



Health Inequities in British Columbia

Discussion Paper

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Purpose of this Document:

The intent of this paper is to use BC data to describe health inequities in this province, and to discuss policy options that offer the greatest opportunities to effectively address those inequities.

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Acronyms

CFAI	Community Food Action Initiative (BC)
CPP	Canada Pension Plan
CSDH	Commission on Social Determinants of Health (World Health Organization)
CVD	cardiovascular disease
ECD	early childhood development
EU	European Union
GBA	gender and diversity-based analysis
GDP	gross domestic product
GIS	Guaranteed Income Supplement (Canada)
LEo	life expectancy
NGO	non-governmental organization
NHS	National Health Service (UK)
OAS	Old Age Security (Canada)
OECD	Organization for Economic Cooperation and Development
PHAC	Public Health Agency of Canada
PHO	Provincial Health Officer (BC)
PHSA	Provincial Health Services Authority (BC)
QPP	Quebec Pension Plan (Canada)
SDH	social determinants of health
SPA	Spouse's Allowance (Canada)
WHO	World Health Organization

Executive Summary

The World Health Organization (WHO) Commission on Social Determinants of Health and Canada's Chief Public Health Officer have both recently issued reports on health inequities.

This discussion paper is intended to contribute to a better understanding of health inequities and the extent to which they exist in British Columbia, support informed discussion about health inequities among a broad range of audiences, and promote consideration of policy approaches for tackling this issue. It is not intended to be a comprehensive literature review. In addition to the WHO and Canada's Chief Public Health Officer, many well-known and respected national and international offices and organizations have produced such reviews and this report has drawn heavily from those existing pieces of work.

The intent of this paper is to use BC data to describe the existing of health inequities in this province, and to discuss policy options that offer the greatest opportunities to effectively address those inequities.

The Concept of Health Inequity

Inequities in health are the focus of this paper. Such inequities concern systematic differences in health status between different socioeconomic groups. But what exactly does that entail, and what is the difference between health inequalities, disparities, and inequities (three terms that are often used interchangeably)?

Within any country, differences in health can be observed across the population. Genetic and constitutional variations ensure that the health of individuals varies, as it does for any other physical characteristic. The prevalence of ill health also differs between different age groups, with older people tending to be sicker than younger people, due to the natural ageing process. Biologically, women in older industrialized countries demonstrate an advantage in survival over men at every stage of life.

These types of unavoidable differences are considered health *inequalities* or *disparities*. A genetic predisposition to heart disease or diabetes, for example, is not more likely to exist among people in Prince George than in Burnaby, or among people earning minimum wage compared to millionaires in the province.

The World Health Organization (WHO) defines health equity as “the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically.”

Using the WHO definition, British Columbia could be said to have health equity if the general health of people throughout the province was not unduly affected by where they live or their position within the socioeconomic hierarchy. Regardless of whether you were a sales manager on Vancouver Island, a forestry worker in the Cariboo, a bank teller in the Okanagan, or an unemployed individual in Vancouver, your chances for enjoying good health and reaching the normal life expectancy for people of your sex in the province would be about the same.

Health Inequities in British Columbia

As demonstrated in the data presented in this report, BC's population does not have health equity. In this province, as in other jurisdictions in the developed world, health tends to be unevenly distributed among social groups within the population on a gradient corresponding to socioeconomic status. The data in this report show that, in general, people from more advantaged socioeconomic groups enjoy longer life expectancy and better health than people from less advantaged groups. Inequities are reflected by consistent differences in the prevalence of chronic diseases (e.g., heart disease, kidney disease and diabetes) among people from the highest and lowest income and education groups across the province; the lower a person is on the socioeconomic hierarchy, the greater their risk of developing these diseases.

While on the whole, British Columbians are among the healthiest people in the world, there is a relatively large number of disadvantaged people in the province – the unemployed and working poor, children and families living in poverty, people with addictions and/or mental illness, Aboriginal people, new immigrants, the homeless, and others – all of whom experience significantly lower levels of health than the average British Columbian. In fact, BC has the highest rates of poverty (particularly child poverty) in Canada. This presents a paradox: despite having by some measures the best overall health outcomes in Canada, BC also has the highest rates of socioeconomic disadvantage in the country. This 'BC paradox' can be explained by two factors:

1. The overall average health status data in BC for measures such as life expectancy do not reveal the significant inequities that exist within the province. For example, there is a ten year difference in life expectancy for people in Richmond compared to people in the downtown eastside of Vancouver.
2. BC has not always been behind the rest of the country in measures such as childhood poverty rates. It is only over the past decade that BC has fallen behind the other provinces, to a large extent because of proactive and successful anti-poverty strategies introduced in provinces such as Quebec and Newfoundland. The overall poverty rates in BC families have been relatively stable over the last ten years (except for lone-parent families). But, in the coming years, as we start to see expected health status improvements in the provinces that have been more aggressive in reducing poverty (it is likely too early to see those improvements just yet), BC is also likely to fall behind in its average health status as well.

Determinants of Health and Health Inequities

According to the WHO Commission on the Social Determinants of Health “the poor health of the poor, the social gradients in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services.”

To fully understand why there is unequal distribution of money, power, material goods and services, one needs to look further upstream, at the structural roots of health inequities – within the education, taxation and health care systems, in labour and housing markets, and in urban planning and government regulation. These structural components of our socioeconomic system shape the differential vulnerability of people to health-affecting conditions and are powerful determinants of health.

Unlike the behavioural determinants of health (downstream factors), these upstream factors are ones over which individuals have no direct personal control, but which can only be altered through social and economic policies and political processes. A ‘real life’ example will help demonstrate the importance of addressing upstream factors.

The Case for Addressing Health Inequities

In addition to the strong moral argument for addressing health inequities based on principles of social justice and equality, a powerful economic case can be made for reducing the gap in health status between the richest and poorest sectors of our society. This case involves recognizing the substantial social, economic and political costs associated with widespread inequities in health, and the benefit of improved overall health for individuals, communities and society as a whole.

A recent report that focused on identifying the cost of poverty in the US concluded that the total cost of poverty was estimated to be \$1.5 trillion in 2005 US dollars. In European research, health inequities-related losses are estimated to be €1 trillion per year in the EU, or 9.4 percent of GDP. In terms of a local estimate, the BC Healthy Living Alliance has estimated that three major risk factors associated with poverty and health inequity (tobacco use, physical inactivity and overweight/obesity) cost the BC economy approximately \$3.8 billion annually. If we extrapolate a high level estimate of the proportion of health care costs in BC attributable to inequities by calculating 20% of the total annual health care spending in BC (\$13 billion) we also get a very high number (\$2.6 billion annually).

Health Care Expenditures vs. Investments in Other Social Programs

What is the solution to reducing health inequities related costs? It has been noted that the level of expenditure on health care is not necessarily a dominant factor in determining the health of a population. This observation is well supported by comparing Cuba and the United States on life expectancy and health care spending. Cuba, with an average life expectancy of 77.1 years, is ranked 28th in the world, just behind the US (78.0 years). However, the annual per capita spending on health care in Cuba is among the lowest in the world; at \$186 it is a small fraction of the \$4500 per person spent in the US.

It appears that simply spending more money on health care is not the most effective strategy for increasing the overall health of a population. The Public Health Agency of Canada (PHAC) has reached this same conclusion. PHAC has stated that “there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. On the other hand, there are strong and growing indications that other factors such as living and working conditions are crucially important for a healthy population.”

Canadian senator Wilbert Keon, co-chair of the Senate Standing Committee on Social Affairs, Science & Technology, has taken this line of thinking one step further. He has gone so far as to call increased health care spending a threat to population health:

“...increased expenditures on health care are likely impacting negatively on the general health of our population by virtue of diminished investments in other areas like education (especially early childhood education), public housing, income security and other public services.”

Senator Wilbert J. Keon

Quoted in The Hill Times, 2008

The Benefits of Addressing Health Inequities

Evidence and experience have shown that action on reducing health inequities has many potential benefits for the health system, health outcomes and the overall quality of life of Canadians in the following three ways.

1. Given that there is a gradient of health status across the entire range of socio-economic determinants, addressing health inequities will improve the health of all.
2. Better health enables more people to participate in the economy, reducing the costs of lost productivity. Healthier employees, customers and communities will positively affect economic growth and the financial bottom line of BC companies by increasing competitiveness, productivity and profitability.
3. A further advantage of addressing health inequities is the potential for stemming the rapid increase in usage of health services. Easing the demand for services would decrease system cost drivers, reduce pressures on the delivery of health services, and, over the long term, contribute to the financial sustainability of our health care system.

Demonstrated Success Around the World

While health inequities exist for every nation in the world, many countries, especially in Europe (for example the UK, Sweden and Ireland) have developed dedicated, coordinated, and significantly resourced intersectoral strategies for reducing health inequities that are demonstrating positive outcomes. Quebec and Newfoundland & Labrador have also successfully implemented provincial anti-poverty strategies. At the national level, Canada has significantly decreased poverty amongst seniors over the past forty years, through the introduction of various employment and income-based public pensions. These achievements are encouraging for BC, as they provide a model for addressing health inequities in this province.

Guiding Principles & Key Policy Considerations in Addressing Health Inequities

Based on a review of promising practices in other jurisdictions, guiding principles for a well-founded and effective policy approach to addressing health inequities include:

- Levelling up, not down. The goal should be to continuously raise standards of health, education, living and working conditions and social well-being for all citizens; the challenge is to achieve both a raising and a levelling of the social gradient in these areas by ensuring that the most disadvantaged benefit most.
- Not making the inequities worse – helping the worst-off first. Universal interventions can have the unintended effect of providing the most help to the groups who need it least and therefore increasing inequities. It will be important to develop intervention programs based on a combined universal/targeted

approach (i.e., additional targeted interventions may be needed for the more disadvantaged members of society).

- Using a combination of regulatory and structural interventions for greatest impact in reducing socioeconomic stratification.
- Recognizing that complex problems require complex solutions; health inequities must be addressed on many fronts, through multiple, interrelated strategies.

A review of the efforts in other jurisdictions reveals a number of common features, presented here as key considerations for any activity undertaken in British Columbia to reduce health inequities:

- Making the reduction of health inequities a government and societal priority and allocating resources accordingly;
- Developing a multisectoral approach involving cooperation across all levels and areas of government, and across the public, private, NGO and community sectors; and,
- Setting clear goals and targets for all initiatives, and tracking progress on specific measures related to health inequity as part of a continuous improvement process.

Policy Options for Consideration

Based on the information, evidence and promising practices identified in this paper, taken together with the input obtained through a province-wide consultative process, five broad policy areas for reducing health inequities are offered for consideration. These policy areas and associated policy options are:

1. Income and Food Security

Ensuring adequate incomes and access to affordable, nutritious food:

- **Minimum Wage** – Increasing the minimum wage and indexing it to the annual cost of living. It is important that the minimum wage reflect a ‘living wage’ in order to eliminate the situation faced by the working poor – people working full time but still facing poverty.
- **Earned Income Benefit** – Ensuring that federal and provincial earned income benefits work to augment the incomes of people who are normally in the paid labour force.
- **Federal Child Benefit** – Combining the Canada Child Tax Benefit base benefit and National Child Benefit Supplement into a single refundable benefit and making it available to all low-income families, with no reduction of other benefits to offset the increase. Considering revising income thresholds and benefit reductions to avoid undue hardship on lower-income families as their work incomes rise.
- **Income Assistance** – Increasing welfare rates and indexing the rates to annual increases in the cost of living. About half of the increase will be required to make up for the erosion in purchasing power since 1994. Considering a mechanism to improve the income status of pregnant women.
- **Food Security** – Developing a healthy eating and food security strategy that includes:
 - Ensuring income assistance rates are determined with consideration for the actual cost of food.

- Addressing issues of availability and accessibility determined by the food system by engaging stakeholders (particularly local governments) to pursue strategies and community-based food security initiatives that focus on capacity building and community development.
- **Nutrition** – Supporting stronger labelling requirements on all packaged foods, banning trans-fats, reducing salt content requirements, restricting advertisements and sales of junk foods, implementing subsidy programs for nutritional foods, and promoting nutrient fortification (e.g., folic acid).

2. Education and Literacy

Increasing access to education, improving educational outcomes, and enhancing literacy skills:

- **Strong Start Program** - Enhancing the Strong Start program so that it is based on evidence of what works, is appropriately funded, and has a strong evaluation component.
- **Child Care Subsidy Program** - Reinvesting in the Child Care Subsidy Program.
- **Community Links** - Enhancing the Community Links program, that provides resources to students from disadvantaged backgrounds, to help reduce the number of students who drop out from high school.
- **BC Loan Reduction Program** - Reinvesting in the BC Loan Reduction Program to encourage more low-income students to attend university.
- **Support for Low-Income Students** - Strengthening support for low income students by extending financial support to students in one-year programs.
- **Adult Literacy, Education & Training** - Increasing resources for adult literacy, basic education and skills training.

3. Early Childhood Development

Ensuring that children are provided as many advantages as possible for optimal development:

Affordable High Quality Child Care and Other Early Learning Programs – Developing an affordable, accessible, high quality child care system and early learning opportunities for British Columbia (e.g., full-day kindergarten options for children aged three to five, such as those being explored by BC's provincial government).

These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modelling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families.

Healthier Families – Improving the health of children and families through policies that promote comprehensive, quality and affordable early childhood development and parenting services and programs ensuring that priority is given to those neighbourhoods and communities with the highest numbers of vulnerable children. Particular consideration should be given to the following components of early childhood development that have been shown to be successful and are recommended by First Call: BC Child and Youth Advocacy Coalition:

- Early Childhood Development (ECD) public health initiatives (e.g., home visits of all newborns by community health nurses, and vision, hearing, dental and speech screening).
- Adequately resourced and well-coordinated supports for parents, families and other caregivers (e.g., information, resources and workshops about child development and parenting, clothing exchanges and toy lending, drop-in, emergency and respite childcare, and outreach through mobile drop-in programs and playground programs).
- Targeted early intervention strategies and services (e.g., supports for high-risk mothers during the pre and post-natal period, and specific supports for children with developmental delays, disabilities, and behavioural issues).
- Strategies to improve access to ECD resources:
 - Community based information and referral services (e.g., well-resourced information and referral services to help families connect with ECD supports and services as well as broader community resources).
 - Designated resources for access and participation (e.g., proactive outreach strategies such as resources for transportation, translation, interpretation, literacy assistance, or provision of food and childcare as part of programs in order to address barriers to access).

In order to maximize effectiveness, it is further recommended that these services be delivered by an ECD Central hub and co-located with child and family-friendly agencies (e.g., family resource centres, schools, libraries, neighbourhood houses, community centres). Consideration should be given to prorating charges according to family income with low or no fees required for low income families.

4. Housing and Healthy Built Environments

Ensuring access to safe, affordable housing and enhancing the health and liveability of neighbourhoods:

- **Affordable Housing** – Ensuring there is an adequate supply of appropriate, safe and affordable housing for low-income families and individuals.
- **Housing First** – Developing policies to provide a range of housing and related supports for the homeless, and particularly for those with mental illness and/or addictions. A full continuum of housing options should be provided and matched to individuals' needs, including emergency and temporary accommodation (e.g., shelters), transition housing, and supportive (e.g., group homes often with on-site staff) and supported housing (e.g., co-operatives or independent apartments with off-site staff or case management support).
- **Healthy Built Environments** – Exploring policy options focused on making changes to the built environment such as:
 - Increasing housing density
 - Increasing the usage of mixed land-use patterns
 - Increasing the connectivity of urban streets to enable easier (shortest distance) walking between locations
 - Improving public transit as an effective alternative to the automobile

- Increasing the supply of recreation facilities and parks
- Enhancing streetscape design to improve aesthetics and safety for pedestrians and cyclists (e.g., adequate lighting, pedestrian crossings, sidewalks, bike paths)
- Improving physical access to healthy foods and discouraging junk foods through zoning and neighbourhood design where needed to support grocery stores, farmers' markets and restaurants

5. Health Care

Ensuring equal access to health services, and ensuring health care programs and services apply an 'inequities lens':

- Making health inequities reduction a health sector priority
- Engaging with other sectors toward reducing health inequities
- Integrating inequities reduction into health programs and services
- Strengthening knowledge development and exchange
- Reducing financial and other barriers to preventive and curative health care services
- Providing information to patients in a format that they can understand

Many different actions could be taken within each of these five policy option areas. The actions identified here have been selected because they have been articulated in existing documents or through consultative processes as being promising practices. When implementing any one of these actions, there is a great deal of best practices literature that should be consulted regarding criteria for designing and implementing programs and policies most effectively.

It is also critical to note that of all the policy options presented here, this paper supports the conclusion of the BC Healthy Living Alliance which has said that, "No single policy will be effective in itself. What is required is an integrated approach that will deal with the complex problems of health inequities from various angles."

Purpose of this Report

This discussion paper is intended to contribute to a better understanding of health inequities and the extent to which they exist in British Columbia, support informed discussion about health inequities among a broad range of audiences, and promote consideration of policy approaches for tackling this issue.

To that end, the paper:

- Explains the concept of health inequity and the social determinants of health
- Examines the extent of health inequities in British Columbia
- Outlines some of the social and economic costs of health inequities, as well the benefits of addressing health inequities
- Provides a number of health inequity policy considerations
- Presents policy options for consideration towards addressing health inequities

It is important to note that this paper is not intended to be a comprehensive literature review with policy recommendations flowing directly from that review. Many well-known and respected national offices and organizations (e.g., Canada's Chief Public Health Officer, the Senate Sub-Committee on Population Health) and international organizations (e.g., the World Health Organization) have produced papers thoroughly describing the social determinants of health, identifying the causality behind and scope of health inequities, and proposing solutions based on best practices to reduce health inequities. This report has drawn heavily from (and referenced where appropriate) those existing pieces of work.

The intent of this paper is to use BC data to describe the health inequities in this province, and to discuss policy options in five areas that have emerged through a local and ongoing consultative process that has included workshops, discussions, and reviews of this paper by key stakeholders interested in addressing health inequities. Those stakeholders represent various sectors including several provincial ministries, all of BC's health authorities, academia, non-profit organizations, municipal organizations and others.

Limitations

The data presented in this paper provide a broad picture of health inequities in British Columbia for men and women from the general population. It must be acknowledged, however, that members of some specific population groups in the province (e.g., First Nations' people) are at a higher statistical risk for developing chronic disease and experiencing health inequities than are people from the general population.

To ensure the high-level consistency and applicability of the findings and policy considerations presented in this report, the authors have deliberately excluded application of a health inequities lens to First Nations people and first generation immigrants. A proper assessment of health inequities for these more vulnerable population groups requires different considerations from those used in the current paper, with a sharp focus on more specifically relevant data, and required ownership of the process by the affected groups – particularly First Nations communities.

A gender and diversity-based analysis (GBA) of the information contained in this paper would greatly enhance our understanding of health inequities and where to focus efforts on addressing them. During the winter, 2008/09, the Provincial Health Services Authority (PHSA) intends to undertake a GBA of this paper with an eye toward developing a policy discussion paper for further consideration by relevant stakeholders.

I. What are Health Inequities?

Inequities in health are the central focus of this paper. Such inequities concern systematic differences in health status between different socioeconomic groups. But what exactly does that entail, and what is the difference between health inequalities, disparities, and inequities (three terms that are often used interchangeably)?

Within any country, differences in health can be observed across the population. Genetic and constitutional variations ensure that the health of individuals varies, as it does for any other physical characteristic. The prevalence of ill health also differs between different age groups, with older people tending to be sicker than younger people, because of the natural ageing process. Biologically, women in older industrialized countries demonstrate an advantage in survival over men at every stage of life. Chance also plays a role in everyone's life, with luck deciding which individuals avoid a particular infectious disease or hazard and which succumb.¹

These types of unavoidable differences are considered health *inequalities* or *disparities*. A genetic predisposition to heart disease or diabetes, for example, is not more likely to exist among people in Prince George than in Burnaby, or among people earning minimum wage compared to millionaires in the province.

The World Health Organization (WHO) defines health equity as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.”² Health inequities, therefore, involve more than inequality – whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health.

The key concept within this definition is ‘the absence of unfair and avoidable or remediable differences in health.’ Health inequities are health differences which are: socially produced; systematic in their distribution across the population; and unfair.³ Identifying a health difference as inequitable is not an objective description, but necessarily implies an appeal to ethical norms.⁴ Because they are systematic and socially produced, the further implication is that they are modifiable.⁵

When disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups (‘social advantage’ refers to one’s relative position in a social hierarchy determined by wealth, power, and/or prestige), inequities can be said to exist.

Using the WHO definition, British Columbia could be said to have health equity if the general health of people throughout the province was not unduly affected by where they live or their position within the socioeconomic hierarchy. So regardless of whether you were a sales manager on Vancouver Island, a forestry worker in the Cariboo, a bank teller in the Okanagan, or unemployed in Vancouver, your chances for enjoying good health and reaching the normal life expectancy for people of your sex in the province would be about the same.

As we shall see from the data presented in this report, this is certainly not the case in BC. Unfortunately, some BC residents will die younger or become disabled because they are worse off socio-economically. A description of these health inequities, their associated costs and what might be done to address them, constitutes the bulk of this report.

While health inequities exist for every nation in the world, jurisdictions that have committed to specific objectives for reduced inequities in health and are supported by appropriately integrated social, economic and health policies, are achieving progress toward their objectives. This is good news for BC, as it provides a model for addressing health inequities in this province.

Social Gradients in Health and Health Risks

In BC as in other jurisdictions in the developed world, health tends to be unevenly distributed among social groups within the population on a gradient corresponding to socioeconomic status. In general, people from more advantaged socioeconomic groups enjoy longer life expectancy and better health than people from less advantaged groups.

“We have a great deal of knowledge of the causes of non-communicable disease that represents the major burden of disease for people at the lower end of the social gradient in middle and high income countries...underweight, overweight, smoking, alcohol consumption, hypertension, sexual behaviour... the question is how these causes, and their inequitable distribution come about. That is, what are the causes of the causes? This brings us to the social determinants of health and health equity.”

World Health Organization

Achieving Health Equity: From Root Causes to Fair Outcomes, 2007.⁶

This correlation between health and socioeconomic status has been observed for many different health conditions, populations, and settings. In the UK, the correlation was starkly revealed by a series of studies (the Whitehall research)⁷ which categorized British civil servants into socioeconomic groups based on their occupation – from unskilled manual labourers to the highest government executives. The result revealed a clear gradient in morbidity and mortality rates across the entire socioeconomic hierarchy, with health status consistently improving in relation to position in the hierarchy. This gradient existed even though none of the civil servants were financially poor, and all had free access to medical care through the UK’s National Health Service.

These results clearly revealed that in addition to obvious health-affecting behaviours, factors related to socioeconomic position (e.g., educational level, income, working conditions, psychosocial stress) also have an impact on the health of people. These factors are commonly referred to as social determinants of health (SDH). They constitute long-term, systemic influences on health and must be distinguished from behavioural determinants of health (e.g., smoking). Because inequities in the SDH are avoidable, they are also fundamentally different from the unavoidable genetic determinants of health. Let us look briefly at the full list of determinants of health, and where the social determinants fit into that list.

Determinants of Health and Health Inequities

According to the WHO Commission on the Social Determinants of Health “the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services.”⁸

To fully understand why there is unequal distribution of money, power, material goods and services, one needs to look further upstream, at the structural roots of health inequities – within the education, taxation and health care systems, in labour and housing markets, and in urban planning and government regulation. These structural components of our socioeconomic system shape the differential vulnerability of people to health-affecting conditions and are powerful determinants of health.

The federal government notes that at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual characteristics and behavior. These factors are referred to as ‘determinants of health’. They do not exist in isolation from each other. It is the combined influence of the determinants of health that determines health status.⁹

The following are the commonly acknowledged key determinants of health.^{10,11} They have been organized into economic and social determinants (also referred to in this paper as structural or ‘upstream’ factors) and community and individual characteristics (also referred to in this paper as ‘downstream’ factors).¹²

Economic and Social Determinants (‘Upstream’ Factors):

- **Macroeconomic policies** – Includes taxation, monetary and international trade policies.
- **Culture, ethnicity and values** – Includes issues of racism, marginalization and traditional beliefs and practices.
- **Governance** – includes form of government (e.g., parliamentary democracy), political values (e.g., welfare state) and control of corruption.
- **Income and social status** – Differences in income significantly affect the availability and quality of many health-influencing factors, including good food, shelter, education and health services. Lower income and status also results in less control over life circumstances and discretion to act, which are key influences in peoples’ health.
- **Employment and working conditions** – Adverse working conditions (e.g., exposure to hazards, lax safety standards, lack of control) can present health risks that are more prevalent for people from lower paid occupational groups.
- **Education and literacy**– Differences in educational level are associated with differences in health awareness, health literacy skills and socioeconomic status, all of which are related to health inequity.
- **Early childhood development** – Children from disadvantaged families tend to do less well at school, are less likely to graduate from high school, and as adults, are less successful in attaining and holding well-paid jobs. These limitations, stemming from issues of childhood development, contribute to significant social disadvantage and health inequity.

Community and Individual Characteristics (‘Downstream’ Factors):

- **Physical (built) environments** – Differences in the distribution and quality of environmental factors (e.g., clean water, air and soil, housing) between urban and rural locations and among different neighbourhoods, and differences in the built environment (e.g., playgrounds, walking trails, sidewalks) from one area to another can contribute to inequities in health.
- **Social support networks** – Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal

with adversity, as well as helping them maintain a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being seem to act as a buffer against health problems.

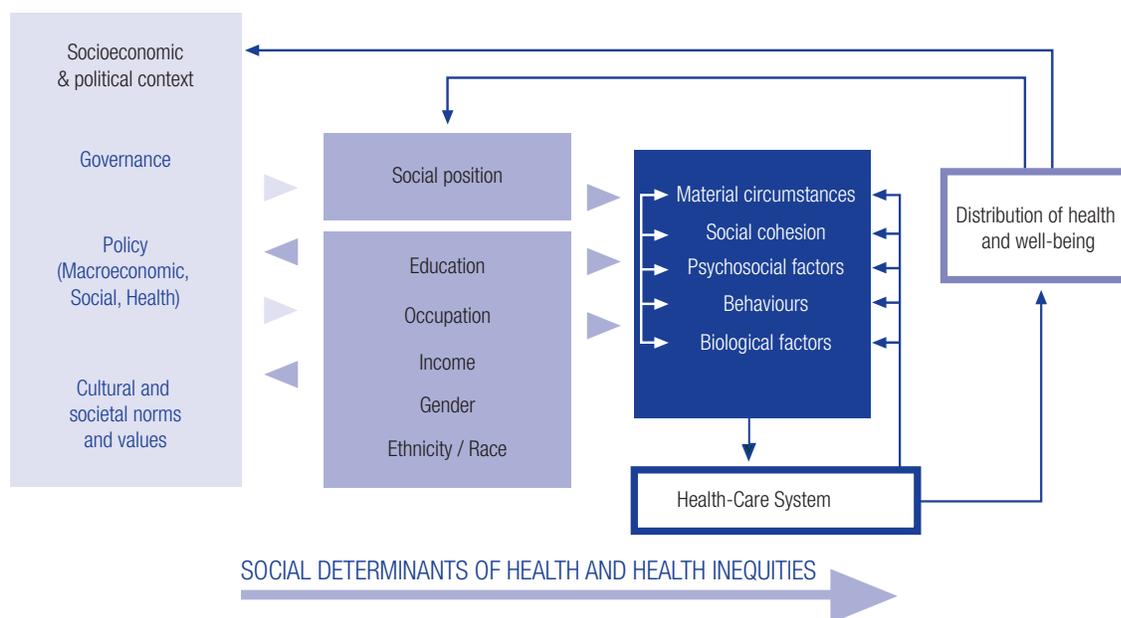
- **Social environments** – The importance of social support also extends to the broader community. When individuals are engaged with their social environment (e.g., as volunteers, as members of a community organization) they develop enhanced strategies to cope with changes and foster health.
- **Access to effective health care services** – Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs – all of which has an impact on health outcomes.
- **Risk behaviours** – This refers to risky behaviours individuals engage in such as smoking, alcohol or drug use, poor dietary choices, physical inactivity, and risky sexual behaviour.
- **Personal health practices and coping skills** – This refers to actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health.
- **Gender** – Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, and the relative power and influence that society ascribes to the two sexes on a differential basis. ‘Gendered’ norms influence the health system’s practices and priorities. Many health issues are a function of gender-based social status or roles. Differences in the distribution of material and social resources between men and women can contribute to health inequity. For example, lone-parent families are almost always headed by women. In BC, lone-parent families are also much more likely to live in poverty than any other type of household group.
- **Biology and genetic endowment** - The basic biology and organizational make-up of the human body are a fundamental determinant of health.

Causes of Health Inequities

Health inequities stem largely from an unequal distribution of (or exposure to) significant determinants of health. People from lower socioeconomic groups tend to be more exposed to health hazards in the physical environment, experience more psychosocial stress, suffer more material deprivation (e.g., poor nutrition, inadequate housing) and have fewer opportunities to make health-promoting behavioural choices such as getting regular physical exercise.¹³ Increased exposure to stress, as well as a lack of resources, skills, social support and connection to the community can contribute to less healthy coping skills and poorer health behaviours such as smoking, over-consumptions of alcohol and less healthy eating habits.¹⁴ These same people are often less likely to have the opportunity to use health care, usually because of direct or indirect financial barriers. As a result, people from lower income groups are subject to higher rates of disease and disability than are people with higher income levels.^{15,16}

The WHO’s Commission on Social Determinants of Health (CSDH) has developed a conceptual framework that identifies the major categories of social determinants and the processes and pathways that generate health inequities.¹⁷ (see Figure 1)

Figure 1. Commission on Social Determinants of Health Conceptual Framework



Source: CSDH Final Report, 2008 (Amended from Solar & Irwin, 2007).

The extent of the difference in health status between people from the bottom and the top of the socioeconomic hierarchy is a measure of the health inequity of a society. In order to understand how such health inequity develops, it is necessary to closely examine the relationship between the *upstream determinants of health* (the far left, lightly shaded box on this diagram, that includes elements of the socioeconomic and political context and the middle, medium shaded box on this diagram that includes social position, education, occupation, income, gender and ethnicity/race) and the *downstream determinants of health* (the darkly shaded box on this diagram that includes material circumstances, social cohesion, psychosocial factors, behaviours and biological factors, as well as the health-care system).

The framework shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to education, occupation, income, gender, ethnicity and race. These socioeconomic positions in turn shape specific determinants of health (downstream factors). Based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions.¹⁸

Upstream (Structural) Social Determinants of Health

Peoples' lives are shaped by a wider set of forces: economics, social policies and politics. This socioeconomic and political context is broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including (but not limited to): policies concerning the labour market, the educational system, medical care, public health, and housing distribution; political institutions and governance processes; and, other cultural and societal biases, norms and values. "Among the contextual factors that most powerfully affect health are the welfare state and its redistributive policies (or the absence of such policies)."¹⁹

These social structures and processes contribute to social stratification – “the systematically unequal distribution of power, prestige and resources among groups in society.”²⁰

The most common proxies used to measure social stratification include income, education and occupation. Income and education can be understood as social outcomes of the stratification process, while occupation serves as a proxy for social stratification. Social class, gender and ethnicity also operate as important structural determinants.

Downstream Social Determinants of Health

The upstream or structural determinants shape the distribution of downstream social determinants of health. There are differential exposures to disease-causing influences in early life, social and physical environments and work experiences, associated with social stratification. Depending on the nature of these influences, different groups will have different experiences of material conditions, behavioural options, and psychosocial support, which make them more or less vulnerable to poor health.²¹

Many risk factors for morbidity and mortality are more prevalent in lower socioeconomic groups, and it is these inequalities in exposure to specific health determinants which should be seen as the main explanation of health inequities. These ‘downstream’ risk factors fall into several categories described next.

Socioeconomic disadvantage may affect health through various downstream mechanisms: material deprivation, social cohesion (supports), psychosocial risk factors, risk behaviours, biological factors, and access to effective health services.

‘Material deprivation’ associated with low income includes exposure to environmental toxicants (e.g., poor air quality, lead and other heavy metals, etc), inadequate housing and homelessness, poor working conditions (e.g., injuries, toxic exposure) and inadequate access to healthy food and facilities for physical activity.

‘Social cohesion’ or ‘social capital’ is “looked upon as an extension of social relationships and the norms of reciprocity, influencing health by way of the social support mechanisms that these relationships provide to those who participate on them.”²²

A third group of specific determinants which contribute to the explanation of health inequities are **‘psychosocial risk factors’**. Those who are in a low socioeconomic position on average experience more psychosocial stress in the form of negative life events (e.g., loss of loved ones, financial difficulties), daily hassles, ‘effort-reward imbalance’ (high levels of effort without appropriate material and immaterial rewards), and a combination of high demands and low control. These forms of psychosocial stress can in their turn lead to ill-health, either by affecting biology (e.g., compromised immune systems) or by inducing risk-taking behaviours.

Another group of contributory factors are health-related **‘behavioural risk factors’** such as smoking, inadequate diet, excessive alcohol and/or drug consumption, and lack of physical exercise, that influence an individual’s health. While these are behaviours of individuals and to some extent reflect personal choice, for people living on low incomes in inadequate housing and poor

neighbourhoods, there is often little opportunity to access healthy food or recreational facilities. Hence these behaviours are far more prevalent among the disadvantaged and marginalized.

Biological risk factors, i.e. an individual's genetic make-up and predisposition towards particular conditions and/or disease influence health outcomes, but these risk factors can be exacerbated by (or alternatively, mitigated by) other determinants of health.

Finally, the **health system** plays an important role in mediating the differential consequences of illness in people's lives. Social stratification determines differential access to and utilization of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival.

'Reverse Causality'

Although Figure 1 suggests causality moving in a single direction (downstream), in fact, the causal pathway is not so straightforward, with downstream factors feeding back to influence less immediate (upstream) factors, and health outcomes themselves influencing preceding factors along the causal pathway. For example, a chronic condition such as type 2 diabetes – which can often be attributed to both socioeconomic factors (e.g., poverty, which makes it challenging to buy healthy food and exercise) and behavioural factors (e.g., diet) – can lead to more complicated health conditions like kidney disease. Kidney disease, in turn can further increase the negative impact on an individual's situation, affecting their employment status, financial circumstances (material factors) and even their position within the socioeconomic hierarchy.

"[The link between the social determinants and health] is a two-way street. Health is a product of income, employment, housing, education and other factors. At the same time, health is itself a resource for seeking and securing adequate income, employment, housing, education and others. It is a resource for living."

*Health Nexus and Ontario Chronic Disease Prevention Alliance
Primer to Action: Social Determinants of Health, 2008.²³*

The reverse causation theory - that poor health limits the ability to engage in paid work and, therefore, leads to poverty - has, for the most part, been discredited in the literature as the main direction of causality.²⁴ For example, longitudinal studies (which take a life-course approach) such as those conducted in England or reviewed by Michaela Benzeval and Ken Judge, have consistently seen poverty occurring before and leading to ill health.²⁵ According to another reviewer, "most of the studies reviewed ... conclude that *reverse causation* is not a serious problem and that the main direction of influence is *from poverty to poor(er) health*."²⁶

Two 'real life' examples will help demonstrate the influence of upstream and downstream factors.

Julie's Story

Julie (Julie's name has been changed to protect her identity) is a single woman in her 40's who lives in a rural and remote location in BC with her two children.²⁷ Julie struggles with obesity and has diabetes which

is poorly controlled. During the past several years, Julie's primary health care nurse encouraged her to lose weight by eating a nutritious and balanced diet, and following an exercise program. The nurse also provided information to Julie about how she could more regularly monitor and control her diabetes. Over time, the nurse has grown increasingly frustrated with Julie, who has not changed her diet or engaged in exercise, lost any weight, or in any way attempted to control her diabetes more effectively. Julie, meanwhile, has also grown increasingly frustrated because she feels that the nurse doesn't understand the reality and pressures of her life, which make it extremely difficult for her to follow the nurse's advice.

As the frequency of the confrontations about Julie's continuing poor health increased between the two women, Julie thought it might help improve the nurse's understanding of her situation if she showed her a picture of where she lives. To one appointment Julie brought a picture of her house...essentially it is a poorly constructed shack with a roof that is covered with a tarp. Julie explained to the nurse that she has a leaky roof and no running water. Julie further explained that as part of her daily routine, she has to fetch water and cut wood to feed the stove that heats the house. Julie continued with her story....she lives ten miles from town and has no car, so she must rely on the schedules and kindness of others to assist with getting groceries home. Several factors combined make it impossible for Julie to access fresh fruit and vegetables for her family: 1) the fact that she is on welfare, has a limited budget, and fruits and vegetables are more costly in rural and remote communities makes it difficult for her to afford them, and 2) the fact that she is not able to shop frequently makes it impossible for her to keep fresh produce in the house, even if she were able to afford them.

After hearing more about Julie's living conditions and life stressors, the nurse came to develop a greater understanding of the many barriers that keep Julie from being healthy. She realized that Julie spends a significant amount of time and energy dealing with basic issues related to her own and her children's survival (e.g., fetching water, heating the house, dealing with the leaky roof, figuring out how to get food home). She came to understand further that this situation, compounded by the stress associated with living in poverty, leaves Julie with no time and energy left over to take care of her own health in terms of eating a nutritious diet, engaging in exercise, or taking other necessary steps to control her diabetes.

Dana's Story

Dana (Dana's name has been changed in order to protect her identity) is a woman in her thirties from the Cowichan Valley area of Vancouver Island.²⁸ She was the oldest of three children, all born before her mother was 22. As a teen, her mother had suffered a nervous breakdown and had spent time in a hospital psychiatric unit, where she met Dana's father, who was an alcoholic.

While her children were still very young, Dana's mother left her husband after he physically assaulted her. Dana's childhood years were marked by poverty, hardship and frequent moves. By grade five she had already attended four different schools, and over the course of her childhood experienced three different step-fathers. At 16, Dana left school and began living with a 25-year-old man. She had her first child at 17 and by the time she was 21, she was a single parent living on welfare with two young children.

Over the next ten years Dana repeated with her children many of the experiences she lived through as a child. Although she completed her high school and various employment training programs, the demands of raising her children – including a third son with muscular dystrophy – prevented her from accepting more than part-time work. This made her dependent on income assistance and other forms of government support. Following a particularly desperate period in her life, during which she made repeated visits to a

hospital emergency department demanding help, she was arrested and committed to a two-week stay in a psychiatric unit where, she says, “they discovered my need for help was real.” Like her mother, Dana has experienced physical abuse from a partner. She also has issues with chronic pain and depression, and says she has always lived with the fear of poverty and her inability to provide for her children.

Looking on the broad circumstances of Dana’s life and those of her mother, the repeating patterns are evident. These are lives shaped from their earliest years by social determinants that set the parameters for the socioeconomic and health outcomes that follow. Although it is clear nobody would freely choose a life of poverty and deprivation for themselves and their children, we see generation after generation of people finding themselves in these circumstances. Breaking these patterns requires social, economic and political policies that effectively address such social determinants as early childhood development, income security and housing/homelessness toward reducing health inequity for all groups within the population.

A Lesson for Policymakers: Focusing on the Upstream

Health planners and policymakers have something to learn from examining Julie’s and Dana’s lives. It is clear that in order for Julie and Dana (and the many individuals who live in circumstances similar to theirs) to be able to improve their health status, focusing on individual health behaviour will be ineffective; the social and economic determinants of health such as housing, income and food security first need to be addressed.

This approach is supported by the US’s Institute of Medicine which has concluded that such factors as “stress, insufficient financial and social supports, poor diet, environmental exposures, community factors and characteristics, and many other health risks,” which contribute significantly to the risk of disease and death, are probably more effectively addressed at the level of community and environmental interventions than through individual-level interventions.²⁹

To fully understand why people with less money and education tend to experience more health problems than people higher up the scale on those measures, we need to look further upstream, at the structural roots of health inequity – within the education, taxation and health care systems, in labour and housing markets, and in urban planning and government regulation. These structural components of our socioeconomic system shape the differential vulnerability of people to health-affecting conditions and are powerful determinants of health.

Unlike the behavioural determinants of health, these upstream factors are ones over which individuals have no direct personal control, but which can only be altered through social and economic policies and political processes. When planning initiatives to improve health outcomes, it is imperative to “recognize that people live in social, political and economic systems that shape behaviours and access to the resources they need to maintain good health,”³⁰ and that “while biological interventions and exhortations to individuals to change their behaviours are easier to administer, changes in social factors, policies, and norms are necessary for improvement and maintenance of population health.”

For policymakers, this means looking well beyond measures targeting health affecting behaviours – such as smoking cessation or wellness promotion campaigns. For real traction on achieving gains in health equity, the focus must be on tackling the upstream, macroenvironmental factors – the social determinants of health – and ensuring that measures toward this end are included as an integral part of any policy package. As the WHO’s Commission on Social Determinants of Health (CSDH) notes, “Strengthening health equity...means

going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavour, the Commission focuses on the ‘causes of the causes’ – the fundamental global and national structures of social hierarchy and the socially determined conditions these create in which people grow, live, work and age.”³¹

The Commission identified three principles of action, which it used to structure its overarching recommendations and the entire final report.* They are:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

* See Appendix 1 for more detail re: the CSDH’s Framework for Action, principles, and overarching recommendations.

II. Health Inequities in British Columbia

The 'BC Paradox'

On the whole, British Columbians are among the healthiest people in the world. Average life expectancy at birth (LEo) for BC men is higher than the life expectancy for men in any other province of the country,³² and BC men assumed the front rank in life expectancy globally in 2003, after surpassing the Japanese.³³ It is also interesting to note that BC men's LEo is also increasing at almost twice the rate for BC women.

BC women also have a relatively high average life expectancy, and live longer on average than their male counterparts. BC women currently rank third (based on the most recent data) against the leading nations for LEo, behind only Japan and Spain.³⁴

British Columbia also has the lowest rates of smoking and obesity and the highest rate of physical activity in the country.³⁵

While these comparative measures reflect favourably on the overall health of British Columbians, they do not tell the whole story. It must also be noted that although British Columbians currently enjoy a relatively high average level of health, improvements in BC's and Canada's health statistics are not keeping up with the improvements being made in many of the other healthiest nations of the world.³⁶ The average life expectancy for both BC men and women, for example, is rising much less quickly than the life expectancies for men and women in Japan and a number of European nations. In fact, according to trending data, by 2010, BC women are projected to fall from third to seventh place behind the women of Japan, Spain, Australia, Japan, France, Italy and Switzerland.³⁷

And, even more serious, is the fact that in the midst of this picture of general good health there is a relatively large number of disadvantaged people in this province – the unemployed and working poor, children and families living in poverty, people with addictions and/or mental illness, Aboriginal people, the homeless, and others – who experience significantly lower levels of health than others.

In fact, BC has the highest rates of poverty (see Figure 3) and particularly child poverty (see Figure 5) in Canada. This presents a paradox: despite having by some measures the best overall health outcomes in Canada, BC also has the highest rates of socioeconomic disadvantage in the country. This 'BC paradox' can be explained by two factors:

1. The overall average health status data in BC for measures such as life expectancy do not reveal the significant inequities that exist within the province – averages conceal differences. For example, looking at just one indicator of health inequity among British Columbians, there is a difference of almost ten years between the average life expectancy for people in Richmond (84.81 years) and people in the downtown eastside of Vancouver (75.01 years).³⁸ Similar inequities of health are reflected by differences in the prevalence of chronic disease for people from the highest and lowest income groups, as will be shown later in this report.
2. BC has not always been behind the rest of the country in measures such as childhood poverty rates. It is only over the past decade that BC has fallen behind the other provinces (See Figure 3), to a large extent

because of proactive and successful anti-poverty strategies introduced in provinces such as Quebec and Newfoundland[†]. As shown in Figure 4, the overall poverty rates in BC families have been relatively stable over the period (except for female lone-parent families). But, in the coming years, as we start to see expected health status improvements in the provinces that have been more aggressive in reducing poverty (it is likely too early to see those improvements just yet), BC is also likely to fall behind in its average health status as well.

A further consideration is the time lag in the causal link between performance on the social determinants of health (including educational achievement, poverty, early childhood development, housing, etc.) and outcomes on health measures such as life expectancy. The full impact of the effects of the upstream determinants of health may not yet be fully realized or apparent from our current population health statistics.

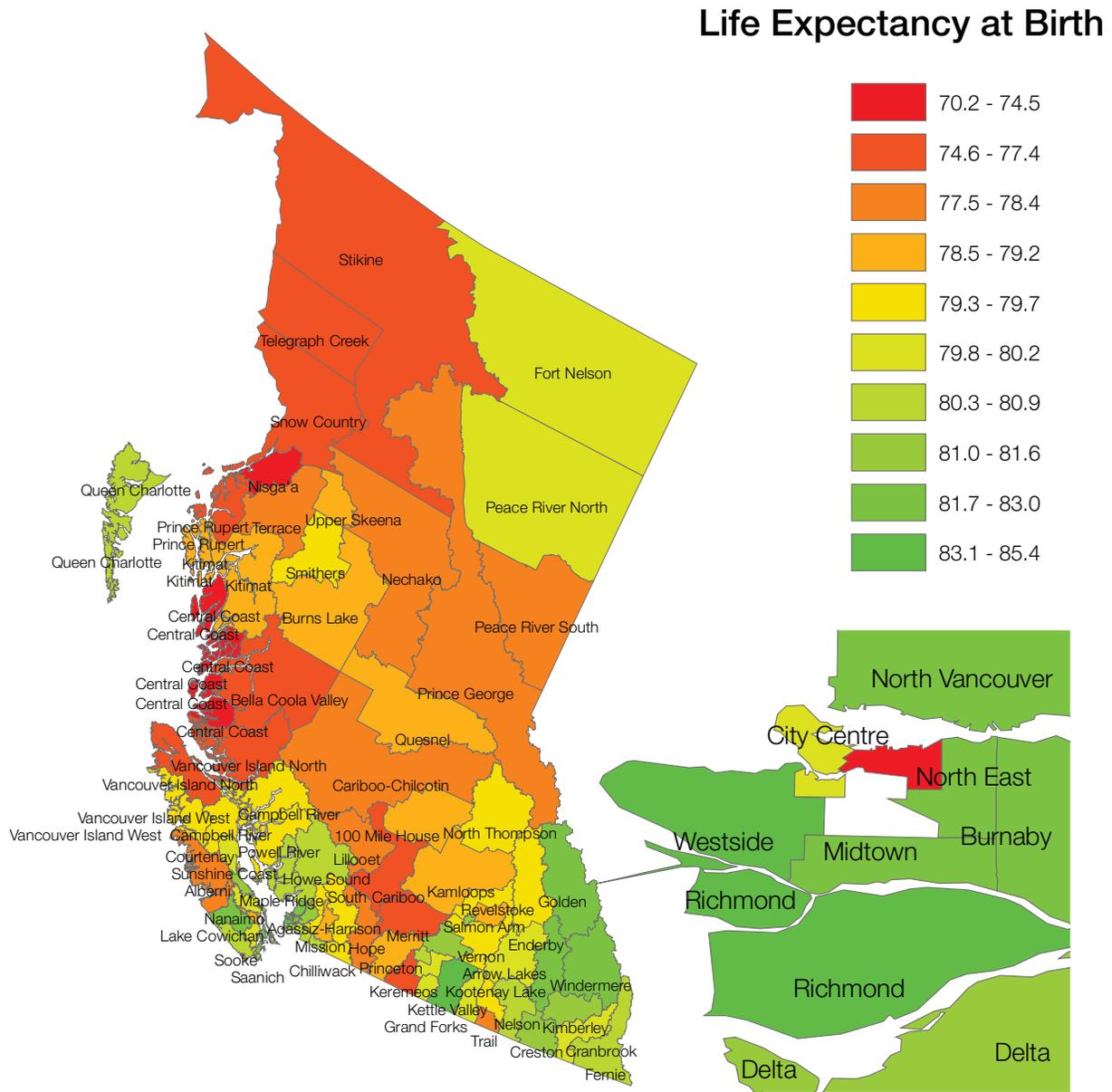
Inequities in BC

Inequities in Life Expectancy by Geographic Location

Life expectancy is a commonly used general measure for comparing the relative health of populations. If life expectancy is used as an indicator for health inequity across BC's geographic regions, we can see that the highest life expectancies are found in the southern, urban areas, and the lowest in the north and central coast regions (see Figure 2). The gap of 10-14 years in average life expectancy between these regions constitutes a significant degree of health inequity.

[†] During the past decade, both provinces have made significant progress in decreasing their poverty rates (see Figure 3). In 1983 Newfoundland had the highest poverty rate in the country at 20.2%. It stayed quite high for several years after that, hovering around 16%. It declined for a few years and then increased steadily again until it reached a spike in 1995 with a poverty rate of 17.1%. In 2006 it had a poverty rate of 7.6%. In eleven years, that represents a 9.5% reduction. Although it had some minor dips between 1984 and 1992, Quebec's poverty rate was on an overall incline during the seventeen years between 1980 and 1997, when it peaked at a poverty rate of 19.3%. Since 1997, it has been on a steady decline and is now at 11.6% (a 7.7% decline over nine years from its highest point).

Figure 2. Life expectancy by geographic region in BC (2001 – 2005)



(Data source: BC Health Data Warehouse and BC STATS five year data from 2001 to 2005)

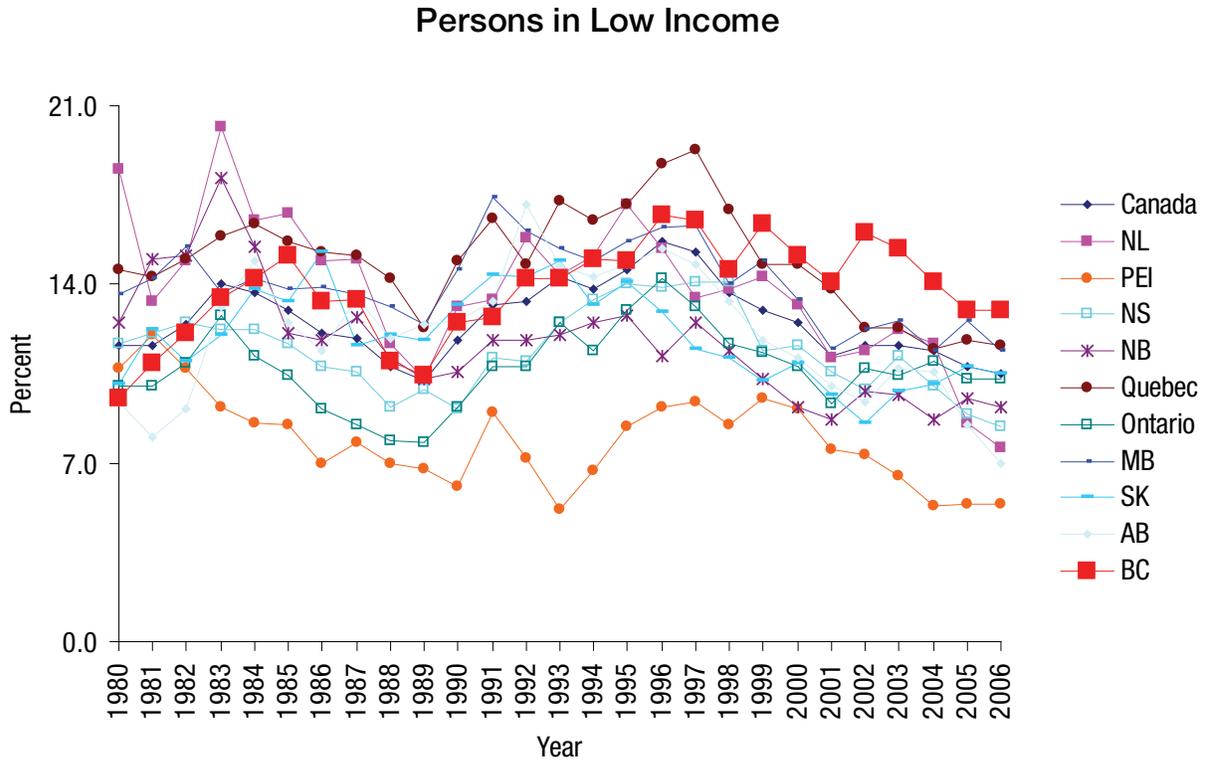
Inequities in Income

Poverty

Although the primary social determinants of health (SDH) are closely interrelated, poverty is arguably the most dominant factor within the SDH matrix. And on this measure, British Columbia stands apart from the rest of Canada.

During the last 20 years, BC has consistently had one of the highest poverty rates in the country (see Figure 3). It is interesting to note that while BC had the lowest poverty rate in Canada at one time (1980), the poverty rate in BC has been higher than the Canadian average since the mid-1990s. From 1999 to 2006, BC had the highest poverty rate of all the provinces in Canada, peaking in 1996 at 16.7%. Although there has been a declining trend in the provincial and national rates of poverty since that time, the rate in BC (13%) remains the highest in the country, and about 2.5 percent higher than the national average (10.5%).

Figure 3. Poverty rates for all persons - Canada and all provinces (1980 – 2006)



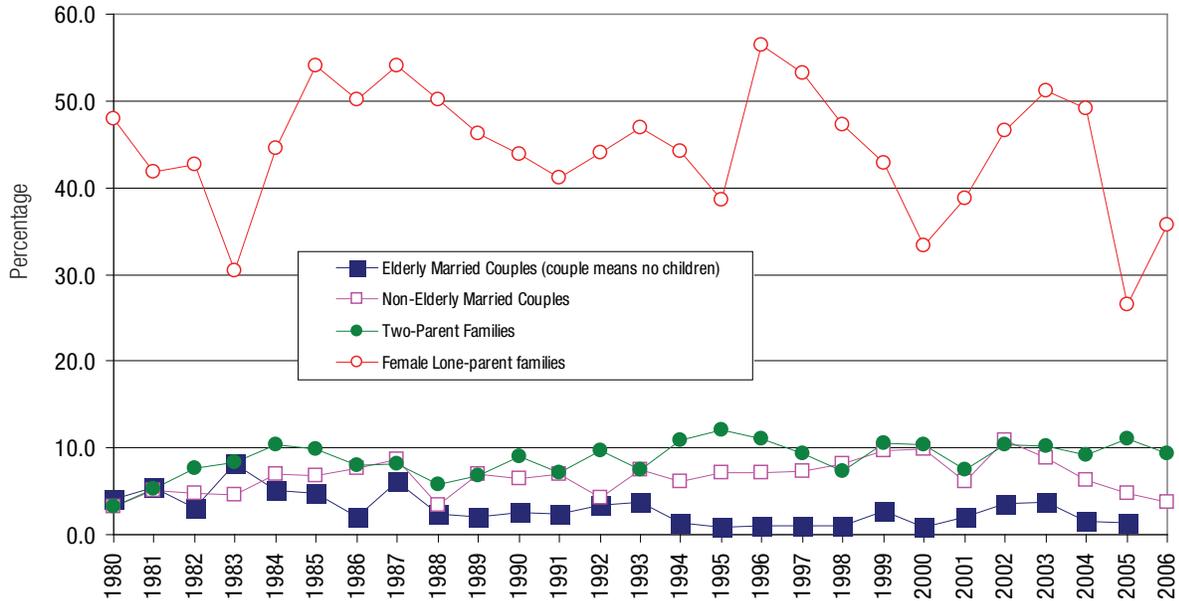
Based on after-tax income, standardized to 2006 dollars. Data source: Statistics Canada Income Trends in Canada (2006)

Although it is true that BC, like the rest of Canada, has enjoyed a relatively buoyant economy over recent years, it is important to note that these economic benefits have not been equitably distributed. This is shown by comparing the significant income gap between the richest 10 percent and the poorest 10 percent of families, and how that gap has grown over time. In 1979 Canada’s richest families had 31 times the income of this country’s poorest families. By 2004 the income gap had expanded to where the richest families had 82 times the income of Canada’s poorest families.³⁹

Within BC, the group most vulnerable to poverty is lone-parent women with children. As shown below (Figure 4), in 2006 about 37 percent of lone-parent women in BC lived in poverty - which is significantly higher than the poverty rates of all other families (the poverty rate of two-parent families in BC is less than 10 percent). Thirty-seven percent is a high number, but it is actually lower than what it was during most of the previous 25 years (it peaked close to 60 percent in 1996). In fact, BC currently has the highest rate of poverty for lone-

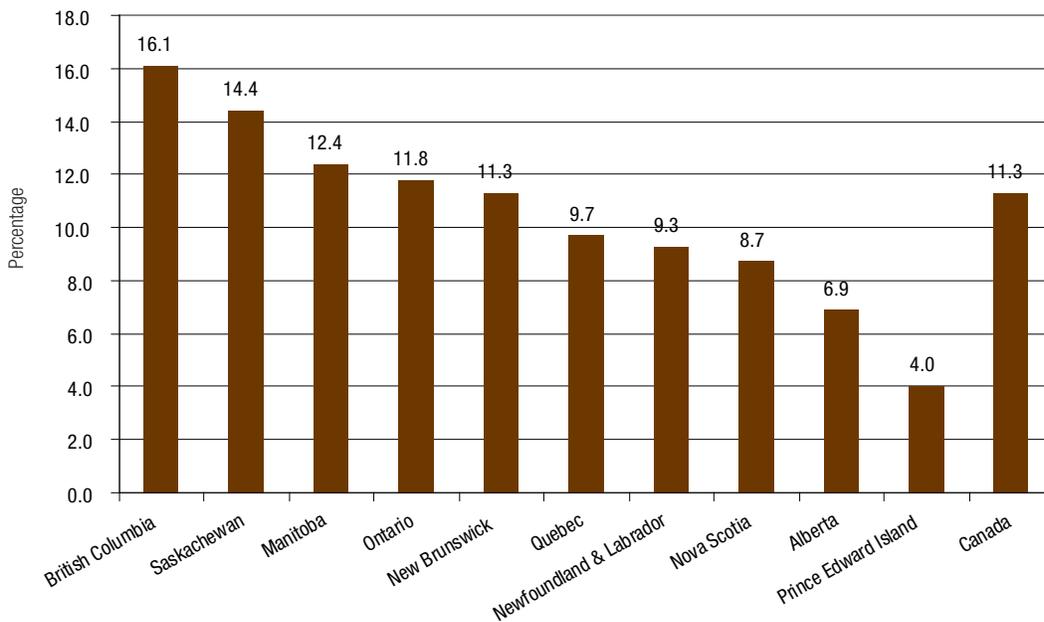
parent families in Canada.⁴⁰ As a direct result of this, BC also has the highest rate of childhood poverty in the country (see Figure 5).

Figure 4. BC poverty rates by family type (1980-2006)



Based on after-tax income, standardized to 2006 dollars. Data source: Statistics Canada Income Trends in Canada (2006)

Figure 5. Child poverty rates by province - 2005

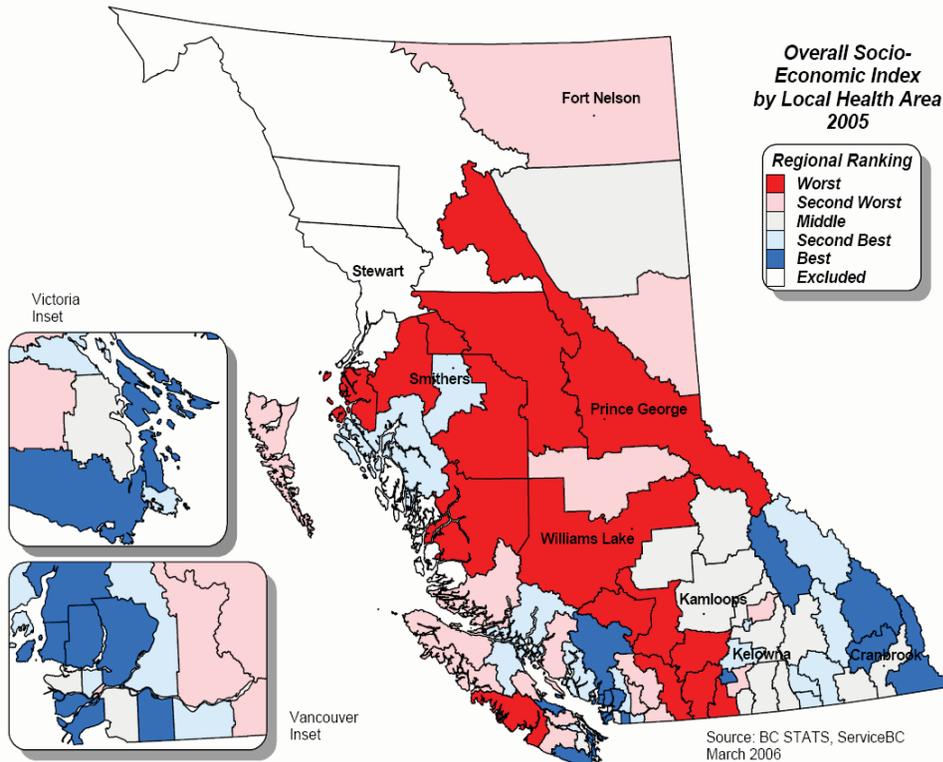
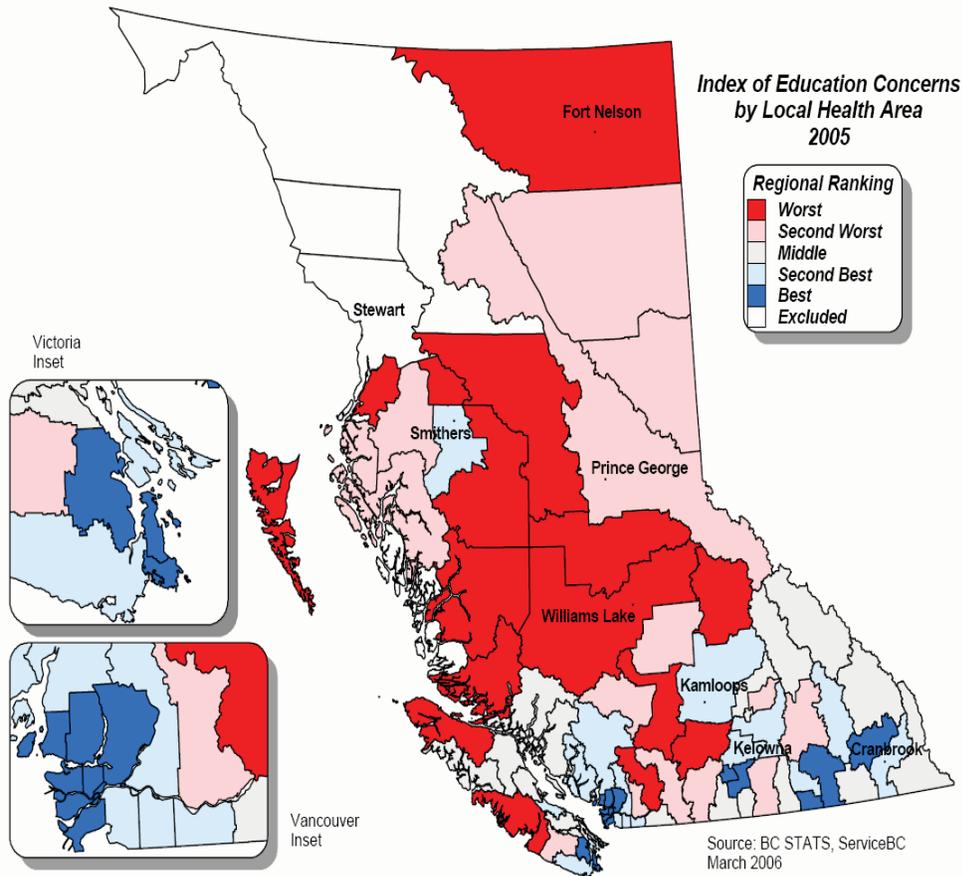


Based on after-tax income, standardized to 2006 dollars. Data source: Statistics Canada Income Trends in Canada (2006)

There is also considerable inequity in the geographic distribution of poverty, socioeconomic disadvantage and educational concerns across BC. As shown in Figure 6, the poorest regions are the rural and northern areas of the province. The exception is Vancouver, which ranks in the middle on the socioeconomic index. One may have expected Vancouver to rank higher, however, it is clearly being influenced by the data coming from seriously socioeconomically disadvantaged neighbourhoods such as the city's downtown eastside. On the other hand, the urban centres of Vancouver and Victoria, along with portions of the Okanagan and the Kootenays have the highest educational levels in the province. It is no surprise that educational levels by region across the province correspond quite closely to regional income levels.

Generally, children from families with lower income and lower levels of education have poorer overall health and higher rates of cognitive difficulties, behavioural issues, hyperactivity and obesity through childhood.^{41,42} The consequences of these disadvantages include children growing into adults with lower educational attainment, weaker literacy and communication skills, fewer employment opportunities and poorer overall physical and mental health.⁴³

Figure 6. Regional distribution of average socioeconomic condition and educational level in BC (2005)

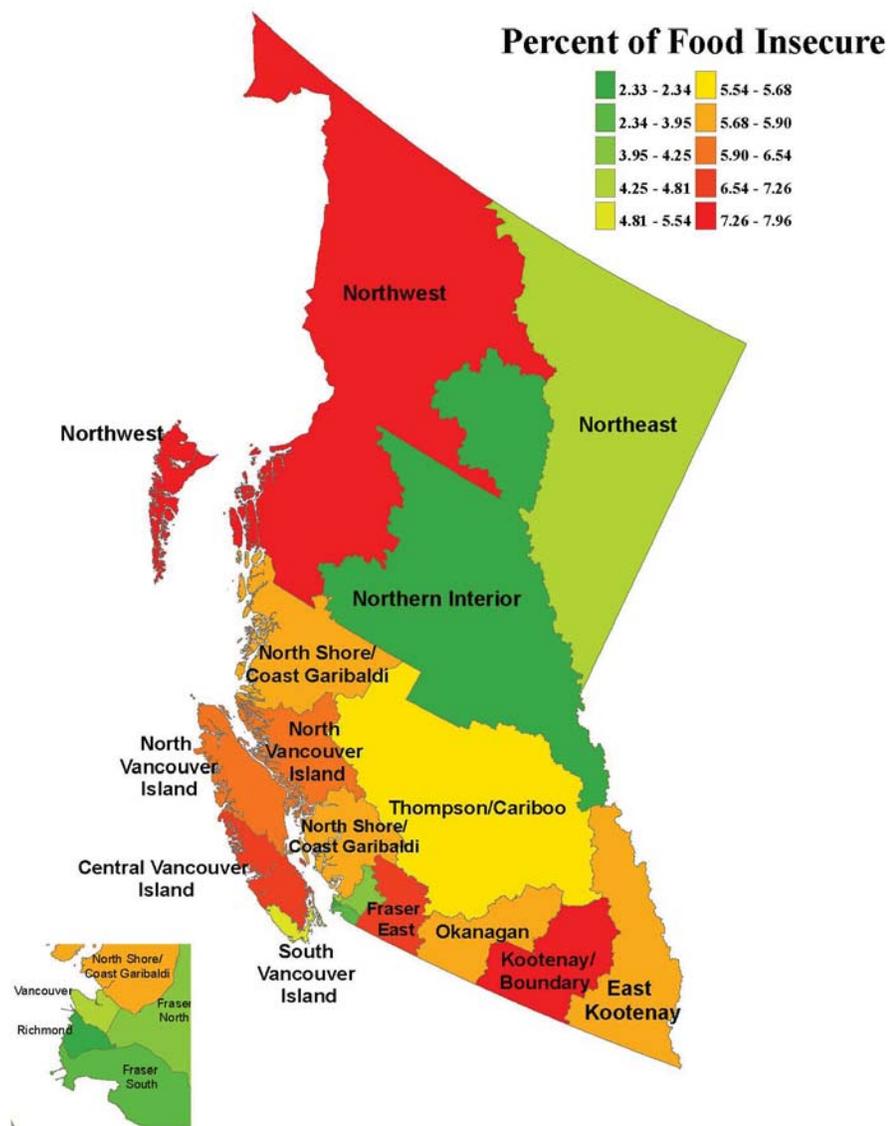


Food security

Food security is closely related to poverty. People are defined as being food insecure when they lack physical and economic access to sufficient, safe and nutritious food at all times to meet their dietary needs for an active and healthy life.⁴⁴

As shown in Figure 7, the areas where food insecurity across the province is greatest are the northwest part of BC, as well as the southern half of the province, particularly Central Vancouver Island, Fraser East and Kootenay/Boundary areas.

Figure 7. Regional distribution of food insecure households in BC (2005)

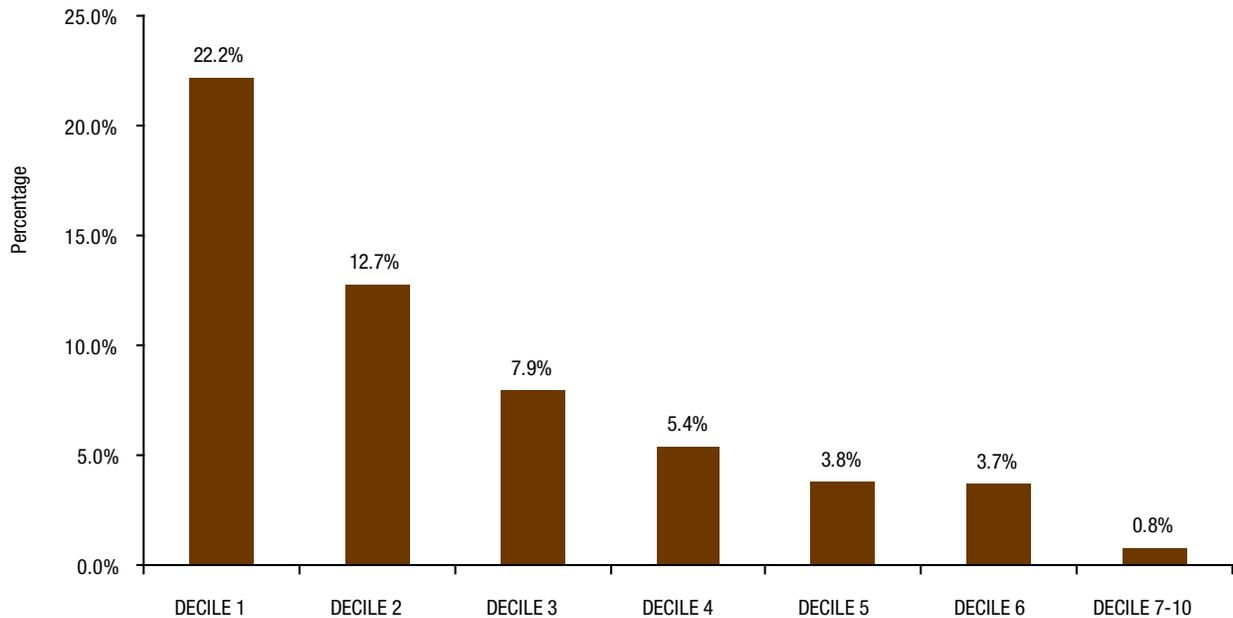


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

Figure 8 shows the extent of food insecurity in BC across ten divisions of gross household income (i.e. before taxes and transfers). The graph indicates that nearly a quarter of all people in the lowest decile of household income in BC are food insecure. At the other end of the spectrum, food insecurity is so insignificant, the top three deciles must be lumped together in order to obtain a statistical measure.

Figure 8. Percentage of food insecure households in BC by income decile (2005)

(1 = lowest household income level; 10 = highest household income level)

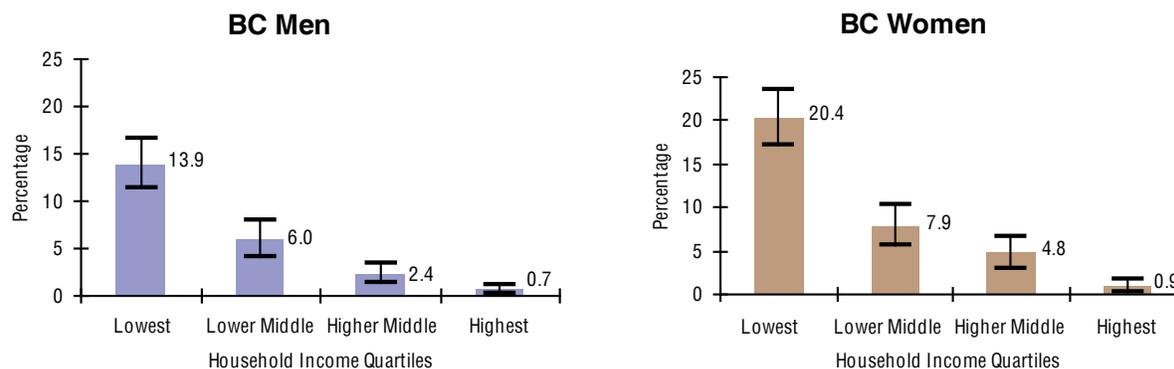


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Public Use Microdata File (2005).

This gradient is significant to note because of the relationship between food security and health outcomes - poorly nourished people are less resistant to infections, tend to heal more slowly, acquire more diseases and experience longer hospital stays.⁴⁵

Gender also plays an additional role in determining the extent of inequity on this measure. As shown in Figure 9, women in the lowest income group are much more likely to be food insecure than men in the lowest income group.

Figure 9. Prevalence of BC men and women with food insecurity in the past 12 months by gross household income quartiles (i.e. before taxes and transfers) (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005)†.

Accounting for the difference between men and women, it should be noted that average incomes are lower for women than men, and that women are most often the responsible parent in single-parent families, i.e. their incomes must cover the food, shelter and other costs for both themselves and their children.

Homelessness

Related to poverty is the growing issue of homelessness in British Columbia, especially in the urban centres of the province. The Greater Vancouver Regional District's 2005 Homeless Count identified 2,174 homeless people in the Vancouver area, almost double the number from its 2002 survey.⁴⁶ Also significant is the fact that the number of homeless seniors more than doubled over this same period. This growth in homelessness among seniors will likely continue as the average age of the BC population rises (over the next few decades the proportion of seniors among the BC population is expected to increase from its current level of 14 percent to 24 percent by 2035).⁴⁷

In Metro Vancouver, with the highest real estate values in the country, 126,515 people (who are part of 56,215 households) are living at risk of homelessness. Typically, these people occupy substandard housing and must spend more than 50 percent of their incomes on shelter.⁴⁸

Another recent report, issued by Simon Fraser University's Centre for Applied Research in Mental Health and Addictions, estimates that up to 70 percent of BC's homeless people suffer from both a mental illness and a drug addiction. It estimates that 130,000 British Columbians have a severe addiction and/or a mental illness, and that 26,500 of these people are inadequately housed, including 11,750 who are 'absolutely homeless.'⁴⁹ (the report defines the 'absolutely homeless' as those who live on the street or cycle through shelters and rooming houses).

† The 'whiskers' at the top of each bar in most of the Figures contained in this report indicate a 95% confidence interval. The interval represents the range of values, consistent with the data, which is believed to encompass the 'true' value with high probability (i.e., the experimental results are true and not the result of chance alone). When comparing rates in the bar charts, if there is no overlap between the confidence intervals ('whiskers') of two rates, we can say that they are significantly different. In many of the bar charts in this paper it would be inaccurate to say that some of the rates positioned immediately beside each other on a given chart are significantly different from one another. It is fair and reasonable to say in the great majority of the charts, however, that there is a significant difference between the highest rate and the lowest rate depicted on the chart. This difference represent the concept of a **'gradient'** referred to in this paper.

Inequities in the Prevalence of Chronic Disease

Given that poverty is arguably the most significant social determinant of health, and in view of BC’s relatively high rate of poverty, it should be no surprise that significant inequities in health are revealed across the provincial population when segmented by **gross household income** (i.e. before taxes and transfers).

For this paper, household income has been broken into quartiles and further divided by gender so that any existing gradients within genders could be identified.

For men in BC, the gross household income quartiles are:

Lowest income:	< \$30K per yr.	Upper middle income:	\$50K - \$80K per yr.
Lower middle income:	\$30K - \$50K per yr.	Highest income:	> \$80K per yr.

For women in BC, the gross household income quartiles are:

Lowest income:	< \$22K per yr.	Upper middle income:	\$40K - \$70K per yr.
Lower middle income:	\$22K - \$40K per yr.	Highest income:	> \$70K per yr.

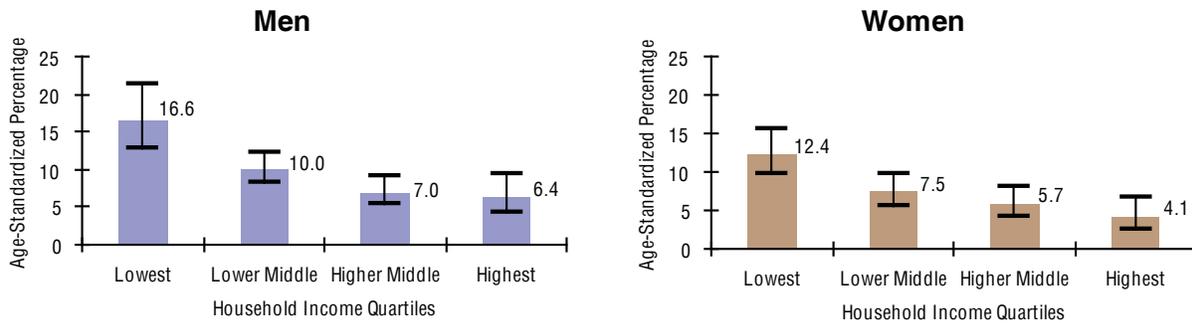
It is important to note that for each of the genders, different cut-offs have been used for the four quartiles. This means that it is not possible to compare across men and women, but it is fair to examine gradients within each gender.

Following are prevalence levels for a variety of health conditions in relation to gross household income. The results reveal a consistent pattern of health inequity among British Columbians based on income level. Also shown are two health risk factors, smoking and obesity, in relation to differences in education, which reflect a similar gradient of health inequity based on educational level.

Heart Disease

BC men from the lowest income households group are more than twice as likely to report suffering heart disease as men from the highest income group, as seen in Figure 10. Women in the lowest income group are three times more likely to experience heart disease than women from the highest income group.

Figure 10. Prevalence of heart disease among BC men and women in relation to gross household income (2005)

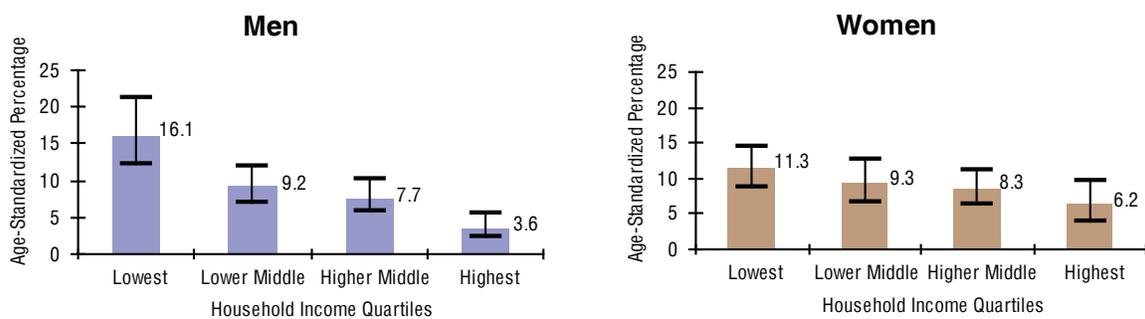


Data source: Statistics Canada Canadian Community Health Survey Cycle 3.1 Share File (2005).

Diabetes

Figure 11 below reveals that BC men from the lowest income group are almost five times more likely to develop diabetes than men from the highest income group. BC women from the lowest income group face almost twice the risk of developing diabetes as women from the highest income group.

Figure 11. Prevalence of diabetes among BC men and women in relation to gross household income (2005)

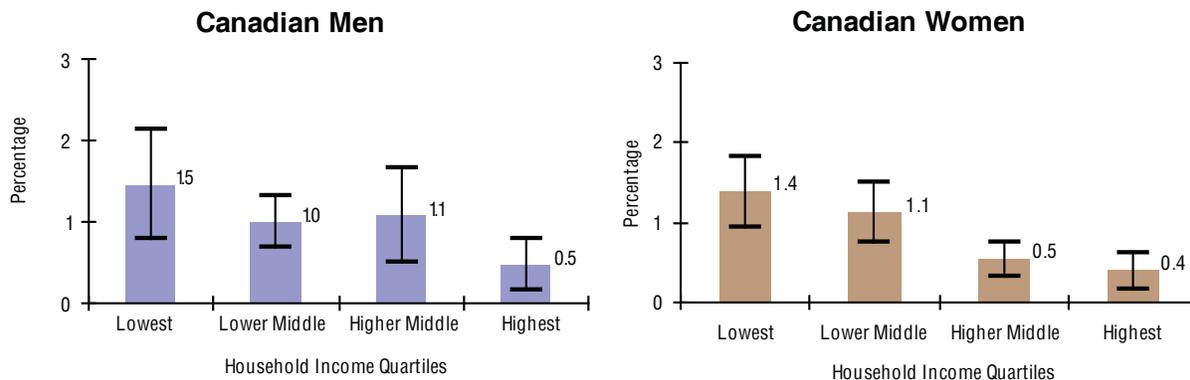


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

Cancer

Looking at the national level (Figure 12), Canadian men and women from the lowest income groups are more likely to develop colorectal cancer than their counterparts in the highest income households (Note: the gradient for women is statistically significant, while the gradient for men is not).

Figure 12. Prevalence of colorectal cancer in Canadian[§] population aged 45 or older (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

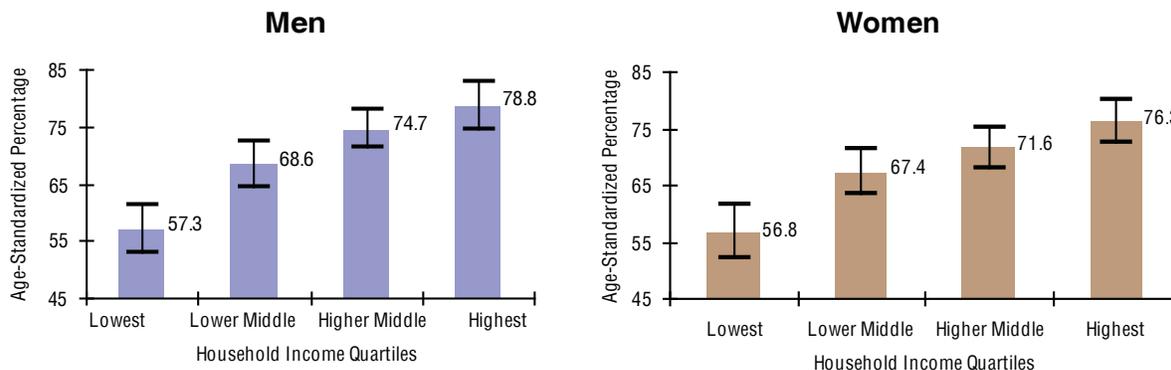
Inequities in Mental Wellness

People with severe and persistent mental illnesses are heavily concentrated within the poorest sector of our society. In 1991 almost 27% of Canadian adults with mental illness were living in poverty, compared with 12.6% of people without a mental health issue.⁵¹ It is also apparent that a high percentage of BC's homeless people are affected by mental illness. Many of these people also live with the further challenge of a drug or alcohol addiction, and for a whole host of reasons are particularly vulnerable to socially determined health risks.

§ Canadian data are being used to illustrate this point rather than BC data, because in this situation the BC sample size is too small to support a statistically sound analysis.

Figure 13 demonstrates that individuals in higher income quartiles have significantly higher self-perceived mental health than individuals in the lower income quartiles (especially the lowest).

Figure 13. Self-perceived mental health as excellent or very good among BC men and women (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

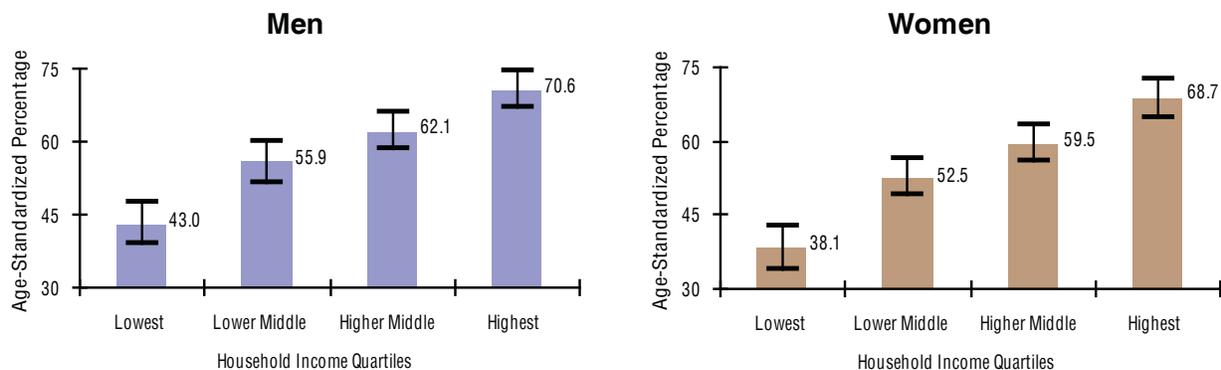
There is some evidence that demonstrates that mental health issues such as depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment and thus have adverse economic implications for the individual, their families and society. Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk of suffering from these disorders than those who are at the upper end.⁵²

Depression, an important public-health problem, and one of the leading causes of disease burden worldwide is often comorbid with other chronic diseases and can worsen their associated health outcomes.⁵³ The comorbid state of depression incrementally worsens health compared with depression alone, with any of the chronic diseases alone, and with any combination of chronic diseases without depression.⁵⁴

Inequities in Self-perceptions of Health

Differences in self-perceived health among British Columbians show a consistent gradient of self-perceived good health rising directly in relation to income for both men and women, such that for both genders, people in the highest income group are almost twice as likely to consider themselves in good health as people in the lowest income group (see Figure 14).

Figure 14. Self-perceived health as excellent or very good among BC men and women (2005)

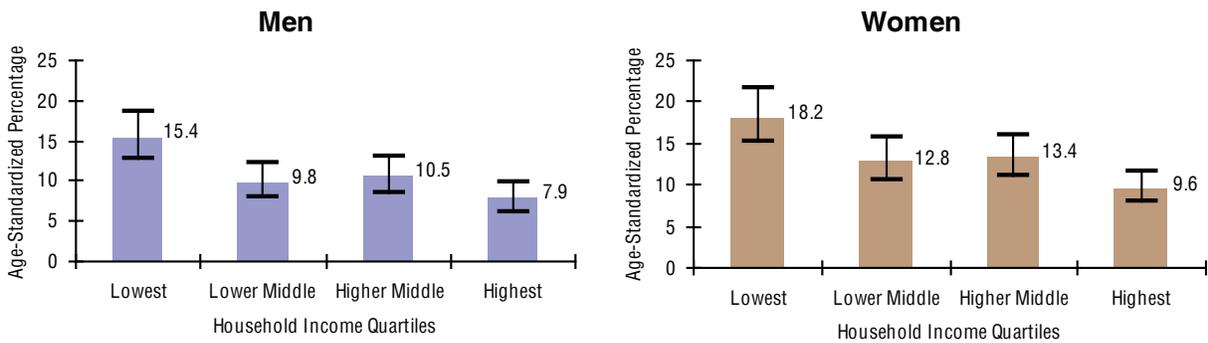


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

Inequities in Perceptions of Unmet Health Needs

Overall, women in BC are more likely than men to report their health needs are not being met, typically due to waiting times, service availability (when and where required) and personal circumstances.⁵⁵ For both BC men and women there is a gradient related to unmet health needs – individuals in lower income households are almost twice as likely as those in higher income households to report unmet health needs during the previous 12 months (see Figure 15).

Figure 15. Unmet health care needs in the previous 12 months for BC men and women - by income level (2005)



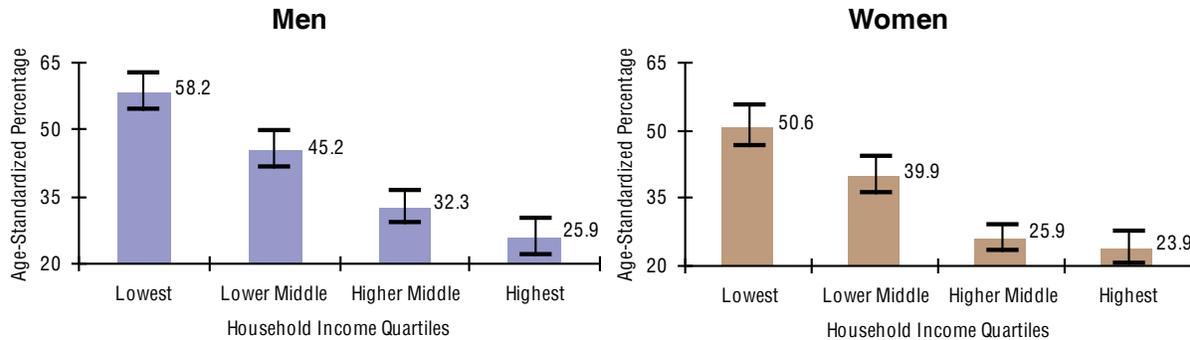
Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

The reasons for the gradient are varied; unfortunately, some people face barriers to health care services including physical inaccessibility, socio-cultural issues, language barriers, or the cost of non-insured services (e.g., eye and dental care, mental health counselling and prescription drugs).⁵⁶

Inequities in Accessing Services

Predictably, men and women in BC from higher income households, who are certainly more likely to have insurance coverage for dental health than people with lower incomes, are much more likely to self-report that they have visited a dentist within the past year (see Figure 16).

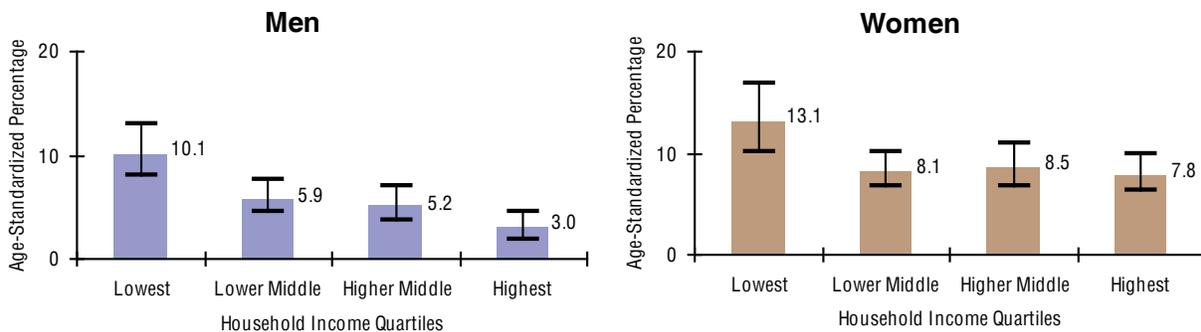
Figure 16. Percentage of BC men and women who did not see a dentist in the previous 12 months - by income level (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

The opposite is true, however, with respect to accessing universally available hospital services. As shown in Figure 17, people in BC from lower income households are much more likely to have spent a night in hospital than people from higher income groups. This may be the result of the combined effects of a higher prevalence of chronic disease in lower income groups together with lower levels of literacy and reduced access to effective preventive and primary care services, as well as the fact that hospital-based care is free at the point of service.

Figure 17. Percentage of BC men and women who were overnight hospital patients in the previous 12 months, by income level (2005)



(Data source: Statistics Canada Canadian Community Health Survey Cycle 3.1 Share File (2005))

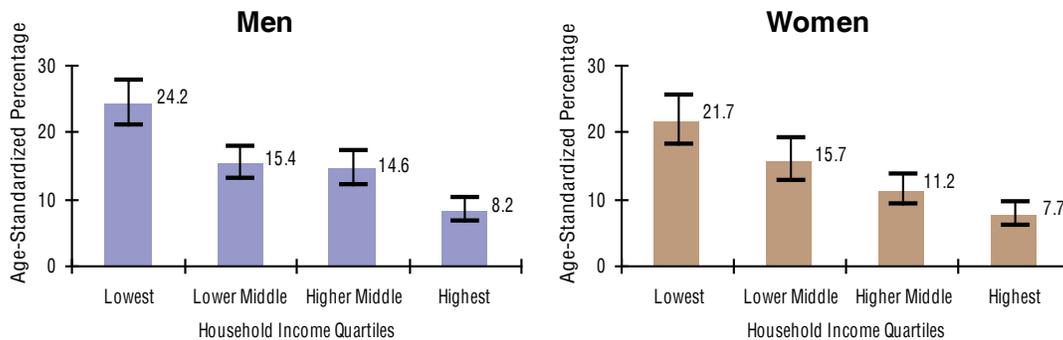
Inequities in Behavioural Risk Factors

As discussed earlier, health inequities emerge from a combination of structural (upstream) elements of the socioeconomic system, over which individuals have little control, and from behavioural (downstream) factors as well as access to health care services. The most common behavioural factors related to health inequity are smoking, physical inactivity, poor diet and obesity, all of which tend to be most prevalent among the lowest income and education groups. It is important to note that although these behavioural factors are ostensibly within the realm of individual control, they cannot be considered separately from upstream social determinants of health such as income. For example, as will be shown below, the higher prevalence of obesity among people in the lowest income group can be related in part to food costs and the relatively low cost of energy dense/nutrient poor foods with high fat and sugar content.

Smoking

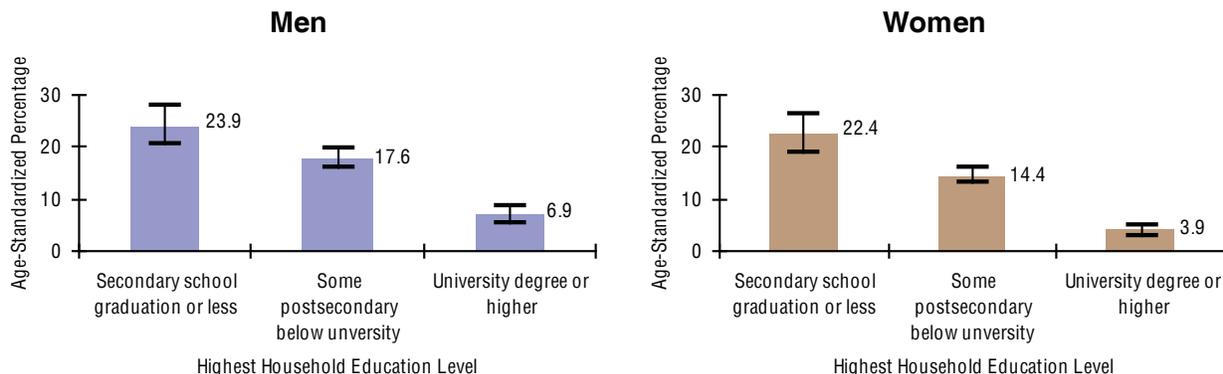
Smoking is associated with a range of chronic diseases, including cancer, chronic lung disease, cardiovascular disease (CVD) and stroke. Even in BC, with the lowest percentage of smokers among Canadian provinces, smoking is directly associated with over 5,000 deaths a year.⁵⁷ As shown in Figures 18 and 19 below, the incidence of smoking among British Columbians follows a consistent and very significant gradient in relation to both household income and educational level.

Figure 18. Prevalence of daily smokers among BC men and women in relation to household income (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

Figure 19. Prevalence of daily smokers among BC men and women in relation to highest household education level (2005)

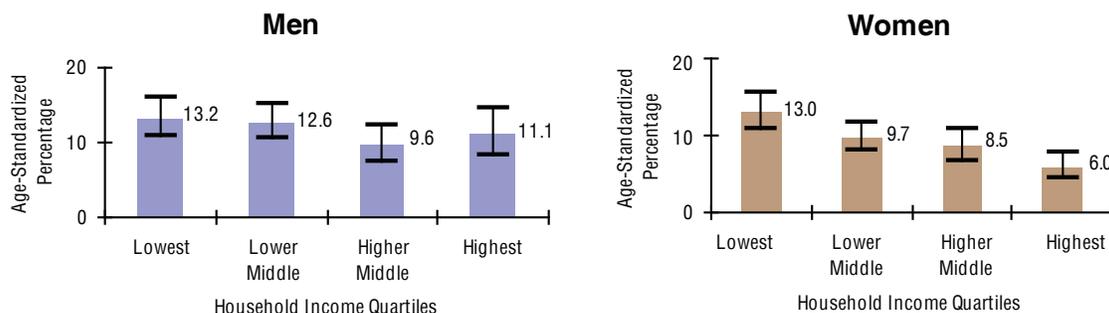


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

Physical activity

Like smoking, daily physical activity is a prominent health risk factor that varies according to socioeconomic status. As shown in Figure 20 below, the gradient for men is not entirely consistent, but for women, the gradient is consistent with women in the lowest income households being twice as likely to be physically inactive as women in the highest income group.[¶]

Figure 20. Prevalence of physical inactivity among BC men and women in relation to household income (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 3.1 Share File (2005).

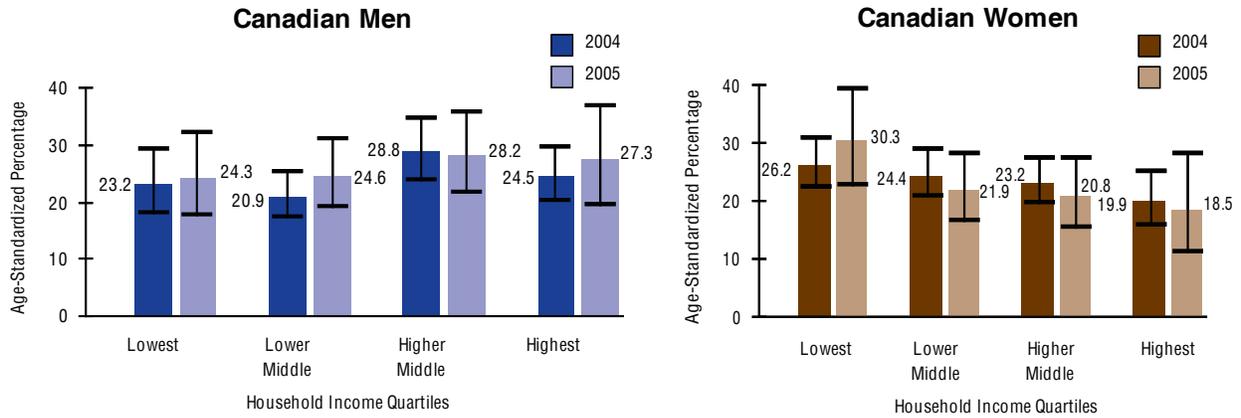
Obesity

Obesity is strongly related to the development of such chronic health conditions as cardiovascular disease (CVD), type 2 diabetes, and various cancers. CVD is the leading cause of death in Canada and accounts for a loss of 4.5 years of life expectancy among Canadians.⁵⁸

¶ It must be noted that British Columbians are more physically active than the residents of any other Canadian province.

Figure 21 below shows only a minor (and not statistically significant) gradient with respect to income level and obesity rate. It also shows that, except for women in the lowest income group, the rate of obesity for Canadian women declined between 2004 and 2005 (again keeping in mind that the rates are not statistically significant). For men a very different picture emerges, with obesity rates increasing for Canadian men in all income groups except one – the higher middle group – and with obesity rates comparable for men at the highest and lowest income levels.

Figure 21. Measured adult obesity (BMI ≥ 30) among Canadians in relation to income level (2005)**

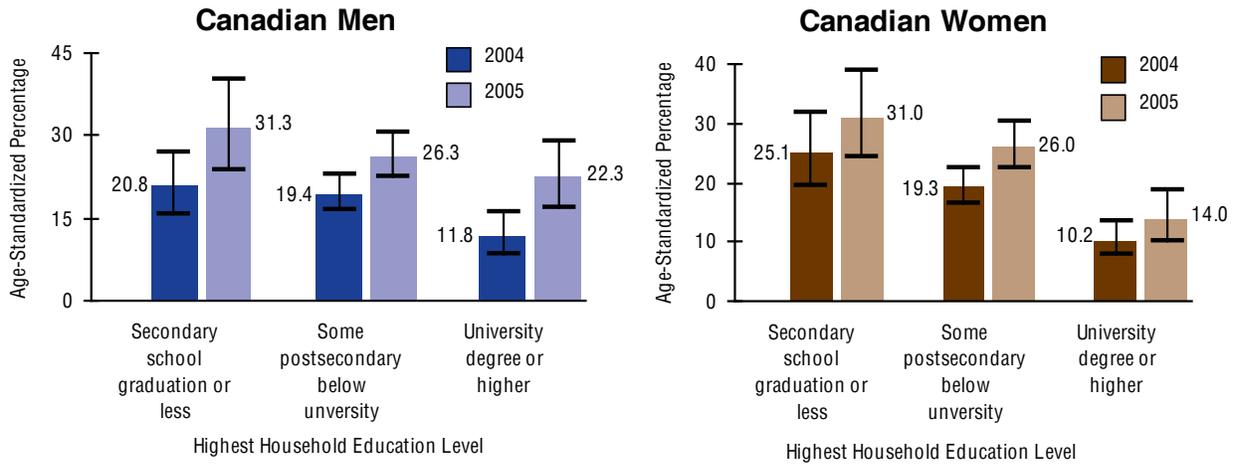


Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 2.2 (2004) and Cycle 3.1 (2005) Percentages were age-standardized to the 2004 Canadian population.

** Canadian data is being used to illustrate this point rather than BC data, because in this situation the BC sample size is too small to support a statistically sound analysis.

When obesity rates are shown in relation to education (see Figure 22), however, the gradient assumes its more familiar pattern, with obesity rates increasing for both men and women from highest to lowest educational levels. The rate of obesity for women in the lowest educational group is more than twice the rate for women from the highest education group.^{††}

Figure 22. Measured adult obesity (BMI ≥ 30) among Canadians^{‡‡} in relation to education level (2005)



Data source: Statistics Canada, Canadian Community Health Survey (CCHS) Cycle 2.2 (2004) and Cycle 3.1 (2005). Percentages were age-standardized to the 2004 Canadian population.

^{††} Although obesity is a significant and growing health concern in every province, British Columbia has the distinction of having the lowest rate of obesity in the country.

^{‡‡} Canadian data is being used to illustrate this point rather than BC data, because in this situation the BC sample size is too small to support an effective and statistically sound analysis.

III. The Case for Addressing Health Inequities

In addition to the argument for addressing health inequities based on principles of social justice and equality, a powerful economic case can be made for reducing the gap in health status between the richest and poorest sectors of our society. This ‘case’ involves recognizing the substantial social, economic and political costs associated with widespread inequities in health, and the benefit of improved overall health for individuals, communities and society as a whole.

These costs and benefits as well as some of the best practices evidence that supports interventions to reduce health inequities are provided next.

General Economic Impact of Health Inequities

Health disparities are health system cost drivers. Because they are more often and more severely sick or injured, people in the lowest quartile of income groups use approximately twice as much in the way of health care services as those in the highest quartile. On the basis of an estimation of health care resources used by Canadian households, one estimate is that approximately 20% of the total health care spending may be attributable to income disparities.⁵⁹

One team of researchers, Jerrold Oppenheim and Theo MacGregor, legal and energy consultants, presented their findings on the costs of poverty to the U.S. House of Representatives Committee on Ways and Means Hearing on the Economic and Societal Costs of Poverty.⁶⁰ Oppenheim and MacGregor’s report includes factors such as transfers from government programs, direct costs to victims of crime, and some unemployment costs. The report calculates avoidable annual costs of poverty using 2005 data for four broad categories: crime, health, unemployment/underemployment, and current anti-poverty investments. The total cost of poverty was estimated to be \$1.5 trillion in 2005 US dollars. While not entirely generalizable to the Canadian context, this report does give an idea of the enormous costs to society that accrue from uncorrected health inequities.

The economic impact of health inequity has also been assessed in European research that distinguishes between health as a ‘capital good’^{§§} (i.e. associated with labour productivity) and as a ‘consumption good’^{¶¶} (i.e. contributing to an individual’s happiness and well-being). Although the health inequities-related losses ascribed to health as a capital good appear modest in relative terms (1.4 percent of GDP), they are significant in absolute terms (€141 billion per year). Valuing health as a consumption good, however, reveals the much larger estimated impact of €1 trillion per year, or 9.4 percent of GDP stemming from health inequities. The separately calculated impact on costs of social security and health care systems and health care support these conclusions. Across the 25 European Union nations, inequities-related health issues are estimated to account for 15 percent of social security system costs and 20 percent of health care system costs in the EU as a whole.⁶¹

The BC Healthy Living Alliance estimates that three major risk factors associated with poverty and health inequity (tobacco use, physical inactivity and overweight/obesity) “cost the BC economy approximately

§§ Included in the measure of health as a ‘capital good’ are the following GDP income components: wages and salaries, firm profits, mixed income, etc., and total income.

¶¶ Included in the measure of health as a ‘consumption good’ are the following: mortality, morbidity (40% of mortality) and total health.

\$3.8 billion annually.”⁶² If we extrapolate a high level estimate of the proportion of health care costs in BC attributable to inequities by calculating 20% of the total annual health care spending in BC (\$13 billion)¹⁶³ we also get a very high number (\$2.6 billion annually).

The methodology of these various cost analyses can be questioned, but from the magnitude of the impacts being examined, it is fair to conclude that the general costs to society associated with poverty and health inequities are significant and wide-reaching. In the following pages, some of the costs of specific health inequities will be examined more closely.

Chronic Disease

Preventable chronic diseases such as type 2 diabetes and heart disease are huge drivers of cost within our health care system, and their incidence and prevalence rates are climbing steadily. In Canada, chronic disease accounts for approximately 67 percent of all direct health care costs and 60 percent of total indirect costs, including lost productivity and foregone income.⁶³ Investments and efforts to address the social determinants of chronic disease toward reducing their prevalence would almost certainly contribute to reduced overall health care costs and the greater sustainability of our health care system.

As noted in the previous section, the prevalence rates for these chronic diseases reflect the health inequity within our society. For example, men in BC’s lowest income households (earning less than \$30,000/year) are more than twice as likely to have heart disease than men with household incomes of more than \$50,000 per year. Similarly, BC women in the lowest income households (earning less than \$22,000/year) are more than three times as likely to have heart disease as women in households earning more than \$40,000 per year. The implication is clear. Efforts to address these health inequities could achieve a significant reduction in the prevalence of chronic disease, and a corresponding decrease in the demand for health services related to those conditions.

Poverty

A US study claims the potential economic savings from the eradication of poverty in that country are so substantial that it would be cost-effective to give cash grants to every low-income American household.⁶⁴ The study estimates the cost of such a plan at \$397 billion a year, but contends that giving more money to all American families for spending on food, housing and other necessities, would raise education levels, reduce crime, reduce homelessness, and in so doing, greatly increase the health of the nation. Through these outcomes, the authors contend that even a simple cash grant scheme like this would save the US economy almost four times its cost.

Food Insecurity

As reported previously, there is a large difference in reported food insecurity between households in the lowest and highest income levels. There is also evidence that individuals with higher social and economic status more regularly consume nutritious foods.⁶⁵ It is important to note the great number of children living in those households reporting food insecurity may be going to school hungry or poorly nourished, which

means that their energy levels, memory, problem-solving skills, creativity, concentration and behaviour are all negatively impacted.⁶⁶

For low-income individuals, maintaining a nutritious diet can be a significant challenge. In 2007 the average cost of a nutritious monthly basket of food in BC was \$715, representing 43 percent of the income of a family of four on income assistance.

British Columbia's Provincial Health Officer underlined the connection between income and food security in his 2005 annual report and made sixteen recommendations for individuals, communities and governments to address the problem. As he put it, "A collaborative effort at the community, provincial and national levels is needed to address the underlying cause of household food insecurity – poverty."⁶⁷

In recognition of the strong correlation between food security and income security, a set of policy considerations recently presented for discussion by PHSA all involve measures to increase income security.⁶⁸ The report in which those considerations were presented notes that people with low-incomes spend a disproportionate and significantly high amount of their income on housing, which results in less money for food and other essentials. It further proposes that although there is no existing research on this issue, it can be assumed that in most cases low-income British Columbians would use additional income to improve their living conditions, with increased food security and improved nutrition as a natural consequence. Among poor families, increased income would almost certainly translate into better nutrition for their families.

The Community Food Action Initiative (CFAI) is a health promotion initiative of BC's provincial government aimed at increasing food security for all British Columbians. The CFAI is a collaborative effort of BC's six health authorities and the BC Ministry of Health. In a recent report⁶⁹ the CFAI notes that although policies that improve income security for British Columbians can provide an essential foundation for improving food security, such policies should also be considered within a broader context. In addition to addressing the issue of affordability, it also identifies issues of availability and accessibility, which are determined by the industrialized food system. It proposes that in order to address these issues most effectively, stakeholder engagement is critical and identifies local governments as a key stakeholder group. The CFAI recently published a resource guide⁷⁰ that further builds on this work by providing strategies and local examples of community-based food security initiatives that focus on capacity building and community development. In this resource guide, some of the many ways different local governments in BC are taking action to strengthen their local food systems are highlighted.

The CFAI guide notes that improving food security involves integrating health, economic, ecological and social factors, and action to increase food security can be seen as a continuum that ranges from providing emergency food for those in need, to building capacity and access within the community, to redesigning the local food system for sustainability.

Lack of Access to Education and Low Literacy

Education

There are significant differences in educational outcomes across BC's various school populations, and often dramatic differences across the provinces' school districts. More generally, there are significant social gradients in childhood development, educational accomplishment, and literacy.⁷¹

Toward levelling the social gradient in education, the BC Progress Board, in its 2006 report on the social condition in BC, recommended specific actions at all four levels of the learning ladder (early childhood, primary and secondary schooling, post-secondary education, and adult training)⁷², including the need to consolidate the administration of programs designed to lower the social gradient like Strong Start, CommunityLinks and child care programs in an agency whose primary purpose is to enhance the development of children.

In terms of childhood education, BC's Provincial Health Officer (PHO) notes in his 2006 Annual Report that there are several groups of students who do not do very well in school settings and whose developmental and health status can be severely compromised.⁷³ These are children in government care, those who have been abused or have challenging home lives, those whose sexual orientations are not shared by the majority of other students, and those who are marginalized or street involved. There are many overlaps among these groups. Many come from families with low socio-economic status, and a disproportionate number of these marginalized students are Aboriginal. The school is often not a welcoming place for them and so they are at higher risk of dropping out, engaging in risky behaviours, running away from home, and/or becoming street-involved. The PHO recommends that these at-risk students require special attention if they are to thrive as healthy adults.

Literacy

An Expert Panel brought together by the Canadian Public Health Association defines health literacy as "the ability to access, understand, evaluate and communicate information as a way to promote maintain and improve health in a variety of settings across the life-course."⁷⁴

Research suggests that levels of literacy and health literacy vary significantly from jurisdiction to jurisdiction in Canada and among different population groups.⁷⁵ The Expert Panel on Health Literacy (referenced above) recently identified that seniors, recent immigrants, those with lower levels of education and with low French or English proficiency and people receiving social assistance tend to have lower levels of literacy and health literacy. Both are related to health outcomes and those with lower skill levels are more likely to experience negative health outcomes. Low levels of health literacy present a formidable challenge to the effective, widespread (and increasing) use of patient self management of chronic disease. Other outcomes of low literacy and health literacy include lower incomes and less community engagement, which are associated with poorer health and quality of life.

Although the evidence of the financial costs associated with low health literacy in Canada is sparse, there is enough Canadian and American research to suggest that policies designed to raise average health

literacy levels might lead to improvements in population health and concomitant reductions in health costs.⁷⁶ Attention should be directed to the population groups described previously that appear most likely to have low levels of health literacy. These include seniors, recent immigrants, those with lower levels of education and low French or English proficiency, people with lower incomes and Aboriginal people. Policies and programs are required to reduce the numerous and interconnected individual and system barriers to health literacy.

Early Childhood Development: Unequal Opportunities, Unequal Outcomes

Healthy early childhood development is a powerful determinant of health.⁷⁷ Research shows that the emotional, social and cognitive development of infants and children not only determines their immediate health status, but contributes to lifelong competence, achievement and long-term health and social outcomes.⁷⁸ Early experiences can exert a powerful influence in altering well-being, building coping abilities and competencies and helping make children physically strong and emotionally healthy.⁷⁹

Children from disadvantaged backgrounds tend to be less ready for school from the start, and their educational impairment can continue throughout their school years, as evidenced by behavioural problems, lower cognitive performance, increased likelihood of dropping out of high school, and lower rates of participation in post-secondary education.

Studies have shown, however, that disadvantaged children who participate in quality early childhood development programs have higher educational and occupational outcomes, including staying in school longer and earning higher wages later in life.⁸⁰ Quality childcare programs also provide support to the family by helping reduce stress on parents and enabling them to pursue employment or education opportunities.

In terms of a cost-benefit analysis, there is a growing body of evidence that some of the greatest returns on taxpayer's investments are those targeted to Canada's youngest citizens.⁸¹ Every dollar spent in ensuring a healthy start in the early years will reduce the long-term costs associated with health care, addictions, crime, unemployment and welfare.⁸² As well, it will ensure Canadian children become better educated, well adjusted and more productive adults.⁸³

Studies in the US have shown that increased investments in pre-school education for low-income families have a benefit-cost ratio of about 9:1.⁸⁴ International research indicates that the return on investment can be as high as \$7.00 for every \$1.00 invested when children living in high risk situations are provided appropriate early support.⁸⁵ Overall, strong evidence exists for the net benefit preschool programs provide for disadvantaged children - i.e. they demonstrate cost savings from the societal, general public and program participants' perspective. Benefit/cost ratios range from 3.8 to a high of 8.7.⁸⁶

A considerable body of economic evaluation evidence is also available for universal day care or preschool programs. A recent cost-benefit analysis undertaken in Canada showed that for every \$1.00 invested in licensed high quality childcare for children and their families, at least \$2.00 of taxpayer's money is saved in the long-term.⁸⁷ A review of five economic evaluations of day care or preschool programs (one set in Canada, one set in the UK and three set in the US)⁸⁸ measured program benefits such as child developmental effects, increased labour force participation, decreased welfare payments, increased lifetime

income, and decreased crime. Results from these five economic evaluations indicate that day care or preschool programs are cost-saving from the societal perspective.

Inadequate Housing, Homelessness and Unhealthy Communities

Inadequate Housing

Housing, particularly in a country with Canada's climate, is one of the most basic requirements for a healthy life. All people need housing that is permanent, decent, affordable, and accessible if we are to realize our potential in society.⁸⁹

The relationship between housing and health is complex, and has been investigated in numerous studies.^{90,91} Some researchers have identified a subset of seven dimensions of housing as potentially influential factors on health: physical hazards including chemical and biological exposure, physical design, social dimensions of housing, psychological, political and financial dimensions of housing and location. There is a growing body of evidence that housing circumstances affect the mental health of families and individuals, has an impact on educational outcomes for children, and influences how well new immigrants are able to integrate into a new society.^{92,93}

The housing need is being addressed to some extent through the government's housing strategy, Housing Matters BC and through other programs, but the need for affordable housing in BC remains greater than the supply. In 2008, there were 11,000 households on the wait list for subsidized units with BC Housing.⁹⁴ BC has the highest core housing need in Canada, since 15% of citizens spend more than 30% of their income on housing. When adequate house repair and size is factored in, the proportion of those spending in excess of 30% climbs substantially: 43% of renters and 24% of home owners.⁹⁵ When people spend excessive amounts of income on housing, fewer resources are available for other health essentials.⁹⁶ The impacts on children in families spending the majority of their income on rent are particularly severe, including a high risk of malnutrition and higher risk of respiratory and other diseases.⁹⁷

According to the Canadian Policy Research Network in its report "Housing is Good Social Policy," the cost to our society of not providing appropriate housing far exceeds the cost of doing so, when all factors are considered. On the other hand, studies suggest that affordable housing improves health outcomes by: freeing up resources for nutritious food and other essentials, reducing stress, exposure to allergens, neurotoxins and other dangers, and providing stability enabling patients with chronic diseases to access and maintain the level of care they need.⁹⁸

Homelessness

From a public health perspective, perhaps the most acute manifestations of the housing issue relate to homelessness. The homeless population in Vancouver increased significantly between 2002 and 2005 – and half of those persons were not staying in emergency shelters but living outside.⁹⁹

Homelessness has very serious negative health consequences associated with it. Poor health is shown to cause homelessness, but poor health is both caused by and exacerbated by homelessness. Those sleeping rough or living in hostels have a higher risk of death and disease than those who are well-housed (mortality rates for people who are homeless can be up to 10 times higher than people who are adequately housed).¹⁰⁰ Homeless people have a range of chronic health problems due to their extreme poverty, lack of stable housing and exposure to the elements on the street. They are less likely to receive adequate medical care and more likely to draw upon emergency medical services.¹⁰¹

There is a strong economic rationale for transitioning the homeless into supportive housing. In British Columbia, a recent report has estimated that the current annual cost of maintaining a homeless person with a dual diagnosis of mental illness and drug addiction living on the street (including health and prison system costs only) is \$55,000 per year. Based on an estimated 11,750 of such individuals throughout the province, this amounts to a total annual expenditure of about \$644 million.¹⁰²

The same report proposes that by providing adequate housing and related support for this population, annual health and prison system costs could be cut by \$211 million, reducing the cost of support for each of these people by a third, to \$37,000 per year.

Unhealthy Communities

How communities are planned and built can significantly impact the health of the people living there. The phrase ‘built environment’ refers to the surroundings that we humans have created. These surroundings include both indoor and outdoor places and vary from large-scale urban areas to smaller rural development and personal spaces.¹⁰³ Built environments can influence physical and mental health through factors such as community design, adequate housing, access to safe water, good sanitation, safe neighbourhoods, and adequate access to education, recreational services, public transit and child care.¹⁰⁴ In essence, the built structure provides the setting for many of the social determinants of health.¹⁰⁵

In a recent evidence review, the majority of the research examined found a clear relationship between the built environment, physical activity and body weight.¹⁰⁶ More specifically, the following relationships were identified:

- Walkable neighbourhoods are associated with changes in travel behaviour (i.e., less driving and more walking, cycling and use of public transit)
- Walkable neighbourhoods are associated with lower body weights
- Increased density is associated with less pollution
- Pedestrian-friendly streetscapes encourage physical activity
- Pedestrian-friendly streetscapes are associated with fewer traffic accidents and less crime
- Public transit encourages physical activity
- Improving the food environment can improve nutrition

The conclusion of this review was that there is strong support for making changes to the built environment to help promote healthy body weight and improve population health.

Failure of Underregulated Market Mechanisms

To a certain extent, the existence of health inequity in our society represents a failure of the laissez faire economic model under which we live. Under ideal conditions, the free coordination of individuals produces an outcome that is not only in the best interest of the individual but also represents the best possible outcome for society. The neoclassical model, on which this ideal view is based, is based on the following central assumptions:¹⁰⁷

- All costs and benefits are internal (or ‘private’): All the costs and benefits associated with a given choice are taken into account and borne by the person making that choice.
- Rationality: Individuals maximize some objective function (e.g., their utility function) under the constraints they face, weighing the cost they would expect to incur with the expected benefits of the choice in question. The decision ultimately taken is the one that maximizes net benefits (or utility).
- Perfect information: Individuals have complete information about the expected consequences of their actions.
- Preferences are time-consistent (or put simply: individuals face no serious self-control problems).

If these assumptions are met, there is no justification for public policy intervention. In reality, however, one or more of the above assumptions often do not hold true. The end result is that the market – left alone – does not achieve the outcome most desirable for society.

An example of how this market failure occurs is helpful to examine. One of the functional strengths of our market-based economy rests on an assumption of all citizens being rational and well informed about the goods and services they consume. This assumption, however, is based on the construct of an ideal market in which all consumers are equally able to assess the costs and benefits of the choices presented to them. Significantly, this scenario does not take into account the extraordinary power of advertising as an influence on consumer decisions. The ability of advertising and marketing to influence consumers to make choices that are not in their best interests for health is well established, and evidenced by the epidemic of obesity in our society. Customers of fast food restaurants, for example, are invariably presented with options for ‘super sizing’ their meal choices, and high-fat/high-sugar junk foods are treated by many families as a normal part of their daily diet.

In these and other respects, advertising has contributed to a failure of the market mechanism that hinges on consumers making informed, rational choices that maximize their benefit. In fact, the most successful advertising motivates consumer choice on the basis of emotion rather than reason. These concerns are made more serious by the extent of advertising directed at children, especially regarding food products that contribute to the rising incidence of childhood obesity.

Counteracting the impact of advertising for products and behaviours associated with negative health outcomes (e.g., tobacco, alcohol, fast food, soft drinks) through government-funded public information campaigns is only part of the solution. The vast resources and creativity of advertisers will always limit the effectiveness of public awareness initiatives. Ultimately, the failure of the market mechanism to ensure rational, healthy choices by consumers – and the consequent health problems and related cost impacts on our health care system – has created a situation where public policy intervention is justified. Such public policy has long been used in British Columbia for the regulation of tobacco and alcohol, and is now

increasingly emerging in other areas toward serving the same goal of improved population health (e.g., eliminating low-nutritional junk food from vending machines in schools).

Another example arises in the area of 'externalities'. Many industries in the market such as tobacco, soft drink, fast food and car manufacturers are not responsible for the damage their products cause to the health of the population. If the huge health care costs that these products cause were built into their pricing, consumption would likely decrease substantially.

In summary, where any of these conditions are not being met in the marketing of a product (e.g., there is a lack of rational, well-informed consumers and/or producers who are not responsible for externalities), economists recognized (even before the recent, massive failure of financial institutions) that there is a need for government intervention when the market mechanism has failed and is causing societal harm.

Health Care Expenditures vs. Investments in Other Social Programs

In comparative reviews of population health levels among developed nations, it has been observed that the overall health of a population declines as economic inequality within the population increases.¹⁰⁸ In Sweden and Norway, for example, where economic disparity is relatively limited, people enjoy longer average life spans than do people in the US, the wealthiest nation in the world, but also one with significant economic disparity. Similarly Japan, with the longest life expectancy in the world, has a narrower gap in income distribution than most countries in the developed world. From these observations it seems that economic equality can be more important than wealth for the overall health of a population.

It is interesting to note that countries characterized by higher social spending in support of policies to reduce social, economic and health inequalities are not, as a result, disadvantaged in their ability to compete in trade with other nations. Sweden, for example, is ranked fourth in the world by the World Economic Forum, for the competitiveness of its economy, just behind Denmark, the country with the lowest rate of childhood poverty in Europe. The US is first and Canada is 13th on this widely-accepted annual ranking of global competitiveness.¹⁰⁹

On a related point, it has been noted that the level of expenditure on health care is not necessarily a dominant factor in determining the health of a population. This observation is well supported by comparing Cuba and the United States on life expectancy and health care spending. Cuba, with an average life expectancy of 77.1 years, is ranked 28th in the world, just behind the US (78.0 years). However, the annual per capita spending on health care in Cuba is among the lowest in the world; at \$186 it is a small fraction of the \$4500 per person spent in the US.¹¹⁰

A recent report by an expert commission on health inequalities in Europe also came to the disturbing conclusion that the health gap between Europe's most affluent and least affluent citizens has actually increased during the past twenty years, despite substantial improvements in health care systems.¹¹¹

From the foregoing it appears that simply spending more money on health care is not the most effective strategy for increasing the overall health of a population, whereas efforts to reduce social and economic inequities are likely to be more effective in leading to overall improvements in population health.

Another US study takes issue with the current concentration of investment in medical technologies as an avenue for improving population health. Although technological advances have certainly contributed to longer life expectancy, producing an average incremental gain in life span of about one percent a year over the past 100 years, given the prodigious levels of investment in the technologies of medical care – at billions of dollars a year – this modest annual gain hardly seems impressive. In fact from a cost-benefit perspective, there is weak support for investing in new medical technologies to achieve gains in population health. Although there will always be a need for medical innovation, to achieve real progress in population health these efforts would be much more effective in combination with initiatives to reduce health inequities.¹¹²

In support of this position, researchers reviewed US vital statistics from 1996 to 2002 to determine the number of deaths averted through medical advances in comparison with the number of deaths that would have been averted if mortality rates among adults with lesser education were raised to the rate for college-educated adults. The results showed that medical advances averted about 178,193 deaths during the study period, while correcting disparities in education-associated mortality rates would have saved almost eight times as many lives (1,369,335 lives) over the same period. From this perspective, spending massive amounts of money on medical advances instead of addressing the social determinants of health (in this case, improved access to education) does not serve the public health needs of the nation.¹¹³

The Public Health Agency of Canada (PHAC) has reached this same conclusion. PHAC has stated that “there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. On the other hand, there are strong and growing indications that other factors such as living and working conditions are crucially important for a healthy population.”¹¹⁴

“The kind of communities that we develop is a more important determinant of health status of the population than the kind of health care we construct.”

Vancouver Island Health Authority
*Understanding the Social Determinants of Health, 2006.*¹¹⁵

Canadian senator Wilbert J. Keon, co-chair of the Senate Standing Committee on Social Affairs, Science & Technology, has taken this line of thinking one step further. He has gone so far as to call increased health care spending a threat to population health:

“Increased expenditures on health care are likely impacting negatively on the general health of our population by virtue of diminished investments in other areas like education (especially early childhood education), public housing, income security and other public services.”

Senator Wilbert Keon
*Quoted in The Hill Times, 2008.*¹¹⁶

The Cost of Inaction

Some of the direct costs to the health care system resulting from health inequities have been identified, and these costs will only grow if the causes of health inequities are not addressed. There are also indirect costs such as lost productivity, that have negative repercussions for the entire economy.¹¹⁷

Some of the significant costs to the private sector associated with health-care spending and unhealthy populations will be examined next.¹¹⁸ First, businesses bear a portion of the burden of supporting public health-care spending through taxation. When health-care costs rise in our publicly funded system, higher taxes may affect Canadian businesses' ability to grow and compete in the global economy. Second, businesses suffer when their workforce is unhealthy, as demonstrated through the costs of both absenteeism and *presenteeism*, a phenomenon whereby workers are physically present at work, but less than maximally productive due to fatigue, stress, mental illness or other health issues.¹¹⁹ In 2006, the Halifax Chamber of commerce estimated that the province of Nova Scotia lost \$1.185 billion in productivity due to absenteeism. One study suggests that employers can lose "up to 32 times as much productivity from presenteeism as from absenteeism."¹²⁰ Third, Canada's current tight labour market means that employers are finding themselves engaging in aggressive competition for workers. Employers recognize the importance of keeping their workers healthy so that business can continue.

Both government and business are negatively affected by poor health and health-care costs; both have tremendous economic and social gains to make when good population health is achieved. Recent reports and evidence reviews have suggested that investing in health should not just be seen as a cost to society, but also as a potential driver of economic growth.¹²¹

Benefits of Addressing Inequities

Evidence and experience have shown that action on reducing health inequities has many potential benefits for the health system, health outcomes and the overall quality of life of Canadians in the following three ways.¹²²

1. Given that there is a gradient of health status across the entire range of socio-economic determinants, addressing health inequities will improve the health of all.
2. Better health enables more people to participate in the economy, reducing the costs of lost productivity. Addressing inequities by tackling the socio-economic determinants of health will also result in healthier employees, customers and communities generally. This, in turn, will positively affect economic growth and the financial bottom line of companies by increasing competitiveness, productivity and profitability.
3. A further advantage of addressing health inequities is the potential for stemming the rapid increase in usage of health services. Easing the demand for services would decrease cost drivers, reduce pressures on the delivery of health services, and, over the long term, contribute to the financial sustainability of our health care system.

It is important to note that a comprehensive review of economic evaluations of prevention initiatives, commissioned by the Canadian Medical Association and released in May, 2004 by the Canadian Coalition

for Public Health in the 21st Century,¹²³ has demonstrated that engaging in prevention activities and easing demand for services comes with its own costs. The areas of intervention examined in this review showed a net benefit to society, while not necessarily being a cost-saving from a payer perspective.

The review goes on to explain that economic evaluation evidence is lacking for the majority of recommended prevention initiatives, and suggests that this might be because the costs and consequences of health promotion, health protection and healthy public policy interventions are difficult to measure credibly because they are spread across multiple health and social domains.

It provides the following cautionary note regarding the interpretation and application of economic evaluation information:

“Policy decision making that incorporates economic evaluation evidence cannot be reduced to rank ordering of programs by summary measures of efficiency and the mechanical application of thresholds to determine which programs will be implemented or continued. Although economic evaluation evidence can make a useful contribution to policy decision making, we do not recommend that economic evaluation be a prerequisite for policy action. Requiring economic evidence as a mandatory input to decision making would, in the short term, delay the implementation of preventive programs with demonstrated large population health effects that had not yet been subjected to economic evaluation.”

Canadian Medical Association

*Economic Evaluation Across the Four Faces of Prevention: A Canadian Perspective, 2004.*¹²⁴

IV. Health Inequity Policy Considerations

Success in Other Jurisdictions

In 1980, Great Britain's Black report on inequalities in health marked a milestone in understanding how social conditions shape health inequity.¹²⁵ Black and his colleagues revealed a basic conundrum – that health inequalities in Britain had worsened over the decades since the introduction of the National Health Service in 1948. They contended, however, that the inequalities were not the result of a failure of the health care system, but stemmed from an increase in social inequalities. They argued that reducing the health gap between privileged and disadvantaged social groups in Britain would require reducing the social inequalities, through ambitious intersectoral interventions involving education, housing and social welfare reforms, in addition to improved clinical care.

The Black Report inspired similar national inquiries in such countries as the Netherlands, Spain and Sweden. By the late 1990s, health equity and the social determinants of health were being embraced as explicit policy concerns by countries across the European Union in response to mounting evidence that existing health and social policies were not reducing persistent gaps in health equality.¹²⁶ Reducing inequities in health is now an objective for public health policies in many countries around the world. Several countries have proposed goals to reduce the gap in health status for specific groups by amounts ranging from 10 to 50 percent.¹²⁷

In Europe, the UK, Sweden and Ireland are three countries that have made significant efforts to address health inequity through broad-based policies directed at the structural determinants of health, and it is informative to look more closely at what actions they have taken.

The UK

In 1998, the UK government conducted a study of health inequalities, examining the social, economic and environmental factors affecting peoples' health, and a summary report provided forty recommendations to tackle the underlying issues at the root of health disparities. It also emphasized that addressing the short-term consequences of ill health is not enough and that efforts must be made in partnership with the voluntary, community and business sectors, as well as individual citizens to prevent ill health and promote healthy living.¹²⁸

In 1999, "The National Health Services (NHS) Plan: A Plan for Investment, A Plan for Reform" committed government to local targets to reduce health inequalities with reinforcement from proposed national health inequalities targets.¹²⁹ A cross-cutting federal review followed in 2002 that examined how government spending could be applied to greatest effect on health inequalities.¹³⁰

Based on this research and advice, the Department of Health committed to reducing inequalities in health outcomes by 10% by the year 2010 as measured by infant mortality and life expectancy at birth. A high-level, government-wide strategy called "A Programme for Action" was then developed. The first principle of the strategy was to stop the UK's health gap from widening further, before trying to narrow it.¹³¹

The following table outlines the key areas of focus in the UK for achieving its goals and addressing health inequality, with a brief description of the policy approach for each area. It is important to note that although this initiative to reduce health inequality is being driven by the Department of Health, the policy areas include employment, education, taxation and even elements of constitutional reform.

Table 1. Key areas of health inequality policies in the UK

Determinant	Policies
Child poverty	Prominent reduction target. Major tax benefit reforms benefiting low-income families with children.
Working-age poverty	Policy focus on worklessness, not on poverty itself. Policies aimed at employment and income at work.
Income inequality	Reduction in overall income inequality not an aim. Focus on relative poverty for selected groups and on life chances. Income inequality monitored at EU level.
Employment	Clearest initial policy area and priority. Action through New Deals and 'active' policy towards unemployment.
Education	Targets for school attainment. Increased spending.
Health inequalities	Main thrust of policy is on overall health and NHS spending.
Political participation	Aspects of constitutional reform and parts of agenda for neighbourhood renewal. Participation requirements in nearly all policy areas. Targets for volunteering and confidence in institutions.

Source: Raphael, D. & Bryant, T. (2006). The State's Role in Promoting Population Health.¹³²

According to one review, the initial evidence shows these efforts toward reducing health inequalities and addressing the conditions that cause such inequalities are achieving some progress in the UK.¹³³ Another report also concludes that although the UK still has a great deal of work to do, it is making progress.¹³⁴ For example, it notes that over a seven year period between 1997/98 and 2004/05, the proportion of children living in a household at-risk-of-poverty decreased 5% and went from being among the highest in Europe to being closer to the EU average. A million pensioners and 800,000 children have been lifted out of relative poverty since 1999. There is also evidence of a narrowing of the gap in heart disease mortality, cancer, influenza vaccinations and educational attainment.¹³⁵

Sweden

Sweden is a leader among nations which have taken seriously the challenge of addressing health inequity. That government has set itself the objective of becoming the world's best country in which to grow old.¹³⁶ Its efforts have given it one of the healthiest national profiles in terms of health outcomes and for many of the broader health determinants. Among the Organization for Economic Cooperation and Development (OECD) nations for the period 2000–2002, Sweden had the lowest levels of infant mortality and mortality from childhood injury, and the fourth highest life expectancy.

On the broader determinants of health, over the same period Sweden had the lowest levels of child poverty, the lowest levels of low paid employment, and the highest levels of public social expenditure and public share of health spending as a proportion of GDP. Income inequality in Sweden was the third lowest among OECD nations, and it had one of the highest levels of women employed in the workplace.¹³⁷

These results can be directly attributed to the Swedish government's explicit recognition of the broad social determinants of health and its willingness to tackle the socioeconomic structural reforms required for reducing health inequity. This recognition is reflected in the following statement from a Swedish Ministry of Health and Social Affairs report:

“A universal welfare policy and an active labour-market policy are characteristic features of the Swedish social model and their poverty rates have for many years been very low compared to Canada, especially for lone parents. Sweden's welfare system includes general health care and social care, social insurance that provides financial security in illness, disability and old age and for families with young children and basic supplementary protection in the form of financial assistance.”¹³⁸

It also has a long-term vision, however, to set specific priorities based on its own areas of greatest need. For example, for the period 2006-2008, it intends to create more jobs, reduce ill-health at work and tackle homelessness (to name only a few priorities). It has made efforts to improve coordination across local, regional and national authorities, and has even created a commission whose work is focused on particularly vulnerable service users.

Ireland

After extensive consultations with stakeholders (including people experiencing poverty), a 10-year National Anti-Poverty Strategy was launched in 1997, which identified specific poverty reduction targets.¹³⁹ Plans to reach the targets included a combination of new and existing measures focused on children – early childhood development and care, improving education and health outcomes, and income support. Ireland's results so far are impressive. The rate of people experiencing consistent poverty dropped from 15.1% in 1994 to 5.3% in 2001. In the year between 2003 and 2004, the rate for children under age 15 dropped from 12.2% to 9.5%.

Other Jurisdictions

A recent WHO document analyzed 18 case studies from a variety of high, middle and low income countries.¹⁴⁰ The case studies outlined diverse experiences of action across sectors with positive impacts for health and health equity. The 18 case studies represented a broad array of initiatives that ranged from relatively small-scale programs that used a community development approach with a marginalized group in one city, to broad, policy-focused initiatives from national governments.

Initiatives were planned and implemented at national, regional and local levels. In the 18 case studies reviewed, true cooperation in planning, implementation and evaluation was facilitated when it took place at several levels simultaneously, especially if the work at each of those levels was integrated through policy or legislation. Almost all of the 18 case studies reported some positive outcomes that were thought to be attributable to intersectoral collaboration.

These various efforts worldwide are supported by a wide variety of policy approaches, taking place at many levels and across many sectors. What is clear for any policy approach to tackling health inequity, is that it must acknowledge a distinction between the behavioural determinants and the social determinants of health. To be successful, interventions to improve health equity must address structural factors (e.g., inequalities in

income and education) as well as physical and social environments. Interventions targeted only at changing adverse health behaviours will have limited overall success, offering only microenvironmental solutions to a macroenvironmental problem.¹⁴¹

A commitment to improving health equity ultimately requires addressing not only the disadvantaged circumstances and health-damaging behaviours of the poorest groups in our society, but also the systemic differences in life chances, living standards and lifestyles associated with people's unequal positions in society.

Success in Canada

In Canada, we have never had a national anti-poverty strategy, but Quebec and Newfoundland & Labrador, however, both have provincial strategies.

Quebec

In Quebec, the anti-poverty strategy was initiated by a broad-based citizens' movement called "Le Collectif pour un Quebec Sans Pauvrete" which involves 30 provincial organizations and 15 regional groups aiming to fight poverty and social exclusion at their root causes. In 1998 the Collectif formed and held public consultations which resulted in the unanimous adoption of the *Act to Combat Poverty and Social Exclusion*¹⁴² by the provincial legislature in 2002. Quebec is currently the only jurisdiction in Canada to enact a law to combat poverty and social exclusion.

Quebec's overall goal is to achieve one of the lowest levels of poverty among industrialized societies by 2013. In Quebec, like in the EU, there is a commitment to the larger objectives of reducing social exclusion, prejudice and inequalities that are detrimental to social cohesion and to encouraging participation in community life and social development.

To achieve this goal, the government proposed different approaches, which included implementing prevention measures, strengthening the social and economic safety net, promoting access to employment, encouraging the involvement of society as a whole, and ensuring consistent and coherent intervention.¹⁴³

An advisory committee that included members from anti-poverty groups and from various sectors of Quebec society ensures there is citizen engagement in the ongoing implementation and evaluation of the strategy. The Act also calls for a monitoring, research and discussion centre which is charged with the task of recommending a series of poverty and social exclusion indicators. Quebec's goals, targets and initiatives also come with significant budgets. In its 2004-05 Budget, the Government of Quebec announced that a total of \$2.5 billion would be allocated over five years to carry out the provisions of the *Act to Combat Poverty and Social Exclusion*.¹⁴⁴

It is premature to assess the success of Quebec's strategy to combat poverty and social exclusion, but available data show that the proportion of people living on low incomes in the province has decreased steadily from 1997 to 2006. According to a progress report on Quebec's action plan, the number of recipients of last-resort financial assistance has decreased from 404,360 in 2003 to 379,694 in 2007.¹⁴⁵

There were also about 20,000 fewer children living in families receiving last-resort financial assistance in 2007 (119,939 children) than in 2003 (139,869 children) – a reduction of 14.2%.

Newfoundland & Labrador

In 2006, Newfoundland & Labrador became the second province in Canada to adopt a comprehensive poverty reduction strategy. In contrast to Quebec, the strategy was initiated by government, and stemmed from a 2003 election promise and Speech from the Throne in 2005, in which the government pledged to transform Newfoundland & Labrador from a province with the most poverty to a province with the least poverty over the next decade. Community groups, business and labour were involved in designing the strategy and its associated initiatives. Consultation continues to be a central part of the strategy, as does strong coordination across different parts of government.

As in Quebec, the Government of Newfoundland & Labrador uses a definition of poverty that not only reflects a lack of adequate financial resources but also includes social exclusion. The specific goals of the province's Poverty Reduction Strategy include: improved access and coordination of services for those with low incomes, a stronger social safety net, improved earned incomes, improved early childhood development, and a better educated population.¹⁴⁶ To fulfill these four goals, a number of initiatives have been undertaken such as: tax reductions for low-income individuals and families; measures to enhance both the supply and demand for labour; increased social and financial supports, increased access to affordable housing; improved access to health programs and other essential services; enhanced justice system supports; and actions to strengthen early learning and child care programs, improve the primary and secondary school system, and provide greater access to post-secondary education, literacy, and adult basic education.¹⁴⁷ Poverty indicators are also a key part of the strategy. As in Quebec, resources are attached to the plans. Budget 2006 committed over \$30.5 million in 2006-07 to develop and implement an integrated package of 20 initiatives aimed at reducing poverty in Newfoundland & Labrador, and \$64 million annually thereafter.¹⁴⁸ Budget 2007 promised an additional \$28.9 million for the poverty reduction strategy, for a total annualized investment of over \$91 million.¹⁴⁹

National Public Pensions

At the national level, Canada and its provinces have made policy decisions that have significantly reduced poverty amongst seniors over the past forty years.¹⁵⁰ At the start of the last century, public pensions were non-existent. At that time, Canadian seniors were much more likely to be economically disadvantaged than the general population, and, as a result, were at risk of much poorer health.¹⁵¹ When Old Age Security (OAS) was introduced in 1952, it was Canada's first universal pension. In the three decades following the creation of the OAS, other pensions were made available: the employment-based Canada Pension Plan (CPP) and Quebec Pension Plan (QPP), the income-tested Guaranteed Income Supplement (GIS), and an income tested Spouse's Allowance (SPA) and Widowed Spouse's Allowance.¹⁵² Provincial/territorial income supplements for seniors were also added along the way. Today, over 95% of seniors receive income from OAS, GIS or SPA. As well, 96% of senior men and 86% of senior women receive CPP/QPP benefits. As Canada's public pension system matured, more seniors than ever became eligible for benefits and their after-tax income increased by 18% between 1980 and 2003.¹⁵³ This maturation has been cited as a key factor in the major shift of Canada's prevalence of low-income among seniors – from one of the highest among industrialized nations in the 1970s to one of the lowest today.^{154,155}

Guiding Principles and Key Considerations for Addressing Health Inequities in BC

Guiding Principles

Based on a review of promising practices in other jurisdictions, guiding principles and key considerations for a well-founded and effective policy approach to addressing health inequities include:

- Levelling up, not down. The goal should be to continuously raise standards of health, education, living and working conditions and social well-being for all citizens; the challenge is to achieve both a raising and a levelling of the social gradient in these areas by ensuring that the most disadvantaged benefit most.
- Not making the inequities worse – helping the worst-off first. Universal interventions can have the unintended effect of providing the most help to the groups who need it least and therefore increasing inequity. It will be important to develop intervention programs based on a combined universal/targeted approach (i.e., additional targeted interventions may be needed for the more disadvantaged members of society).
- Using a combination of regulatory and structural interventions for greatest impact in reducing socioeconomic stratification.
- Recognizing that complex problems require complex solutions; health inequities must be addressed on many fronts, through multiple, interrelated strategies.

Key Considerations

1. Addressing the social determinants of health that contribute to health inequity must be a government priority, and resources must be allocated accordingly.

Those jurisdictions that are making significant progress in addressing the social determinants of health (e.g., Newfoundland, Quebec, UK, Sweden) have specifically identified it as a government priority, and have allocated significant resources towards the efforts. If such objectives are not supported by government as a priority and resourced appropriately, they stand little chance of overall success.

2. Reducing health inequities requires a multisectoral approach, involving cooperation across all levels and areas of government, business and society.

Health inequities develop from such social determinants as income, education, living and working conditions, gender and ethnicity (to name only a few) – areas well beyond the normal reach of health policy. Therefore, to effectively address health inequity, an organized, multisectoral approach is required, involving various ministries of government in a coordinated policy approach, and involving all levels of government ranging from local to national.¹⁵⁶ The business sector has a key role to play in addressing inequities, in order to ensure employees, customers and communities are as healthy as possible. Non-governmental organizations (NGOs) and the community sectors, including labour unions and faith organizations, also have an important role to play, as do community members themselves.

3. **Setting targets and tracking progress is part of the continuous improvement process.**

All jurisdictions with fully-developed strategies for reducing health inequity have established clear targets for their initiatives, and have developed results-based (as distinct from activity-based) mechanisms for tracking results. Results are analyzed and programs and policies are revised accordingly, effectively closing the feedback loop and contributing to a process of continuous improvement.

V. Policy Options for Reducing Health Inequities

In the previous section, an examination is presented of the most serious health inequities in BC and the social determinants of health contributing to those inequities. The case is made as to why addressing the social determinants of health is advisable – from both an economic perspective (costs and benefits), as well as a health outcome perspective. Information from other jurisdictions that have implemented strategies to address poverty and the social determinants of health is reviewed. Guiding principles and key considerations for addressing health inequities in are identified.

Based on the information, evidence and promising practices identified in this paper, taken together with the input obtained through a broad province-wide consultative process, five broad policy areas for reducing health inequities are offered for consideration. These policy areas are:

1. Income and food security (ensuring adequate incomes and access to affordable, nutritious food)
2. Education and literacy (increasing access to education, improving educational outcomes, and enhancing literacy skills)
3. Early childhood development (ensuring that children are provided as many advantages as possible for optimal development)
4. Housing and healthy built environments (ensuring access to safe, affordable housing and enhancing the liveability of neighbourhoods)
5. Health care (ensuring equitable access to health services, and ensuring health care programs and services apply an inequities lens)

It is important to recognize that many specific actions could be taken within each of these policy areas. The options identified here have been selected because they have been identified in other expert-informed documents or through consultative processes as being promising practices with likelihood of success in BC. In implementing any one of these actions, there is a great deal of best practices literature that can be consulted regarding criteria for designing and implementing programs and policies most effectively.

It is also critical to note that of all the policy options presented here, this paper supports the conclusion of the BC Healthy Living Alliance which has said that, “No single policy will be effective in itself. What is required is an integrated approach that will deal with the complex problems of health inequity from various angles.”¹⁵⁷

1. Income & Food Security

Income

Among all the policy areas for addressing the social determinants of health and reducing health inequity, none is more significant than that of income security and measures for reducing poverty in the province.

Toward reducing poverty and increasing income security for British Columbians, areas of consideration for policy include^{***}:

Minimum Wage – Increasing the minimum wage and indexing it to the annual cost of living. It is important that the minimum wage reflect a ‘living wage’ in order to eliminate the situation faced by the working poor – people working full time but still facing poverty.

Earned Income Benefit – Ensuring that federal and provincial earned income benefits work to augment the incomes of people who are normally in the paid labour force. People in low-wage jobs, people who cannot get enough work to meet their basic requirements and people who have to periodically rely on employment insurance could all realize significant economic improvement from a well-designed plan for earned income benefits.

Federal Child Benefit – Combining the Canada Child Tax Benefit base benefit and National Child Benefit Supplement into a single refundable benefit and making it available to all low-income families, with no reduction of other benefits (e.g., provincial income assistance rates) to offset the increase in the federal benefit. Considering revising income thresholds and benefit reductions to avoid undue hardship on lower-income families as their work incomes rise.

Income Assistance – Increasing welfare rates and indexing the rates to annual increases in the cost of living. About half of the increase will be required to make up for the erosion in purchasing power since 1994. Considering a mechanism to improve the income status of pregnant women (e.g., create a maternal nutrition benefit to start once pregnancy is confirmed, that becomes the Child Benefit once the birth is registered). Such a benefit would be cost-neutral if the Child Benefit program was terminated 6 months earlier than at present.^{†††}

^{***} These policy options and the supporting arguments for them are described in more detail in the PHSA report “A Review of Policy Options for Increasing Food Security and Income Security in British Columbia” (September, 2007). Recommendations re: a strong federal Earned Income Tax Benefit, and income assistance benefits can be found in the BC Progress Board report “The Social Condition in British Columbia” (December, 2006).

^{†††} This recommendation was put forward in the BC Provincial Health Officer’s Report “A Review of Infant Mortality in British Columbia: Opportunities for Prevention” (October, 2003).

Food

Some specific policy options in support of increased food security and improved overall nutrition for British Columbians include^{†††}:

Food Security – Developing a healthy eating and food security strategy.

- Ensuring income assistance rates are determined with consideration for the actual cost of food.
- Addressing issues of availability and accessibility determined by the food system by engaging stakeholders (particularly local governments) to pursue strategies and community-based food security initiatives that focus on capacity building and community development.

BC's Community Food Action Initiative has identified some examples from across the province of the many different ways local governments in BC are taking action to strengthen their local food systems:

- Establishing community gardens
- Creating farmers' markets
- Engaging neighbourhood planning to enhance food access
- Supporting local food production
- Providing healthy food options in public buildings
- Creating community capacity to meet current and future food needs
- Conducting assessments and developing proactive charters and policies

Nutrition – Supporting stronger labelling requirements on all packaged foods, banning trans-fats, reducing salt content requirements, restricting advertisements and sales of junk foods, implementing subsidy programs for nutritional foods, and promoting nutrient fortification (e.g., folic acid).

2. Education and Literacy

There are several policy options that could be pursued at various levels of the learning ladder in order to improve educational outcomes in BC and reduce educational disparities. These include^{§§§}:

- **Strong Start Program** - Enhancing the Strong Start program (a pre-kindergarten program providing children with linguistic, physical and social skills training through about 200 schools in BC) so that it is appropriately funded, and has a strong evaluation component.
- **Child Care Subsidy Program** - Reinvesting in the Child Care Subsidy Program.
- **Community Links** - Enhancing the Community Links program, that provides resources (e.g., school breakfasts and lunches, counselling) to students from disadvantaged backgrounds, to help reduce the number of students who drop out from high school.

††† These policy options are described in more detail in the PHSA Report "A Seat at the Table: Resource Guide for Local Governments to Promote Food Secure Communities" (June, 2008).

§§§ These policy options are described in more detail in the BC Progress Board report "The Social Condition in British Columbia" (December, 2006), p. iii.

- **BC Loan Reduction Program** - Reinvesting in the BC Loan Reduction Program to encourage more low-income students to attend university.
- **Support for Low-Income Students** - Strengthening support for low income students by extending financial support to students in one-year programs.
- **Adult Literacy, Education & Training** - Increasing resources for adult literacy, basic education and skills training.

3. Early Childhood Development

Toward supporting early childhood development and healthier families, policy areas for consideration include^{¶¶¶¶}:

Affordable High Quality Child Care and Other Early Learning Programs – Developing an affordable, accessible, high quality child care system and early learning opportunities for British Columbia (e.g., full-day kindergarten options for children aged three to five, such as those being explored by BC's provincial government^{****}).

These programs and services should be flexible, and meet the developmental, language, literacy and cultural needs of all children^{¶¶¶¶}. They should also provide additional opportunities for the early identification of developmental delays, disabilities and other risk factors and appropriate referrals, encourage parent participation, enhance parents' understanding of child development through information, support and role modelling, build supportive social networks amongst children and families, and support and enhance the economic security of women and families.

Healthier Families – Improving the health of children and families through policies that promote comprehensive, quality and affordable early childhood development and parenting services and programs ensuring that priority is given to those neighbourhoods and communities with the highest numbers of vulnerable children. Particular consideration should be given to the following components of early childhood development that have been shown to be successful and are recommended by First Call: BC Child and Youth Advocacy Coalition^{¶¶¶¶}:

- Early Childhood Development (ECD) public health initiatives (e.g., home visits of all newborns by community health nurses, and vision, hearing, dental and speech screening).
- Adequately resourced and well-coordinated supports for parents, families and other caregivers (e.g., information, resources and workshops about child development and parenting, clothing exchanges and toy lending, drop-in, emergency and respite childcare, and outreach through mobile drop-in programs and playground programs).

¶¶¶¶ These policy options are in alignment with the policies for consideration outlined by the BC Healthy Living Alliance in its paper "Discussion Paper: Healthy Futures for BC Families" (September, 2008).

**** The Honourable Steven L. Point, Lieutenant-Governor of BC. (2008). Speech from the Throne: Opening of the Fourth Session, Thirty-Eighth Parliament, Province of British Columbia, February 12, 2008. Retrieved August 8, 2008 from <http://qp.gov.bc.ca/38th4th/4-8-38-4.htm>.

¶¶¶¶ The characteristics of best practices childcare and other early learning programs are outlined by First Call: BC Child & Youth Advocacy Coalition in "Early Childhood Development in BC: First Call's Framework for Action" (Original March, 2003; Revised 2008).

¶¶¶¶ These ECD supports and services are recommended and expanded upon in more detail by First Call: BC Child & Youth Advocacy Coalition in "Early Childhood Development in BC: First Call's Framework for Action" (Original March, 2003; Revised 2008). The specific programs/initiatives listed here are examples for illustrative purposes – more options are provided in the First Call report.

- Targeted early intervention strategies and services (e.g., supports for high-risk mothers during the pre and post-natal period, and specific supports for children with developmental delays, disabilities, and behavioural issues).
- Strategies to improve access to ECD resources:
 - Community based information and referral services (e.g., well-resourced information and referral services to help families connect with ECD supports and services as well as broader community resources).
 - Designated resources for access and participation (e.g., proactive outreach strategies such as resources for transportation, translation, interpretation, literacy assistance, or provision of food and childcare as part of programs in order to address barriers to access).

In order to maximize effectiveness, it is further recommended that these services be delivered by an ECD Central hub and co-located with child and family-friendly agencies (e.g., family resource centres, schools, libraries, neighbourhood houses, community centres). Consideration should be given to prorating charges according to family income with low or no fees required for low income families.

4. Housing & Healthy Built Environments

Housing

Policy areas for ensuring that all British Columbians are able to enjoy safe affordable housing include^{§§§§}:

Affordable Housing – Ensuring there is an adequate supply of appropriate, safe and affordable housing for low-income families and individuals. Some of the housing need is being addressed through the government’s housing strategy, Housing Matters BC and several other programs, but the demand is greater than the current supply.

Housing First – Developing policies to provide a range of housing and related supports for the homeless, and particularly for those with mental illness and/or addictions. A full continuum of housing options should be provided and matched to individuals’ needs, including emergency and temporary accommodation (e.g., shelters), transition housing, and supportive (e.g., group homes often with on-site staff) and supported housing (e.g., co-operatives or independent apartments with off-site staff or case management support).

It will be imperative for non-profit organizations, the private sector and all levels of government to work together and coordinate their efforts and investments to develop this full continuum of housing for those in need.

Carter & Polevychok (2004)¹⁵⁸ clearly illustrate the role that housing plays in people’s lives and the central role housing plays in the success of other social policy initiatives. As BC takes steps towards further developing a continuum of housing options, it will be important to consult best practices documents like Carter & Polevychok’s that propose meaningful housing program changes,¹⁵⁹ as well as how to make housing policy a more effective social policy instrument (housing policy has to be designed not just to improve the

^{§§§§} These policy interventions are in alignment with those in BCHLA’s paper “Discussion Paper: Healthy Futures for BC Families” (September, 2008).

circumstances of low-income and special needs households, but also to facilitate policy development in other areas like immigration, health, education and social assistance).¹⁶⁰

Healthy Built Environments

Policy options favourable to the development of supportive communities that help to improve health outcomes and reduce health inequities should focus on changes to the built environment, such as¹⁶¹:

- Increasing housing density
- Increasing the usage of mixed land-use patterns
- Increasing the connectivity of urban streets to enable easier (shortest distance) walking between locations
- Improving public transit as an effective alternative to the automobile
- Increasing the supply of recreation facilities and parks
- Enhancing streetscape design to improve aesthetics and safety for pedestrians and cyclists (e.g., adequate lighting, pedestrian crossings, sidewalks, bike paths, traffic slowing)
- Improving physical access to healthy foods and discouraging junk foods through zoning and neighbourhood design where needed to support grocery stores, farmers' markets and restaurants

5. Health Care

Toward enhancing health outcomes and improving access to health services for all British Columbians, some policy options for the health care sector include¹⁶²:

- **Making health inequities reduction a health sector priority** - Coordinating efforts on several fronts, with health sector leadership facilitating the roles of the health sector and encouraging policy action in other sectors.
- **Engaging with other sectors toward reducing health inequities** - Requiring participation from those sectors whose work aligns with key health determinants, and also including an extension to the public, private and voluntary sectors.
- **Integrating inequities reduction into health programs and services** – Articulating objectives, deliverables and expected outcomes. Focusing on the needs of disadvantaged populations, and on mitigating the causes and effect of other determinants of health through interventions with disadvantaged populations (with public health services and clinical prevention services having a particular emphasis).
- **Strengthening knowledge development and exchange** – Documenting disparities, developing evidenced-based policies, evaluating interventions, and communicating results.

¹⁶¹ These interventions are supported by the best available evidence and are presented in the PHSA report "Creating a Healthier Built Environment in British Columbia" (September, 2007).

¹⁶² The first four policy options for consideration are described in more detail by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security in its report "Reducing Health Disparities – Roles of the Health Sector: Discussion Paper" (December, 2004). The last two policy options are intended to address inequities identified previously in this report.

- **Reducing financial and other barriers to health care** - Aiming to ensure equitable, timely access to effective preventive and curative health care services.
- **Providing information to patients in a format that they can understand** – Providing health information to patients that is accessible, regardless of their level of literacy or health literacy.

VI. Conclusion

British Columbia is characterized by a relatively high level of health inequity, such that people from more advantaged socioeconomic groups enjoy significantly better health and longer lives than people from less advantaged groups. The extent of such health inequity among British Columbians constitutes an important issue that deserves the careful attention of policymakers and the BC government and society as a whole.

Both government and business are negatively affected by poor health and health-care costs; both have tremendous economic and social gains to make when good health is achieved and equitably distributed. Addressing inequities by tackling the socio-economic determinants of health will result in healthier citizens, healthier employees, healthier customers and healthier communities generally. This, in turn, will reduce pressures on our health care system and contribute to its sustainability over the longer-term, while also positively affecting economic growth in BC.

The encouraging news is that there is a growing body of evidence that health inequities can successfully be addressed. Around the world, and especially in Europe, many countries have developed dedicated, coordinated intersectoral strategies for reducing health inequity that are demonstrating positive outcomes. Quebec and Newfoundland & Labrador have also implemented provincial anti-poverty strategies.

These jurisdictions have been successful because they have been operating at many levels to address both the social and economic determinants of health (e.g., income and education), as well as behavioural risk factors related to adverse health outcomes. Experience and evidence has demonstrated that interventions targeted only at changing adverse health behaviours will have limited overall success, offering only microenvironmental solutions to a macroenvironmental problem.

A review of the efforts in other jurisdictions reveals a number of common features, presented in this report as key considerations for any initiatives or policies that may be undertaken in British Columbia to reduce health inequity. These considerations include: making the reduction of health inequity a government and societal priority and allocating resources accordingly; developing a multisectoral approach involving cooperation across all levels and areas of government, and across the public, private, NGO and community sectors; and setting clear goals and targets for all initiatives, and tracking progress on specific measures related to health inequity as part of a continuous improvement process.

The policy options presented in this report have been highlighted for their potential to address the social determinants of health and begin the process of addressing health inequities. For the great majority of the policy options, a strong economic case can be made; for others the case is based more on the expected health outcomes. Going forward, the body of literature on health inequities would benefit greatly from solid outcome, process and economic evaluations.

Canada's Chief Public Health Officer sums it up well when he says, "Although clarification and better understanding is needed in many areas [in terms of what social policies and programs are most effective at addressing health inequities], waiting for all the answers is not an acceptable option given what is already known, what can be done and the consequences of neglect while waiting."¹⁶¹

The WHO Commission on the Social Determinants of Health supports this sentiment. In its recent report on addressing health inequities through action on the social determinants of health¹⁶² it noted a significant lack

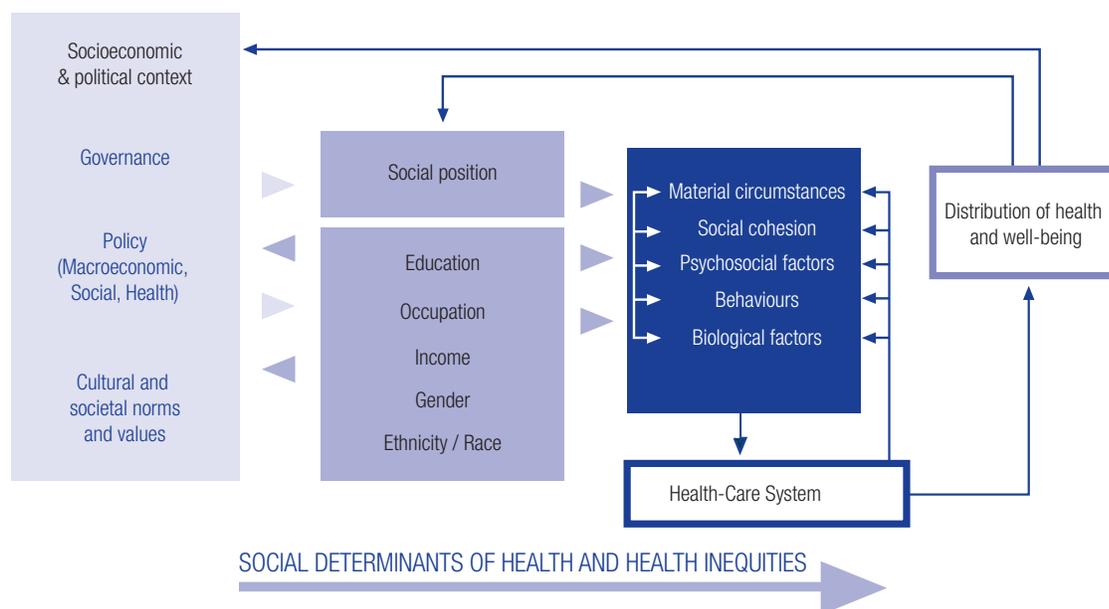
of medical randomized controlled trials that document evidence of what can be done and what is likely to work in practice to improve health and reduce health inequities. It argues that “this lack cannot be a barrier to making judgements with the current evidence” and goes on to incorporate evidence from observational studies, case studies, field visits, expert and lay knowledge and community intervention trials to inform its recommendations for action, which is similar to the approach taken in developing this report.

Appendix 1

A Framework for Action

The WHO's Commission on Social Determinants of Health (CSDH) has developed the following framework as a guide for policy-driven interventions targeting the social determinants of health.

Figure 23. Commission on Social Determinants of Health Conceptual Framework



Source: CSDH Final Report, 2008 (Amended from Solar & Irwin, 2007).

The Commission takes a holistic view of the social determinants of health. The poor health of the poor, the social gradients in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. The Commission argues that this unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

The Commission's Principles of Action

The Commission identified three principles of action, which it used to structure the overarching recommendations and the entire final report. They are:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

These three principles of action identified by the Commission are embodied in the three overarching recommendations below. The Commission states that if action is taken in accordance with these recommendations, and with the more detailed recommendations in subsequent chapters of its final report, it will be possible to achieve a more equitable realization of the rights to the conditions necessary to achieve the highest attainable standard of health.

The Commission's Overarching Recommendations

1. Improve Daily Living Conditions

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

2. Tackle the Inequitable Distribution of Power, Money, and Resources

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

3. Measure and Understand the Problem and Assess the Impact of Action

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

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