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Making the Invisible Visible: Are Health Social Workers Addressing the Social Determinants of Health?

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This study explored the ways in which health social workers (HSW) address the social determinants of health (SDH) within their social work practice. Social workers (n = 54) employed at major hospitals across Toronto had many years of practice in health care (M = 11 years; SD = 10.32) and indicated that SDH were a top priority in their daily work; with 98% intentionally intervening with at least one and 91% attending to three or more. Health care services were most often addressed (92%), followed by housing (72%), disability (79%), income (72%), and employment security (70%). Few HSW were tackling racism, Aboriginal status, gender, or social exclusion in their daily practice.

KEYWORDS *hospital social work, social work, social determinants of health, medical social work, health and social care*

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INTRODUCTION

The social determinants of health (SDH) have been defined as the “causes of the causes” (Marmot, 2007, p. 1153), the environmental, social, political, cultural, and economic factors (Baum, Begin, Houweling, & Taylor, 2009), adverse social conditions (Fisher & Baum, 2010), or social inequalities (Daniels, Kennedy, & Kawachi, 1999) that influence individuals’ health status (Kosny, 1999). These SDH mirror fundamental social hierarchical structures (Marmot, 2007), and affect the degree of health and illness experienced by members of various socioeconomic groups (Halfon, Larson, & Russ, 2010; Raphael et al., 2006). Social determinants, rather than a genetic predisposition or personal health choices (Marmot & Wilkinson, 2003), have been found to be the primary correlates of health (Commission on the Social Determinants of Health [CDSH], 2008). Although all societies are stratified along social axis of differentiation, such as ethnicity, race, gender or occupation, health disparities mainly result from the unequal distribution of power, privilege, and resources among various groups (Marmot, 2007). A significant body of multidisciplinary and international literature has determined that many health and mental health issues are rooted in preventable social inequalities such as poverty, inadequate housing, food insecurity, and social exclusion (Berkman & Kawachi, 2000; Raphael, 2008a; Rosenberg, 2008), themes familiar to social workers.

The social causes of ill health have been recognized since the 1980s, following the public release of the *Black Report* and the *Health Divide* (Raphael, 2004). Starting points for future research studies, these reports explored the relation between social class and health. The *Black Report* was the first to link material deprivation with health differences, as particularly defined by mortality and morbidity rates (Fein, 1995; Raphael, 2004; Smith, Bartley, & Blane, 1990). The materialist-structuralist perspective approach highlighted in the report (Marmot, 2001; Marmot, Kogevinas, & Elston, 1987), identified societal structures’ impact on health (Fein, 1995; Feinstein, 1993; Smith et al., 1990) and proposed long-term policy recommendations to better address health inequalities (Marmot, 2001). Later research studies constructed further knowledge regarding the social causes of health disparities (Fein, 1995; Phillimore, Beattie, & Townsend, 1994), mainly framed in terms of material resources (Feinstein, 1993), as distal causes of disease (Link & Phelan, 1995). By 1995, the link between socioeconomic status (SES) and health outcomes has been well established (Dahl, 1994; Feinstein, 1993). Ten years after the *Black Report*, the awareness of health inequalities (Whitehead, Evandrou, Haglund, & Diderichsen, 1997) and mortality differences across class divisions has increased (Smith et al., 1990).

The SDH paradigm is grounded in values of social justice, human rights, and equality (Bywaters, McLeod, & Napier, 2010). It goes well beyond the bio-medical and behavioral approaches (Watt, 2007), traditionally ingrained

within the public health discourse (Cameron, Mathers, & Parry, 2006) and entails a holistic view of praxis (Nayar, 2007), as a foundational basis of health (Buijs & Olson, 2001). It further defines the social, cultural, and political contextual circumstances (Hankivsky & Christoffersen, 2008; Heinonen, Metteri, & Leach, 2009; Irwin & Scali, 2007) as proxies for opportunities and resources influencing health outcomes (Frohlich, Ross, & Richmond, 2006) and suggests that physical as well as mental health and well being, are conditions embedded in social experiences (Heinonen et al., 2009). Thus, the SDH framework provides a mechanism to understand multilevel policy and practice interventions designed to improve health (Raphael, 2008a).

Health Social Work and the Social Determinants of Health

A SDH perspective fits well with social work's fundamental values of social justice and also with the ecological model emphasizing a broad context of individual functioning (Kasperski, Power, & VanderBent, 2005). The International Federation of Social Work (IFSW) has stated that health is both a human rights and social justice issue (Karban, 2010), yet most of the existent literature is focused on policy directives and fails to adequately address the relevance for social workers in direct practice. HSWs bring a holistic perspective to health care, by incorporating a full range of psychological, social, and emotional factors (Rachman, 1995) and by focusing on the social effects of illness rather than on the illness in itself (Volland, 1996). They are educated to consider the social context more so than any other profession (Lymbery, 2006), with a particular focus on the on the ecological perspective, which suggests that individuals function within larger systems (Claiborne & Vandenburg, 2001), and a biopsychosocial approach, which emphasizes the person in the environment (Berkman, 1996; Cowles & Lefcowitz, 1992). Therefore, HSWs are considered to be closer to service users (Herod & Lymbery, 2008), provide a continuum of care coordination and support for their clients (Keefe, Geron, & Enguidanos, 2009), and identify many more patient psychosocial problems than professionals from other disciplines (Mizrahi & Abramson, 2000). Their presence in health care settings has been associated with fewer emergency visits, less hospital admissions, and reduced lengths of patient stay (Keefe et al., 2009). It has been suggested that other health care professionals would not be able to adequately address these issues, if HSWs were to be withdrawn from medical multidisciplinary teams (Herod & Lymbery, 2008). Although scholarly work has emphasized the need for research related to SDH for many years (Baum et al., 2009; Raphael, 2008) and the need for HSWs to concentrate on social inequalities (Rosenberg, 2008), there has been a lack of practice-based research about how HSWs are addressing these issues. This pilot study aims to understand the relevance of this conceptual framework to social work by exploring those SDH currently attended to by HSWs within their daily work.

The Social Determinants of Health

SDH definitions have been inconsistently reported in the literature (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006), as they dually refer to the social factors determining health, but also to the processes and mechanisms contributing to their unequal distribution (Graham, 2004). Without a SDH universal typology in place, scholarly work has inconsistently been reporting on a variety of health influences (Buijs & Olson, 2001; Courtwright, 2008) including: SES (income, education, employment, working conditions), personal health practices, coping skills, healthy child development, physical environments, social support networks (Buijs & Olson, 2001), Aboriginal status, geographical locations (Frohlich et al., 2006), chronic stressors, racism, or the medicalized stigmatization of disease (Courtwright, 2008). Using Public Health Agency of Canada's categorization of SDH (PHAC, 2004), this article reports on those SDH most frequently cited within the literature and loosely organizes them into several domains of social stratification: (1) SES: income and its distribution; unemployment and employment security; education, employment, and working conditions; early life; (2) social supports: housing, social safety net, food security; (3) diversity and equity: gender, racism, Aboriginal status, disability status, social exclusion; and (4) health care services. Although this article is not intended to provide an exhaustive review of the SDH (see Rosenberg, 2008 for a comprehensive review), each of these categories is briefly described below to contextualize the pilot study.

SOCIOECONOMIC STATUS

Although social SES, as defined by social SES empirical measures, such as occupation, income and education (Fein, 1995), has often been at the center of analyses on health disparities (Marmot et al., 1987), the SDH approach also includes the hierarchized dynamics of social positions (Bartley, Blane, & Smith, 1998). A social gradient (Marmot, 2003), as a relative position in social hierarchy (Marmot, 2001; Marmot et al., 1987) was deemed to affect health (Marmot, 2003) and to translate into differential health outcomes (Marmot, 2001, 2003; Marmot et al., 1991). Social gradient's effect on health (Daniels et al., 1999; MacDonald, 2006) has been explained via a cultural behavioral model (Irwin & Scali, 2007) that identifies chronic stress (Bywaters et al., 2010), links stressors to their contexts (Schulz et al., 2002), and associates the differential distribution of health behaviors and living standards (Graham, 2004) with hierarchical social positions (Frohlich et al., 2006; Irwin & Scali, 2007). Although intersectional SDH perspectives (Hankivsky & Christoffersen, 2008) do not presume the importance of ethnicity, gender, and other singular categorical positionalities (Graham, 2004; Hankivsky & Christoffersen, 2008), health disparities are

related to the inequitable distribution of social and cultural capital among economically variant groups (Frohlich et al., 2006). Overall, SES factors are markers for position in society (Marmot, 2003). Those in a lower economic strata are more likely to experience adverse health outcomes (Rahkonen, Laaksonen, Martikainen, Roos, & Lahelma, 2006; Marmot, 2007; Wilson, 2009), higher rates of mortality and morbidity (Auger, Zang, & Daniel, 2009; Isaacs & Schroeder, 2004), and frequent use of health care services (Barnett, Coyle, & Kearns, 2000); yet individuals' health depends on context specific stressors: physiological, psychological, or behavioral (Fiscella & Williams, 2004; Schulz et al., 2002).

Income inequality at the neighborhood level and socially differentiated material resources have been found to unequally influence the distribution of health outcomes (Irwin & Scali, 2007; Watt, 2007; Whiteside, 2004) and health care (Kilbourne et al., 2006) at the societal, environmental, behavioral, and disease levels (Graham, 2004).

Unemployment and employment insecurity have been associated with poor physical health and well-being (Bambra & Eikemo, 2009; Kalil, Ziolk-Guest, Hawkey, & Cacioppo, 2010), chronic disease (Safaei, 2008), psychological distress (D'Souza et al., 2005; Puig-Barrachina, Malmusi, Martenez, & Benach, 2011; Virtanen, Vahtera, Kivimaki, Pentti, & Ferrie, 2002), poor self-reported health (Bambra & Eikemo, 2009; Burgard, Brand, & House, 2009), higher rates of medical visits (D'Souza et al., 2005), and decreased medical coverage (Kendall, Rose, & Kim, 2009).

Lower educational levels have also been linked to adverse health outcomes in later life (Albert & Davia, 2011; Goldman & Smith, 2002; Stafford, Nazroo, Popay, & Whitehead, 2008), including shorter life expectancies, even after controlling for SES and economic resources (Baker, Leon, Smith Greenaway, Collins, & Movit, 2011). The link between education and health (Marmot, 2003) may be mediated through health behaviors (Daniels et al., 1999), literacy levels (Reading & Wien, 2009), income (Fiscella & Williams, 2004), and labor participation (Fiscella & Williams, 2004).

Poor working conditions (Daniels et al., 1999; Kaikkonen, Rahkonen, Lallukka, & Lahelma, 2009), such as precarious or temporary, employment (Burgard et al., 2009; Kim, Kim, Park, & Kawachi, 2008), occupational status (Clougherty, Souza, & Cullen, 2010), work-related stress (Holmgren, Dahlin-Ivanoff, Bjorkelund, & Hensing, 2009; Vanroelen, Levecque, Moors, & Louckx, 2010), longer working hours (Artazcoz, Cortes, Escriba-Aguir, Cascant, & Villegas, 2009), high level of work-life conflicts (McNamara, Bohle, & Quinlan, 2011), and a lack of job control (Rahkonen et al., 2006), have been associated with adverse health outcomes (Clougherty et al., 2010), including poor self-rated physical (Holmgren et al., 2009; Kim et al., 2008) and mental health (Artazcoz et al., 2009).

From a life course epidemiological perspective (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003), children's development is dependent on

their environments (Daniels et al., 1999; Marmot, 2007). The exposure to risk factors during *early life* (Johnson & Schoeni, 2007) has been found to impact health (McGowan & Szyf, 2010; Melchior, Moffitt, Milne, Poulton, & Caspi, 2007; O'Rand & Hamil-Luker, 2005), throughout all life stages (Marmot, 2007; Reading & Wien, 2009).

SOCIAL SUPPORTS

Social supports such as housing, food security, and a social safety net have been shown to be health predictors. *Poor housing*, defined as unaffordable (Pollack, Griffin, & Lynch, 2010) or unstable (Kushel, Gupta, Gee, & Haas, 2006) is related to poor self-rated health, higher rates of acute health care use (Kushel et al., 2006), chronic health conditions (Pollack et al., 2010), and non-adherence to health care regimes (Pollack et al., 2010). In turn, improvements in housing conditions have been linked to better self reported levels of physical and mental health, along with lower rates of health services use (Thomson, Petticrew, & Morrison, 2001).

Food insecurity, which generally refers to one's inability to afford sufficient food for an active and healthy life (Seligman, Laraia, & Kushel, 2010), has been associated with high rates of acute health services utilization and low rates of access to care (Kushel et al., 2006), as well as adverse physical (Seligman et al., 2010) and mental health outcomes (Stuff et al., 2004).

Social safety networks, as the universal social protection benefits and programs intended to support health, including welfare and unemployment insurance, various social services or health care (Iatridis, 2000) are associated with better population health (Malmberg-Heimonem, 2010; Marmot et al., 2008).

DIVERSITY AND EQUITY

Social exclusion further entrenches inequalities in health (Gray, 2003) and can include aspects of diversity such as disability, gender, and racial discrimination. The association between social marginalization and poor health has been related to levels of chronic stress factors (Fiscella & Williams, 2004). Fair or poor health (Haverkamp, Scandlin, & Roth, 2004) has been more commonly reported by those with disabilities and developmental disabilities compared to non-disabled adults. *Gender differences* are also found. For example, adult women are more likely to be hospitalized for depressive disorder and men are more likely to report bipolar disorder (Savoie, Morettin, Green, & Kazanjian, 2004). *Racial discrimination* has also been associated with poor or fair self-rated health, lower physical functioning, and higher rates of cardiovascular disease (Harris et al., 2006; Keefe, 2010),

and lifetime illness (Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003). Finally, a number of chronic physical (Larson, Gillies, Howard, & Coffin, 2007) and mental health (Reading & Wien, 2009) conditions are more prevalent among Aboriginal individuals than the general population (Anand et al., 2001; Reading & Wien, 2009).

HEALTH CARE SERVICES

The health care system has been considered a social determinant in itself, given it mediates access to all other social determinants (Marmot et al., 2008). Availability and access to health services has been found to significantly reduce people's mortality (Bloom, 2001). A systematic review on the association between health insurance and health status documented poorer general health and higher mortality rates for medically uninsured U.S. residents, in comparison with those insured (Hadley, 2003). Uninsured individuals have also been found to report many more unmet health needs (Ayanian, Weissman, Schneider, Ginsburg, & Zaslavsky, 2000), use fewer preventive services (Sudano & Baker, 2002), and experience cost barriers in seeing a physician (Ayanian et al., 2000), resulting in increased use of emergency rooms for primary care (CIHI, 2012).

METHODS

Sample

Toronto, the largest city in Canada, was chosen for this study, as it contains multiple major hospitals employing many HSWs. A self-report survey collected information from hospital-based social workers about the nature of their daily work. Participants ($N = 65$) were recruited through contact with social work practice leaders in hospitals who distributed an informational flyer to social workers in seven settings. These included hospitals serving adults, children, patients with medical and mental health issues, and encompassed staff who work with a broad variety of medical conditions. Study participants represented a range of professional and demographic backgrounds. Their average age was 43.07 ($SD = 14.02$) and ranged from 22 to 65 years. Participants identified as female (87%) or male (13%), and as heterosexual (91%) or sexual minority (9%). Race and ethnicity included Caucasian (75%); Asian (12%); mixed (9%); Aboriginal (2%); African (2%), and the highest level of education indicated as MSW (83%) followed by BSW (13%) and PhD/DSW (2%). Table 1 presents the demographics of the sample.

Participants reported being engaged in many years of social work practice ($M = 14$ years; $SD = 12.7$), specifically in health care settings ($M = 11$ years; $SD = 10.32$), ranging, on both dimensions, from less than 1 year

TABLE 1 Summary of Participants' Demographic Characteristics

	Number	Percent
Age group (<i>n</i> = 52)		
15–24	3	5.8
25–44	27	51.9
45–64	18	34.6
65–74	4	7.7
Gender (<i>n</i> = 54)		
Female	47	87
Male	7	13
Race/Ethnicity (<i>n</i> = 51)		
Caucasian/White European	36	70.6
South Asian	6	11.8
Mixed Background	4	7.8
East Asian	3	5.9
Aboriginal	1	2.0
African American	1	2.0
Sexual orientation (<i>n</i> = 54)		
Heterosexual	50	92.6
Queer	2	3.7
Gay	1	1.9
Other	1	1.9
Education (<i>n</i> = 54)		
MSW	45	83.3
BSW	7	13.0
PhD/DSW	1	1.9
Other	1	1.9
Years as a social worker (<i>n</i> = 54)		
Less than 1 year	4	7.4
1–5 years	15	27.8
6–10 years	7	13.0
11–20 years	12	22.2
Over 20 years	16	29.6
Years in health care settings (<i>n</i> = 53)		
Less than 1 year	6	11.3
1–5 years	18	34.0
6–10 years	8	15.1
11–20 years	10	18.9
Over 20 years	11	20.8

Not every participant answered each question and therefore, the actual number (*n*) is reported for clarification purposes.

to over 20 years of experience. Their job titles included social worker (66%), professional practice leader (10%), advanced practice clinician (9%), counselor (9%), and case manager (6%). Chronic care, rehabilitation, emergency care, outpatient counseling, oncology, and heart units were the participants' reported workplace settings. In terms of job duties, they conducted assessments (61%), advocacy work (42%), counseling (35%), case management (33%), and research (9%).

Measures

Participants provided basic demographic information (age, race, gender identity, sexual orientation, educational degree), job details (number of years in social work practice, number of years in a health care setting), job title, job duties and overall job satisfaction, ranging from very dissatisfied to very satisfied. Public Health Agency of Canada's explanation of the SDH (PHAC, 2004) was used to capture the key constructs. The final list was generated in collaboration with two HSWs. The 12-item measure included health care services, housing, income and its distribution, social exclusion, gender, unemployment and employment security, aboriginal status, early life, disability status, education, employment and working conditions, and food security. Participants were asked to identify whether or not they addressed each of the SDH through their daily hospital work practice (yes/no). The term *addressing* was operationalized to include HSWs role specific efforts in reducing the impact of social factors and underlying social processes associated with health disparities on their clients, during the assessment, planning, intervention, or referral stages. Data was collected by a two-person team, one who is a member of a social work faculty and the other who is a social work leader in a hospital. Respondents were instructed to complete the survey anonymously. The study was approved by the research ethics board at the principal investigator's university. Using SPSS 19.0, quantitative analysis of the data, including descriptive statistics, correlations, and Chi-square analyses, was conducted.

RESULTS

Findings indicate that SDH were a priority for the participants, with 98% intervening with at least one and 91% attending to three or more of the SDH. HSWs defined intervention activities as the provision of assistance by directly acquiring services for patients, educating them about resources or advocating with the medical team for consideration of the relevant SDH in their care. On average, HSWs in health care settings have been addressing 7 out of the 14 SDH surveyed. Table 2 illustrates the range and frequencies of social work involvement with SDH in their daily practice. Health care services were reported to receive the greatest attention, (92%), followed by housing (72%), disability status (79%), income and its distribution (72%) and unemployment and employment security (70%). A further 60% of medical HSWs were addressing factors related to the social safety net, 57% were attending to those related to employment and working conditions, while others were addressing food security (47%) and education (47%). On the lower end, many participants did not report attending to several SDH, including early life (79%), Aboriginal status (68%), racism (68%) gender (66%), and social

TABLE 2 Frequencies of Self-Reported SDH and Chi-Square Analyses

Socioeconomic status (SES) SDH	%	Income and its distribution	Unemployment and employment insecurity	Education	Employment and working conditions	Early life
Income and its Distribution	72	-	$p < .01^{**}$	$p = .21$	$p = .36$	$p = .11$
Unemployment/Employment Insecurity	70	$p < .01^{**}$	-	$p = .13$	$p = .06$	$p = .33$
Education	47	$p = .21$	$p = .13$	-	$p < .01^{**}$	$p < .01^{**}$
Employment and Working Conditions	57	$p = .36$	$p = .06$	$p < .01^{**}$	-	$p < .01^{**}$
Early Life	21	$p = .11$	$p = .33$	$p < .01^{**}$	$p < .01^{**}$	-
Social Support SDH	%	Housing	Food Security	Social Safety Net	-	-
Housing	72	-	$p < .01^{**}$	-	-	-
Food Security	47	$p < .01^{**}$	-	$p < .01^{**}$	-	-
Social Safety Net	60	$p < .01^{**}$	$p < .01^{**}$	$p < .01^{**}$	-	-
Diversity and Equity SDH	%	Gender	Racism	Aboriginal Status	Disability Status	Social Exclusion
Gender	34	-	$p < .01^{**}$	$p < .01^{**}$	$p = .85$	$p < .01^{**}$
Racism	32	$p < .01^{**}$	-	$p < .01^{**}$	$p = .70$	$p < .01^{**}$
Aboriginal Status	32	$p < .01^{**}$	$p < .01^{**}$	-	$p = .73$	$p < .01^{**}$
Disability Status	79	$p = .85$	$p = .70$	$p = .73$	-	$p = .90$
Social Exclusion	47	$p < .01^{**}$	$p < .01^{**}$	$p < .01^{**}$	$p = .90$	-

Asterisks (**) indicate significance at the .01 level ($p < .1$). Dashes (-) indicate that: (a) no other SDH are self-reported within the categorical axes or (b) the analysis is not feasible within each SDH.

exclusion (53%). To understand whether job factors were associated with particular SDH, chi-square analyses were conducted between the number of years in social work practice, job satisfaction and respectively, each singular and the total number of addressed SDH. For all determinants, no statistically significant differences occurred with respect to participants' experience or job satisfaction.

As seen in Table 2, chi square analyses were conducted to examine the relationships between those SDH addressed by participants in their daily practice. Statistically significant correlations ($p < .1$) were observed between income inequality and unemployment and employment insecurity, early life and education, and early life and working conditions. In contrast, significantly higher percentages were reported within the social supports category. Those participants addressing housing were also more likely to address food security and social safety net factors. However, within the diversity and equity domain, with the exception of disability status, statistically significant associations ($p < .1$) were observed among all other determinants, including gender, racism, social exclusion, and Aboriginal status.

DISCUSSION

This study provided valuable information about the work of HSWs, particularly regarding: (1) the relationship of employment and social supports constructs to the SDH and (2) the most influential SDH addressed in their daily practice. The lack of significant correlations between SDH and participants' employment measures indicated that, regardless of their job satisfaction or professional experience, social workers are dealing with many SDH frequently and concurrently. Although many SDH are addressed by hospital HSWs in their daily practice, efforts solely directed toward disparities related to diversity and equity, such as racism, Aboriginal status, gender, and social exclusion, do not take the majority of their time. Further, participants' self-reported inability to intervene with each one of these determinants was significantly associated with the lack of action on those within the same domain. For instance, if racism was not addressed, the other equity and diversity issues such as Aboriginal status, gender, and social exclusion were also not likely to be a focus.

There are several explanations for why HSWs report the least amount of attention to diversity and equity related SDH. First, it is plausible that, the very same medical settings *per se*, had contributed to HSWs choice of attended SDH. Since prior research findings (Craig & Muskatt, 2013) suggested that HSWs roles within urban hospitals often resembled the figurative work aspects of *firefighter*, *broker*, and *glue*, it is likely that they are focused on proximal concerns, such as health care utilization, rather than on distal and more complex issues such as racism and gender. These findings might

also suggest that HSWs are focused on meeting immediate micro-level needs, with less available time to take on added macro issues.

Second, the medical model's dominance within the health care settings (Baum et al., 2009; Niederdeppe, Bu, Borah, Kindig, & Robert, 2008), which is often criticized for failing to consider the impact of wider environments on individual health outcomes (Raphael, Curry-Stevens, & Bryant, 2008), could potentially impact practitioners' focus on individual treatments over interventions addressing macro social determinants of health. The perspective that an individual bears sole responsibility for health (Kosny, 1999), which links adverse health outcomes with biomedical markers, erroneous personal choice, and risky behaviors (Raphael et al., 2008). In such cases, health promotion efforts become targeted toward changing such unsafe individual behaviors (Baum et al., 2009) and less attention is ultimately paid to the societal context and its influence on health inequities. It is hard to know if a study's participants have been attending to the health service utilization as the main determinant of health, simply because they are employed in health care settings or merely because they share the general public belief that "medical care is the primary determinant of health" (Niederdeppe et al., 2008, p. 492). Practitioners' responses could also be reflective of the overall "public health gaze" (Raphael, 2008, p. 15), which has not adequately developed concrete social policies to address the numerous forms of marginalization impeding on individuals' health (Baum et al., 2009; Raphael, 2008) and to shape the quality of SDHs (Raphael, 2006). HSWs' direct practice occurs in settings shaped by complex political environments and social work funding often requires direct services such as discharge, mental health, or behavioral challenges, hence efforts related to the distal SDH may be further challenging in these environments.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

By increasing the visibility of singular and relational SDH aspects that are attended to by HSWs in their daily work, this study aims to assist them in efforts to better understand and address the socially created inequalities in health (Bywaters et al., 2010), both at the population and individual levels (Graham, 2004). At a policy level, medical HSWs could strengthen their advocacy efforts (Bywaters et al., 2010) and augment the public health discourse focused on health outcomes (Graham, 2004), through the support of employment, fiscal, or housing policies and programs, aimed at reducing disparities that impact health (Graham, 2004). Further, this study identifies that the mutually reinforced (Frohlich et al., 2006) and intersecting (Hankivsky & Christoffersen, 2008) SDH, at both, micro and macro levels of practice are important areas for HSW to address.

At the direct level of practice, HSWs are trained to attend to the diversity of circumstances influencing individuals' physical and mental health and well-being (Heinonen, Metteri, & Leach, 2009). Therefore, although most health promotion workers tend to address SDH symptoms rather than the determinants in themselves (Whiteside, 2004), HSWs have the potential to go beyond such efforts to better facilitate the development and implementation of interventions addressing the social factors and social processes producing health disparities. HSWs can use the SDH framework to address health disparities outside their institutional sphere (Courtwright, 2008) and promote the SDH paradigm within their vast range of assessment, planning and intervention related activities. At a practice level, this could translate in directly supporting clients' health by facilitating their access to health knowledge and education resources (Frohlich et al., 2006), providing them with tangible SDH information, connecting them with appropriate referral services, countering disease stigmatization (Courtwright, 2008), intervening in discrimination within health care, addressing biases related to race and language differences (Nguyen, Ho, & Williams, 2011), promoting social support (Schulz et al., 2002), and developing programs and interventions that could diminish the impact of contextual stressors on health and reduce subsequent health disparities.

This study's limitations must be considered when interpreting the results. Our sample was relatively small and homogenous, with the majority of participants identifying as Caucasian and therefore, it might not be entirely representative of all HSWs or hospital environments. It is important for future SDH research to investigate how the concepts of race, gender, and other social categories operate as social processes within research settings, even more so than participants' independent variables (Cole, 2008). Moreover, data is based on participant self-report, which may contribute to reporting biases. Despite such limitations, this study adds to the existent scholarly knowledge as it relates to hospital HSWs' practice of addressing the vast range of SDH within their daily work.

Further research should create a more complex measure of SDH and detail the specific types of interventions used to address each SDH, have a larger and more diverse sample that compares the impact on SDH across other disciplines, and include participants' feedback about how SDH informs their practice in health care settings. Finally, HSWs should consider the ways in which they impact the SDH in their daily practice, as professional expectations continue to focus on service efficiency and best practices, and strive to demonstrate their efforts as effective and positive influences on vulnerable patients' outcomes (Judd & Sheffield, 2010). Partnerships between community and university based researchers using a practice-based research approach, such as those employed in this study, can assist HSWs to identify their roles, functions, and overall value to the health system.

CONCLUSION

In sum, participants did address many SDH in their health care practice; however, they focused more on proximal SDH, such as access to health care services and housing and less on the complex distal ones, such as social exclusion. This approach may be suitable for the types of roles they are hired to fill. It has been advanced that health services are both causes and solutions to health disparities (Kilbourne et al., 2006). Improving population health requires a vision of social justice (Krieger, 2001) and therefore there is potential for social work to work toward equality in health care (Whiteside, 2004). Health inequalities are located at the heart of social work (Bywaters et al., 2010), and this article hopes to add to a critical knowledge base by discussing how social work practitioners are addressing the SDH. It will be difficult for social workers to achieve goals for a just society until consideration of SDH implications becomes a priority.

REFERENCES

- Albert, C., & Davia, M.A. (2011). Education is a key determinant of health in Europe: A comparative analysis of 11 countries. *Health Promotion International*, 26(2), 163–170.
- Anand, S.S., Yusuf, S., Jacobs, R., Davis, A.D., Yi, Q., & Gerstein, H. (2001). Risk factors, atherosclerosis, and cardiovascular disease among aboriginal people in Canada: The study of health assessment and risk evaluation in aboriginal peoples (SHARE-AP). *The Lancet*, 358(9288), 1147–1153.
- Artazcoz, L., Cortes, I., Escriba-Aguir, V., Cascant, L., & Villegas, R. (2009). Understanding the relationship of long working hours with health status and health-related behaviours. *Journal of Epidemiology & Community Health*, 63(7), 521–527.
- Auger, N., Zang, G., & Daniel, M. (2009). Community-level income inequality and mortality in Quebec, Canada. *Public Health*, 123(6), 438–443.
- Ayanian, J.Z., Weissman, J.S., Schneider, E.C., Ginsburg, J.A., & Zaslavsky, A.M. (2000). Unmet health needs of uninsured adults in the United States. *JAMA: The Journal of the American Medical Association*, 284(16), 2061–2069.
- Baker, D.P., Leon, J., Smith Greenaway, E.G., Collins, J., & Movit, M. (2011). The education effect on population health: A reassessment. *Population & Development Review*, 37(2), 307–332.
- Bambra, C., & Eikemo, T.A. (2009). Welfare state regimes, unemployment and health: A comparative study of the relationship between unemployment and self-reported health in 23 European countries. *Journal of Epidemiology & Community Health*, 63(2), 92–98.
- Bartley, M., Blane, D., & Smith, G.D. (1998). Introduction: Beyond the Black Report. *Sociology of Health & Illness*, 20(5), 563–577.

- Barnett, J.R., Coyle, P., & Kearns, R.A. (2000). Holes in the safety net? Assessing the effects of targeted benefits upon the health care utilization of poor New Zealanders. *Health and Social Care in the Community*, 8(3), 159–171.
- Baum, F.E., Begin, M., Houweling, T.A., & Taylor, S. (2009). Changes not for the faint-hearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, 99(11), 1967–1974.
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, 41(5), 541–551.
- Berkman, L.F., & Kawachi, I. (2000). *Social epidemiology*. New York, NY: Oxford University Press.
- Bloom, G. (2001). Equity in health in unequal societies: Meeting health needs in contexts of social change. *Health Policy*, 57(3), 205–224.
- Buijs, R., & Olson, J. (2001). Parish nurses influencing determinants of health. *Journal of Community Health Nursing*, 18(1), 13–23.
- Burgard, S.A., Brand, J.E., & House, J.S. (2009). Perceived job insecurity and worker health in the United States. *Social Science & Medicine*, 69(5), 777–785.
- Bywaters, P., McLeod, E., & Napier, L. (2010). Social work and global health inequalities – Practice and policy developments. *Social Work Education*, 29(8), 928–936.
- Cameron, E., Mathers, J., & Parry, J. (2006). ‘Health and well-being’: Questioning the use of health concepts in public health policy and practice. *Critical Public Health*, 16(4), 347–354.
- Canadian Institute for Health Information. (2012). *Disparities in Primary Health Care Experiences Among Canadians With Ambulatory Care Sensitive Conditions*. Retrieved from https://secure.cihi.ca/free_products/PHC_Experiences_AiB2012_E.pdf
- Claiborne, N., & Vandenberg, H. (2001). Social workers’ role in disease management. *Health and Social Work*, 26(4), 217–225.
- Clougherty, J.E., Souza, K., & Cullen, M.R. (2010). Work and its role in shaping the social gradient in health. *Annals of the New York Academy of Sciences*, 1186, 102–124.
- Cole, E.R. (2008). Coalitions as a model for intersectionality: From practice to theory. *Women’s Studies and Psychology*, 59, 443–453.
- Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
- Courtwright, A. (2008). The social determinants of health: Moving beyond justice. *The American Journal of Bioethics*, 8(10), 16–17.
- Cowles, L.A., & Lefcowitz, J. (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. *Health & Social Work*, 17, 57–65.
- Craig, S.L., & Muskat, B. (2013). Bouncers, brokers and glue: The self-described roles of social workers in urban hospitals. *Health and Social Work*, 38(1), 7–16.
- Dahl, E. (1994). Social inequalities in ill health: The significance of occupational status, education and income – Results from a Norwegian survey. *Sociology of Health & Illness*, 16(5), 644–667.

- Daniels, N., Kennedy, B.P., & Kawachi, I. (1999). Why justice is good for our health: The social determinants of health inequalities. *Daedalus*, 128(4), 215–251.
- D'Souza, R.M., Strazdins, L., Clements, M.S., Broom, D.H., Parslow, R., & Rodgers, B. (2005). The health effects of jobs: Status, working conditions, or both? *Australian & New Zealand Journal of Public Health*, 29(3), 222–228.
- Fein, O. (1995). The influence of social class on health status. American and British research on health inequalities. *Journal of General Internal Medicine*, 10, 577–586.
- Feinstein, J.S. (1993). The relationship between socioeconomic status and health: A review of the literature. *The Milbank Quarterly*, 71(2), 279–322.
- Fiscella, K., & Williams, D.R. (2004). Health disparities based on socioeconomic inequities: Implications for urban health care. *Academic Medicine*, 79(12), 1139–1147.
- Fisher, M., & Baum, F. (2010). The social determinants of mental health: Implications for research and health promotion. *Australian & New Zealand Journal of Psychiatry*, 44(12), 1057–1063.
- Frohlich, K.L., Ross, N., & Richmond, C. (2006). Health disparities in Canada today: Some evidence and a theoretical framework. *Health Policy*, 79(2–3), 132–143.
- Goldman, D.P., & Smith, J.P. (2002). Can patient self-management help explain the SES health gradient? *Proceedings of the National Academy of Sciences of the United States of America*, 99(16), 10929–10934.
- Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, 82(1), 101–124.
- Gray, B. (2003). Social exclusion, poverty, health and social care in Tower Hamlets: The perspectives of families on the impact of the family support service. *British Journal of Social Work*, 33(3), 361–380.
- Hadley, J. (2003). Sicker and poorer – The consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income. *Medical Care Research and Review*, 60(2 supplement), 3S–75S.
- Halfon, N., Larson, K., & Russ, S. (2010). Why social determinants? *Healthcare Quarterly*, 14, 8–20.
- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271–283.
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine*, 63(6), 1428–1441.
- Havercamp, S.M., Scandlin, D., & Roth, M. (2004). Health disparities among adults with development disabilities, adults with other disabilities and adults not reporting disability in North Carolina. *Public Health Reports*, 119, 418–426.
- Heinonen, T., Metteri, A., & Leach, J. (2009). Applying health determinants and dimensions in social work practice. *European Journal of Social Work*, 12(2), 139–153.
- Herod, J., & Lymbery, M. (2008). The social work role in multidisciplinary teams. *Practice*, 14(4), 17–27.
- Holmgren, K., Dahlin-Ivanoff, S., Bjorkelund, C., & Hensing, G. (2009). The prevalence of work-related stress, and its association with self-perceived health and

- sick-leave, in a population of employed Swedish women. *BMC Public Health*, 9, 1–10.
- Iatridis, D. (2000). State social welfare: Global perspectives. In J.G. Hopps & R. Morris (Eds.), *Social work at the millennium: Critical reflections of the future of the profession* (pp. 207–221). New York, NY: The Free Press.
- Irwin, A., & Scali, E. (2007). Action on the social determinants of health: A historical perspective. *Global Public Health*, 2(3), 235–256.
- Isaacs, S.L., & Schroeder, S.A. (2004). Class—The ignored determinant of the nation's health. *The New England Journal of Medicine*, 351(11), 1137–1142.
- Johnson, R.C., & Schoeni, R.F. (2007). *The Influence of Early-Life Events on Human Capital, Health Status, and Labour Market Outcomes over the Life Course*. Working Paper. Institute for Research on Labour and Employment, University of California, Berkeley, CA.
- Judd, R.G., & Sheffield, S. (2010). Hospital social work: Contemporary roles and professional activities. *Social Work in Health Care*, 49(9), 856–871.
- Kaikkonen, R., Rahkonen, O., Lallukka, T., & Lahelma, E. (2009). Physical and psychosocial working conditions as explanations for occupational class inequalities in self-rated health. *European Journal of Public Health*, 19(5), 458–463.
- Kalil, A., Ziol-Guest, K.M., Hawkey, L.C., & Cacioppo, J.T. (2010). Job insecurity and change over time in health among older men and women. *Journals of Gerontology Series B-Psychological Sciences & Social Sciences*, 65B(1), 81–90.
- Karban, K. (2010). Social work and global health inequalities—Practice and policy developments. *Social Work Education*, 29(8), 928–936.
- Kasperski, J., Power, K., & VanderBent, S.D. (2005). *Social Work, Primary Care and Family Health Teams in Ontario: Delivering Comprehensive, Family-Centered Care*. The Ontario College of Family Physicians, Toronto, Ontario, Canada.
- Keefe, B., Geron, S.M., & Enguidanos, S. (2009). Integrating social workers into primary care: Physician and nurse perceptions of roles, benefits, and challenges. *Social Work in Health Care*, 48(6), 579–596.
- Keefe, R.H. (2010). Health disparities. A primer for public health social workers. *Social Work in Public Health*, 25, 237–257.
- Kendall, D., Rose, S., & Kim, A. (2009). The health care insecurity index. *Health Care Reform*. Retrieved from www.thirdway.org/publications/188/Third_Way_Report_-_The_Health_Care_Security_Index
- Kilbourne, A.M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M.J. (2006). Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health*, 96(12), 2113–2121.
- Kim, M.H., Kim, C.Y., Park, J.K., & Kawachi, I. (2008). Is precarious employment damaging to self-rated health? Results of propensity score matching methods, using longitudinal data in South Korea. *Social Science & Medicine*, 67(12), 1982–1994.
- Kosny, A. (1999). *The Social Determinants of Health: Equity Across the Lifespan*. Maritime Centre for Excellence for Women's Health. Halifax, Nova Scotia, Canada.
- Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology*, 30(4), 668–677.
- Kuh, D., Ben-Shlomo, Y., Lynch, J., Hallqvist, J., & Power, C. (2003). Life course epidemiology. *Journal of Epidemiological Community Health*, 57, 778–783.

- Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine, 21*(1), 71–77.
- Kwate, N.O.A., Valdimarsdottir, H.B., Guevarra, J.S., & Bovbjerg, D.H. (2003). Experiences of racist events are associated with negative health consequences for African women. *Journal of National Medical Association, 95*(6), 450–460.
- Larson, A., Gillies, M., Howard, P.J., & Coffin, J. (2007). It's enough to make you sick: The impact of racism on the health of aboriginal Australians. *Australian and New Zealand Journal of Public Health, 31*(4), 322–329.
- Link, B.G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behaviour, 35*, 80–94.
- Lymbery, M. (2006). United we stand? Partnership working in health and social care and the role of social work in services for older people. *British Journal of Social Work, 36*(7), 1119–1134.
- MacDonald, J.J. (2006). Shifting paradigms: A social determinants approach to solving problems in men's health policy and practice. *Medical Journal of Australia, 185*(8), 456–458.
- Malmberg-Heimonen, I. (2010). The social capital and mental health of long-term social assistance recipients in Norway. *European Journal of Social Work, 13*(1), 91–107.
- Marmot, M. (2001). From Black to Acheson: Two decades of concern with inequalities in health. A celebration of the 90th birthday of Professor Jerry Morris. *International Journal of Epidemiology, 30*, 1165–1171.
- Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet, 370*(9593), 1153–1163.
- Marmot, M.G. (2003). Understanding social inequalities in health. *Perspectives in Biology and Medicine, 46*(3), S9–S23.
- Marmot, M., Friel, S., Bell, R., Houweling, T., Taylor, S., & the Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet, 372*, 1661–1669.
- Marmot, M.G., Kogevinas, M., & Elston, M.A. (1987). Social/economic status and disease. *Annual Review of Public Health, 8*, 111–135.
- Marmot, M.G., Stansfeld, S., Patel, C., North, F., Head, J., White, I., . . . Smith, G.D. (1991). Health inequalities among British civil servants: The Whitehall II study. *The Lancet, 337*(8754), 1387–1393.
- Marmot, M.G., & Wilkinson, R.G. (2003). *Social determinants of health*. New York, NY: Oxford University Press.
- McGowan, P.O., & Szyf, M. (2010). The epigenetics of social adversity in early life: Implications for mental health outcomes. *Neurobiology of Disease, 39*(1), 66–72.
- McNamara, M., Bohle, P., & Quinlan, M. (2011). Precarious employment, working hours, work-life conflict and health in hotel work. *Applied Ergonomics, 42*(2), 225–232.
- Melchior, M., Moffitt, T.E., Milne, B.J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantaged families suffer from poor health when they reach adulthood? A life-course study. *American Journal of Epidemiology, 166*(8), 966–974.

- Mizrahi, T., & Abramson, J.S. (2000). Collaboration between social workers and physicians. *Social Work in Health Care, 31*(3), 1–24.
- Nayar, K.R. (2007). Social exclusion, caste and health. A review based on the social determinants framework. *Indian Journal of Medical Research, 126*, 355–363.
- Nguyen, D.D., Ho, K.H., & Williams, J.H. (2011). Social determinants and health service use among racial and ethnic minorities: Findings from a community sample. *Social Work in Health Care, 50*(5), 390–405.
- Niederdeppe, J., Bu, Q.L., Borah, P., Kindig, D.A., & Robert, S.A. (2008). Message design strategies to raise public awareness of social determinants of health and population health disparities. *Milbank Quarterly, 86*(3), 481–513.
- O’Rand, A.M., & Hamil-Luker, J. (2005). Processes of cumulative adversity: Childhood disadvantage and increased risk of heart attack across the life course. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 60* (Special Issue 2), S117–S124.
- Phillimore, P., Beattie, A., & Townsend, P. (1994). Widening inequality of health in northern England. *British Medical Journal, 308*, 1125–1128.
- Pollack, C.E., Griffin, B.A., & Lynch, J. (2010). Housing affordability and health among homeowners and renters. *American Journal of Preventive Medicine, 39*(6), 515–521.
- Public Health Agency of Canada. (2004). *The Social Determinants of Health: An Overview of the Implications for Policy and the Role of the Health Sector*. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/oi-ar/01_overview-eng.php
- Puig-Barrachina, V., Malmusi, D., Martenez, J.M., & Benach, J. (2011). Monitoring social determinants of health inequalities: The impact of unemployment among vulnerable groups. *International Journal of Health Services, 41*(3), 459–482.
- Rachman, R. (1995). Community care: Changing the role of hospital social work. *Health and Social Care in the Community, 3*, 163–172.
- Rahkonen, O., Laaksonen, M., Martikainen, P., Roos, E., & Lahelma, E. (2006). Job control, job demands, or social class? The impact of working conditions on the relation between social class and health. *Journal of Epidemiology & Community Health, 60*(1), 50–54.
- Raphael, D. (2004). *Social Determinants of Health: Canadian Perspectives*. Toronto, Canada: Canadian Scholar Press.
- Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services Planning Administration Evaluation, 36*(4), 651–677.
- Raphael, D. (Ed.) (2008a). *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto, Canada: Canadian Scholars’ Press Incorporated.
- Raphael, D. (2008b). Getting serious about the social determinants of health: New directions for public health workers. *Promotion and Education, 15*(3), 15–20.
- Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy, 88*(2–3), 222–235.
- Raphael, D., Labonte, R., Colman, R., Hayward, K., Torgerson, R., & Macdonald, J. (2006). Income and health in Canada: Research gaps and future opportunities.

- Canadian Journal of Public Health. Revue Canadienne De Sante Publique*, 97 (Suppl. 3), S16–23, S18–26.
- Reading, C.L., & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal's People Health*. National Collaborating Centre for Aboriginal Health. Prince George, British Columbia, Canada.
- Rosenberg, G. (2008). Social determinants of health: Twenty-first-century social work priorities. In K. Sowers & I. Colby (Eds.), *Comprehensive Handbook of Social Work and Social Welfare*. Hoboken, NJ: John Wiley & Sons.
- Safaei, J. (2008). Long-term employment and health inequalities in Canadian communities. *Canadian Journal of Public Health. Revue Canadienne De Sante Publique*, 99(3), 195–200.
- Savoie, I., Morettin, D., Green, C.J., & Kazanjian, A. (2004). Systematic review of the role of gender as a health determinant of hospitalization for depression. *International Journal of Technology Assessment in Health Care*, 20(2), 115–127.
- Schulz, A., Parker, E., Israel, B., Allen, A., Decarlo, M., & Lockett, M. (2002). Addressing social determinants of health through community-based participatory research: The East Side Village Health Worker Partnership. *Health Education & Behavior*, 29(3), 326–341.
- Seligman, H.K., Laraia, B.A., & Kushel, M.B. (2010). Food insecurity is associated with chronic disease among low-income NHANES participants. *Journal of Nutrition*, 140(2), 304–310.
- Smith, G.D., Bartley, M., & Blane, D. (1990). The Black Report on socioeconomic inequalities in health 10 years on. *British Medical Journal*, 301, 373–377.
- Stafford, M., Nazroo, J., Popay, J.M., & Whitehead, M. (2008). Tackling inequalities in health: Evaluating the new deal for communities' initiative. *Journal of Epidemiology & Community Health*, 62(4), 298–304.
- Stuff, J.E., Casey, P.H., Szeto, K.L., Gossett, J.M., Robbins, J.M., & Simpson, P.M. (2004). Household food insecurity is associated with adult health status. *Journal of Nutrition*, 134(9), 2330–2335.
- Sudano, J.J., & Baker, D.W. (2002). Intermittent lack of health insurance coverage and use of preventive services. *American Journal of Public Health*, 93(1), 130–137.
- Thomson, H., Petticrew, M., & Morrison, D. (2001). Health effects of housing improvement: Systematic review of intervention studies. *British Medical Journal*, 323(7306), 187–190.
- Vanroelen, C., Levecque, K., Moors, G., & Louckx, F. (2010). Linking credentialed skills, social class, working conditions and self-reported health: A focus on health inequality-generating mechanisms. *Sociology of Health & Illness*, 32(6), 948–964.
- Virtanen, P., Vahtera, J., Kivimaki, P., Pentti, J., & Ferrie, J. (2002). Public health policy and practice. Employment security and health. *Journal of Epidemiology & Community Health*, 56, 569–574.
- Volland, P. (1996). Social work practice in health care: Looking to the future with a different lens. *Social Work in Health Care*, 24(1), 35–51.
- Watt, R.G. (2007). From victim blaming to upstream action: Tackling the social determinants of oral health inequalities. *Community Dentistry and Oral Epidemiology*, 35(1), 1–11.

- Whitehead, M., Evandrou, M., Haglund, B., & Diderichsen, F. (1997). As the health divide widens in Sweden and Britain, what's happening to access to care? *British Medical Journal*, *315*, 1006–1009.
- Whiteside, M. (2004). The challenge of interdisciplinary collaboration in addressing the social determinants. *Australian Social Work*, *57*(4), 381–393.
- Wilson, J. (2009). Not so special after all? Daniels and the social determinants of health. *Journal of Medical Ethics*, *35*(1), 3–6.