to half of new specialists
- Feminization: a shift in gender base of a group from being predominantly male to being increasingly female
- Women physicians are less likely than men to enter specialty practice and prefer group over traditional solo practice
- Women tend to work fewer hours and see fewer patients but spend more time with each patient than their male colleagues do
- Female physicians on average prefer working in urban areas, have a preference for family medicine and work fewer hours per week

The Role of Public Health and Health Promotion

- Health is now considered to be a state of complete physical, mental and social well-being
- Health Promotion: any combination of education and related organizational, economic, and political interventions designed to promote individual behavioural and environmental changes conducive to good health, including legislation, community development and advocacy
- Public Health: policies, programs and services designed to keep citizens healthy and to improve the quality of life
- Ottawa Charter for Health Promotion: attempt to integrate health education and individual behaviour-change strategies that aim to fundamentally reorient health-care services and public policies to address the social determinants of health

An Individualist Approach
- Focused around educating people to change their lifestyles
- Pressure that the women faced from their children, who saw food advertised on television
- The dominant approach of government and nongovernment health agencies (Canada Cancer Society, Heart and Stroke) remains that of educating the public

A Materialist/Structuralist Approach
- The problem is with governments and powerful corporate interest, such as tobacco lobby, they do not accept responsibility for major diseases in the community
- Putting pressure on people to change their lifestyles is victim blaming
- Victim Blaming: individuals being solely responsible for what happens to them in relation to the choices they make and their assumed psychological, cultural and/or biological inferiority

Public Health In Canada
- The Public Health Agency of Canada (PHAC) focus on the following:
  - Promoting programs to encourage healthy living
  - Preventing and controlling infectious and chronic illnesses
  - Monitoring health and water safety
  - Ensuring emergency preparedness
- Part of this mandate is to strengthen public health
- Chief public health officer states public health is “the organized efforts of society to improve health and well-being and to reduce inequalities in health”
- Health status of individuals deteriorates as one moves from the highest to lowest income gradients; that biological health is influenced by physical and social environments; that factors like adequate housing have a profound impact on health; and that all Canadians pay high price by failing to address these issues
- Physical and social environments have an impact on the types of choices individuals can make about their health
- An individualist model has widespread support because it makes governments look authoritative and active while at the same time it avoids confrontations that might prove politically costly
- The individualist model has the support of the medical profession because it expands medical turf and provides work for epidemiologists, health professionals, psychologists and educationalists
- Epidemiology: statistical study of patterns of disease in the population

CHAPTER 13: Power, Politics, and Values: The Canadian Health-Care System

The Development of Medicare in Canada
- Allopathic Medicine: a name given to conventional biomedicine. Treatment of diseases is by drugs that have effects opposite to the symptoms
- In 1930's and 1940's Canada's health-care system was dominated by private medicine, similar to that in existence in the USA today
- Government initiatives for a national health plan emerged in Canada in the 1930's
- An important player was the Co-operative Commonwealth Federation (CCF)
- In 1947, CCF government in Saskatchewan with Tommy Douglas as premier, implemented the first public hospital insurance plan in the country
- The plan covered everyone in the province regardless of their ability to pay; money to finance
- The plan largely came from taxes although those who had economic means paid premiums
- Hospital and Diagnostic Services Act in 1957, which covered half of the costs of specified hospital services, on condition that services were provided to everyone on an equal basis
- Tuberculosis hospitals and hospitals for mentally ill were not covered

Tommy Douglas: Planting the Seeds of Medicare
- He created new government departments: Department of Co-operatives, Department of Labour, Department of Social Welfare
- Douglas outlined 5 basic principles for a proposed comprehensive plan that would cover everyone
  1. Prepayment
  2. Universal coverage
  3. High-quality service in both urban and rural areas
  4. Coverage that was government sponsored and publicly paid
  5. Coverage that was acceptable both to those providing the service and those receiving it

Federal Developments
- The Liberal government of Lester B. Pearson acted quickly on Hall's recommendations and introduced the Medical Care Act in 1966
- Medical Care Act criteria:
  1. Universality: health services were to be available to all Canadians on an equal basis
  2. Comprehensiveness: all necessary medical services were to be covered

3. Public Administration: the plan was to be administered on a nonprofit basis
4. Portability: the benefits were to be portable across provinces, and were to be guided by accessibility

- By 1972 all provinces were on board
- Doctors determined what was necessary care
- Prescription drugs, dental and eye examinations, physiotherapy, and counseling are generally not insured under the plan unless the services are provided in hospitals
- Under the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF), the federal government revised its 50-50 cost sharing agreement with the provinces and replaced it with block funding
- Now territorial governments would make the decision of how health-care dollars would be spent
- Extra Billing: an arrangement that allowed doctors to charge patients over and above the set payment schedule, for which the patient was not reimbursed
- National-Provincial Health Program for the 1980s recommended eliminating user fees and extra billing, changing mechanisms for physicians fees, and setting national standards for portability, comprehensiveness, accessibility, public administration and universal coverage
- Canada Health Act: act passed by Parliament in 1984 which outlined the 5 principles of Canada's universal, government funded health care system

Principles of Equity and Justice

- The health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria following the matters:
  - Public Administration
  - Universality
  - Comprehensiveness
  - Portability
  - Accessibility
- Noncompliance with the act would result in the loss of transfer payments for health-care services

Romanow's recommendations for change:

- Establishment of a new Canadian Health Covenant as a guide for the health-care system
- The creation of a Health Council to measure and track the systems peformance
- The expansion of insured services under the Canadian Health Act to include diagnostic services and home care
- A dedicated cash-only Canada Health Transfer that would provide stable, predictable and long-term funding to the provinces/territories

- Immediate targeted funds to improve access in rural and remote areas
- Improve wait times for diagnostic services
- To remove obstacles to primary care
- To begin a national home-care plan
- To improve drug coverage for expensive therapies

- Neo-liberalism: a political ideology that advocates the market as the best vehicle for the production and distribution of various resources and an enhanced role for the private sector

Health Care System and Delivery

- Federal government is responsible for delivering health-care services to specific groups (eg. First Nations, members of Canadian Forces, RCMP)
- The plans are financed through personal and corporate taxes, sales taxes, payroll levies, and other revenues
- Most dental services, drugs, counseling, and alternative therapies are paid by private and supplementary plans or paid for directly by the individual
- There are serious disparities in health outcomes within the country:
  - Canada's Aboriginal peoples
  - People who live in remote and rural areas
  - Those in the Atlantic region
- Women in BC expect to live an average of 2 years longer than women in Newfoundland because primary health care services are more comprehensive and readily available in the richer and more populated provinces

Health-Care Expenditures

- The overall expenditure on health care in Canada is at the level that one would expect given Canada's standard of living and is significantly lower than the health expenditures in the USA
- In Canada both public and private sectors finance health-care services
- In Canada the public sector pays for most physician services
- In Canada the portion paid by the sector is about 38%
- Prescription drugs are the biggest cost drivers in health care, both in public and private spending

Health Status

- A number of factors affect and individuals health: biological, socio-economic, and environmental factors as well as the accessibility of health care
- A common measure of health status is life expectancy at birth
- Health Adjusted Life Expectancy (HALE): used as a measure of the quality of life, that is, how many years people, on average, can expect to live in good health

- Both sex and income are important for determining HALE
- Canadians in higher income groups tend to live longer, healthier lives than those in lower income groups
- A widely used measure of health status in a country is infant mortality

CHAPTER 4: Class, Health Inequality, and Social Justice

Defining Class

- Marx spoke of two major classes
  - Bourgeoisie: those who owned the means of production
  - Proletariat: those who sold their labour power

  Also he spoke of another type of class:
  - Petite Bourgeoisie: independent and small business owners
- Upper class own the means of production and/or controls the labour process; included in this group are company presidents and CEOs
- The middle class includes workers who have more control over the work process than those in the working class; this group includes those in middle-management positions, professionals, and the self-employed
- Those in the working class, the third class, have little control over the work process

Inequality Income Distribution

- Measure inequality in income distribution is to divide the population into fifths or quintiles and then compare the share of total income that each group received
- One way for governments to redistribute income so as to increase equality is through taxation and transfer payments, such as unemployment insurance, social assistance and pensions

Inequality in Wealth

- Another important measure of economic inequality is that of wealth, which refers to an individuals value of all assets minus any debts at a given point in time
- Assets include bank deposits, investment certificates, pension plans, stocks, shares, mutual funds, real estate
- Wealth is generally more unequally distributed than income
- Wealth inequality in Canada is high
- According to Davies, some of this increased inequality in wealth is related to the rise in house prices and increased savings in financial assets, such as registered retirement savings plans
- Ruling Class: upper class in society has political power as a result of its economic wealth (upper class)
- Social Structure: recurring patterns of social interaction through which people are related to each other, such as social institutions and social groups

Inequality in Health

- Economic status, living conditions, Aboriginal status, environment, and gender all have a bearing on the health status of individuals

- Health status declines as one’s socio-economic status declines
- Evidence shows higher economic status and income are associated with better health
- Income is also a good predictor of mortality from a range of diseases
- Canadians who live in the poorest neighbourhoods are more likely to die from cardio-vascular disease, cancer, diabetes and respiratory disease than other Canadians
- Income is a determinant of health in itself but is also a marker of other social determinants such as employment, food security and quality of housing
- The Whitehall studies first found a ‘social gradient’ in the mortality of rate of British civil servants, whereby LE increased for each employment level up to the top of the public-service hierarchy
- What explains the strong relationship between income inequalities and health? Possible theoretical pathways include:
  - Material/Structural pathways
  - Behavioural/Cultural pathways
  - Psychosocial pathways
- Gap between rich and poor in Canada continue to increase
- Richard Wilkinson’s argument is that once a country reaches a certain amount of wealth, determined by gross domestic product per capita, and undergoes the ‘epidemiologic transition’ from infectuous disease to chronic disease as the major cause of mortality; increases in national wealth have little impact on population health

12 Determinants of Health

1. Aboriginal status
2. Early life
3. Education
4. Employment and working conditions
5. Food security
6. Gender
7. Health-care services
8. Housing
9. Income and its distribution
10. Social safety net
11. Social exclusion
12. Unemployment and employment security

- Good education is necessary to obtain a secure, well-paying job

- These factors in turn determine the neighbourhood in which a person lives, the quality of housing, access to higher education, the ability to purchase nutritious food, leisure activities, quality of early childhood health
- Unemployment and low income can lead to financial and life stress, which can have health consequences such as high blood pressure and heart disease
- A lack of resources and skills affect the degree in which people can exercise control over their lives, which can contribute to poorer health behaviours such as smoking and over consumption of alchohol

Explaining Health Inequality

- Health inequality can be roughly divided into two main categories: individualistic explanations and materialist/structural explanations
- Individualistic perspectives focus on individual biomedical and behavioural risk factors as the primary contributors to poor health
- Materialist/Structural explanations are concerned with the role of social, economic and political factors in determining the social distribution of health and illness

Materialist/Structural Explanations

- Concern the role of social, economic an political factors in determining the social distribution of health and illness
- Using social determinants of health illustrates a materialist or structuralist approach
- Influences of social structure on health via three pathways: material, psychosocial and behavioral
- Material factors are the concrete living conditions that individuals find themselves in
- These factors determine an individuals degree of political influence and social standing
- Four additional specific pathways that meditate the social determinants of health and health status:
  1. Materialist
  2. Neo-materialist
  3. Life-course
  4. Social comparison models
- From a materialist view, the three key mechanisms are:
  1. Experience of material living
  2. Experience of psychological stress
  3. Adoption of health-supporting or health-threatening behaviours
- The first component, the quality of material life conditions influences individual development, family life and community environments
- The second component focuses on the relationship between living conditions and life-threatening stress

- The third component focuses on the relationship between stress, a consequence of poor material conditions, and various health-threatening behaviours
- Neo-materialist explanations look at how various societies allocate economic and social resources among their citizens
- Life course approaches pay attention to how the various social determinants of health influence health across the lifespan of emphasize the accumulated effects of adverse social and economic conditions
- Latent effects are biological or developmental early LE's such as low birth weight, which can be good predictors of heart disease and adult onset diabetes later in life
- Pathway effects refer to experiences that set individuals onto trajectories that influence health and well-being over the lifespan
- Cumulative effects refer to the accumulation of these various advantage or disadvantages over time