Social Inequities in Health and Ontario Public Health

Background Document

The Health Gradient

Individually oriented preventive action

Health hazards

Environmental health hazards
Lack of education
Inadequate food and nutrition
Unemployment
Poor Housing
Poverty


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January 15, 2007
This background document was prepared for the January 15, 2007 meeting between the Ministries of Health Promotion, Health and Long-Term Care and Children and Youth Services and the Sudbury & District Health Unit, Northwestern Health Unit and Simcoe Muskoka District Health Unit.

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Current public debate on reforming the health system in Canada focuses on health care. Little attention, however, has been paid to the role of broader determinants of health, such as income inequality. Yet, mounting public-health evidence demonstrates the negative health impacts of poverty.
# Invited Meeting Participants

<table>
<thead>
<tr>
<th>Health Unit</th>
<th>Participant</th>
<th>Position</th>
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<tr>
<td>Sudbury &amp; District Health Unit</td>
<td>Penny Sutcliffe</td>
<td>Medical Officer of Health and Chief Executive Officer</td>
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<td>Sandra Laclé</td>
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<td>Northwestern Health Unit</td>
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<td>Jean Lam</td>
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<td>Director, Strategic Policy and Planning Branch</td>
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<td>Jas Chana</td>
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<td>Ministry of Children and Youth Services</td>
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Introduction and Background

Remarkably few governments have pursued policies to reduce the tens of thousands of extra deaths lower down the social hierarchy that contribute to health inequalities. … If people were dying from exposure of some toxic material the offices would be instantly closed down until the danger had been removed. But because social processes cause these deaths, there is none of the same sense of urgency.2

The *elephant-in-the-room* is social inequities in health.

We are pleased to have this opportunity to sit together to face the fact that not every Ontarian can attain his or her full health potential.

It is our hope that this meeting marks a milestone in our efforts, and those of our many colleagues both inside and outside the local public health system, to reduce social inequities in health. And while we are tremendously grateful to have this opportunity, we are reminded of Stephen Lewis’ passion-filled words regarding the many United Nations conferences to address AIDS in Africa, “Meetings cannot be a substitute for action – we must get the job done at the local level!” (Sounds Like Canada, CBC Radio, December 4, 2006).

Some Ontarians will die younger, become disabled or experience mental illness because they are worse off socioeconomically. These unlucky Ontarians are not chosen randomly. They are chosen systematically. Unjust social arrangements mean that some Ontarians do not have the right to enjoy the highest attainable standard of health in their society as espoused by the World Health Organization Constitution in 1946.

We would like our public health system to take a hard look at what it can/should do to ensure that every Ontarian can attain his or her own full health potential.

Our collective interest in the area of social inequities in health relates to our core interest in public health careers. Improving population health and in particular, the health of those most disadvantaged is foundational to our having chosen professional public health paths.

Our most recent collective work in this area stems from an environmental scan and related discussions in 2004. We recognized that a *critical mass* of local public health activities on social inequities in health was emerging. We did not experience this same resolve or activity at the provincial level. We decided that we needed to create a forum in which to share and learn from our local experiences. The *Determinants of Health: developing an action plan for public health* conference stream was hosted by the Sudbury & District Health Unit at the 2005 Joint Conference of the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA). An oversubscribed event, over 100 public health representatives came together to share their experiences and guidance.
Motions supporting an explicit public health role in addressing social and economic determinants of health were also carried at the respective 2005 annual general meetings of alPHA and OPHA.

Building on the momentum of the conference and the motions, the Sudbury & District Health Unit benefited from a small grant from the Public Health Agency of Canada through the Ontario Prevention Clearinghouse to draft a more detailed discussion paper, *A framework to integrate social and economic determinants of health into the Ontario public health mandate, March 2006*.

Submitted to the Chief Medical Officer of Health in April 2006, it was hoped that this document and related discussions would inform the imminent Mandatory Health Programs and Services review process. Today’s meeting is in follow up to this submission.

In preparation for today’s meeting, we have reviewed and further analysed the recent local public health efforts described above. This background document builds upon these experiences and our earlier submission, *A framework to integrate social and economic determinants of health into the Ontario public health mandate*. It presents a further refinement of our thinking on social inequities in health and public health as we gain more local experience and as we learn more from experiences elsewhere.

We hope that this meeting will serve as the beginning of an earnest dialogue. A dialogue during which, as we share the respective parts of the elephant we see in the room, we will find an effective path forward to improving the health of all Ontarians, especially those who are most disadvantaged.

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**Meeting Goal and Objectives**

**Goal**
To assist the Ministries of Health Promotion, Health and Long-Term Care and Children and Youth Services to develop and implement a comprehensive and coordinated strategy to reduce social inequities in health in Ontario thus improving the public’s health overall.

**Objectives**
1. To discuss our understanding of the issue of social inequities in health
2. To identify barriers to comprehensive action on social inequities in health
3. To identify enablers for comprehensive action on social inequities in health
4. To review potential policy options to reduce social inequities in health within the context of a comprehensive plan for tackling social inequities in health
5. To decide on next steps to achieve the meeting goal

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**Assumptions**
In preparing for this meeting, we have made several assumptions about our shared understanding of social inequities in health and public health. These assumptions are briefly described below as they form our jumping-off points for further dialogue.

**Assumptions**

1. There is a common understanding of the relationship between social determinants and social inequities and individual and population health.

   *Phipps, S. (2003)* This paper assesses the current state of research knowledge on linkages between poverty and health. The conclusion is that there is a clear and robust relationship between individual income and individual health. Inequalities in health status exist among Canadians and there is a clear correlation with inequality in socioeconomic status.

   *Ross, D.P. (2003)* This summary reports that a growing body of knowledge is accumulating about the impact of poverty on health:

   - Poverty affects health throughout the life cycle. Social disadvantage places people on fairly predictable health trajectories beginning before birth, most pronounced at certain sensitive points or developmental transitions (birth, starting school, etc.). These sensitive periods afford particularly effective downstream intervention points. Further, the health impacts of poverty accumulate and reinforce each other over a life time.

   - Poverty does not affect health through a single pathway. There is no magic bullet that could be developed to prevent harm just as immunization does. Multiple factors affect health and relate to the broad negative consequences of poverty (material want and deprivation, psychosocial impairment, social exclusion and negative health behaviours such as smoking).

   - Multiple risk factors and their interactions make interventions challenging and expensive and measuring the effectiveness of interventions can be challenging. The cumulative effects of improving the social environment, including health and education services, social supports, and inclusive policies and attitudes, appear to flatten the gradient.

   - Intervention should occur as early as possible due to the accumulative effects that are difficult to undo later.

2. There is an acknowledgement that public health measures to improve population health are often taken in the context of incomplete science and understanding. This concept is understood at the precautionary principle. Although research questions persist, (e.g. How does poverty cause poor health? Which factors mediate or exacerbate the poverty-health connection?), there is ample evidence of health risk to make protective public health action necessary.

   There is some controversy in the literature regarding the contribution of health risk behaviours to the observed socioeconomic gradient in health. Can socioeconomic differences in health status change be largely explained by the higher prevalence of individual health risk behaviours among those of lower socioeconomic position?
Most studies to date conclude that conventional health risk behaviours (e.g. cigarette smoking, alcohol drinking, sedentary lifestyle, relative body weight) do not explain social inequities in health. However, a recent work has concluded that conventional risk factors do explain the majority of absolute social inequality in coronary heart disease. Action must continue to be taken on health risk behaviours but these actions should be taken through an equity lens.

3. There is an intrinsic and longstanding need for public health actions to be focused on social issues and to also focus on the disadvantaged. This need is not diminished by the multisectoral nature of the determinants of social inequities in health.

Dahlgren, G. & Whitehead, M. (2006) There is a lack of ownership of the determinants of social inequities in health by any one sector. Clearly stated responsibilities for all implementing bodies connected with specific determinants of health can help counteract this problem. The formulation of specific short and long term equity targets for improved health and for specific determinants of health would also be helpful.


4. There is a longstanding need to have equitable public health services and programs available to all Ontarians.

As evidenced by the work of our own Boards of Health and of our colleagues, there is much work on social inequities in health already underway at the local public health and non-governmental organization (NGO) levels. However, work in this area is not occurring across the entire province. Ontarians deserve the right to enjoy the benefits of equitable public health programs and services no matter where they live. Government participation is necessary for a systematic, coherent strategy to reduce social inequities in health. Local public health action would be greatly strengthened and much more consistently applied geographically with the inclusion of goals and activities to address social inequities in health.

5. There is a need to speak the same language; to have common language and definitions when discussing social inequities in health.

A definitions section is appended to this background document.

Because of our frequent use of some key terms, however, several definitions are reproduced below:

**Determinants of health**
These are factors that influence health positively or negatively. This report focuses on social, economic and lifestyle-related determinants of health – that is, factors that can be influenced by political, commercial and individual decisions – as opposed to age, sex
and genetic factors, which also influence health but are not, on the whole, open to influence by political or other types of policy.\textsuperscript{17}

Although there are many ways of conceptualizing the determinants of health, we have chosen to illustrate the determinants with the following \textit{rainbow} diagram:

\textbf{Figure 1}

The Main Determinants of Health

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{rainbow_diagram.png}
\caption{The Main Determinants of Health}
\end{figure}

\textit{Social inequities in health}
These are systematic differences in health status between socioeconomic groups, as measured by income, education and occupation. All systematic social inequities within a country are socially produced, modifiable and unfair.\textsuperscript{18}

\textit{Determinants of social inequities in health}
These are social, economic and lifestyle related determinants of health that increase or decrease social inequities in health. These factors can always be influenced by political, commercial and individual choices/decisions. For example, strategies that deliver health information or services to the general public are more easily taken up by more educated populations compared to those with lower levels of education, thus widening the gap between social groups in their ability to achieve health.\textsuperscript{19}

\begin{table}[h]
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6. A number of jurisdictions have done more to address social determinants of health. \\
7. A number of countries have done more to reduce social inequalities. Equity in health is the overarching objective of Sweden’s public health policy for example. Government income support programs are essential to reduce poverty, particularly in vulnerable populations such as children and seniors. Overall poverty rates in Canada \\

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\end{tabular}
\caption{Social Inequities in Health and Ontario Public Health}
\end{table}
are considerably higher than in a number of countries: 11.9% in 1997 in Canada compared to 5.1% in Germany, 4.8% in Denmark, and 4.1% in Belgium. Similarly, the child poverty rate in Canada in the early 1990’s was 15.5% compared to 2.6% in Sweden, 3.9% in Norway, 4.3% in Finland, and 4.4% (17.8%) in Belgium. \(^{20}\)

### Barriers to Comprehensive Action

**Policy options for addressing poverty as a cause of poor health:**

Recognize that the possibilities of reducing poverty in high- and middle-income countries are related less to economic resources and more to political will and a sense of solidarity and trust in the society as a whole. If there is a political will then there are possibilities. The political will can be rooted in self-interest as well as in genuine solidarity. Focusing on self-interest, Amartya Sen expressed the following thoughts, “I sometimes wonder whether there is any way of making poverty terribly infectious. If that were to happen, its general elimination would be, I am certain, remarkably rapid” (Sen, 1995).


Why are income, wealth, educational attainment, social status and their distributions in populations not subject to the same risk reduction efforts as smoking, physical activity or clean drinking water? Facing and naming the barriers to action are essential steps in addressing them. Potential barriers are named below:

From the literature:\(^{21,22}\)

- **Fear of reprisal by employer**
- **Lack of political will or non-supportive political ideology**
- **Lack of knowledge.**
- **Lack of financial resources.**
- **Lack of coordination and management capacity.**
- **Lack of ownership.**
- **Lack of policy audit and evaluations.**

From our practice: \(^{23}\)

- **Our own personal attitudes (power, discrimination)**
- **Restrictions in public health mandate**
- **Perceptions of subject being threatening and ideologically based vs ‘neutral and scientific’**

Social Inequities in Health and Ontario Public Health
• Scope of public health practice (discomfort, legitimate role, tradition)
• Workforce reflecting diversity
• Long-term and attribution of gains
• Multiple “ownership” of the SDOH
• Gaps in evidence and knowledge transfer

Enablers for Comprehensive Action

Policy Precedents
There are enablers for action on social inequities in health from within existing government policy and strategic directions:

• Ministry of Health Promotion Strategic Framework: This document identifies that many complex factors affect health including social and economic determinants. It is recognized that partners are required to overcome some of the barriers to good health. It is also recognized that there is a growing health gap in Ontario - many Ontarians are getting healthier, others are being left behind. The strategic framework incorporates the principles of empowerment, engagement and education.

• Ministry of Health and Long-Term Care: A recently announced initiative is underway to develop a strategic plan for health care. There is recognition of the importance of planning ahead for our needs 10 years from now. This initiative may present a policy window.

• Mandatory Public Health Programs and Services Review: This has been mentioned earlier and is a key initiative that could be leveraged to effect change in the mandates for local public health.

• Development of the Ontario Agency for Health Protection and Promotion: The final report of the AITF, From Vision to Action: A Plan for the Ontario Agency for Health Protection and Promotion recommends a vision and next steps for establishing an independent agency to provide scientific and technical advice to service providers who protect and promote the health of Ontarians. In particular, the AITF report recommends that the work of the Agency should be guided by a population health approach that supports improving the health of all Ontarians throughout their lives and commits to reducing inequities in health status between population groups.

• The Capacity Review Report: The CRC released its final report entitled Revitalizing Ontario’s Public Health Capacity: The Final Report of the Capacity Review Committee in May 2006. This report sets out a vision and recommendations/blueprint for the restructuring of the public health system at the local health unit level. The CRC report identifies that an important strength of public health is its multidisciplinary nature, workforce, programs and services which reflect its broad-based mandate to address the various determinants of health – biological, social, cultural and environmental. The report includes statements regarding the key
role public health has to play in working with other sectors to tackle the social, economic, and other determinants of health.

- **Interministerial committees:** A Healthy Living Interministerial Committee and an Interministerial Committee to consult on the public health mandate review have been struck. It is essential to reducing inequities in health that diverse sectors become engaged with a common vision and targets.

- **National Health Goals for Canada:** These goals are broadly worded, and inclusive of concepts of social inequities in health.

**Public and Professional Readiness**

There are indications of both public and professional readiness to see and engage in actions to reduce social inequities in health:

- **Canadian Population Health Initiative (2005)**24 In a recent survey, the Canadian Population Initiative sought to find out Canadians’ opinions on what constitutes health and what factors influence health. They wondered if the public equates health with health care, or whether the public views health more broadly. They asked if people consider that certain factors like income, education, housing or social support could influence health and whether they believe that health could be improved by addressing these factors. The overall findings indicated that while personal lifestyle factors (a person’s eating habits (72%), amount of exercise a person gets (65%), whether a person smokes (80%)) were recognized as having a very strong or strong impact on the health of Canadians, broader factors were not ignored. For broader determinants, one in three Canadians reported that social and economic conditions (a person’s level of income (33%), availability of quality housing (34%); a person’s level of education (33%); safety of communities (35%)) influenced the health of Canadians.

- **Reutter, L. Neufeld, A. Harrison, M. (1999)**25 In this study, 91% of survey respondents agreed that poverty is linked to health, while 68% agreed that low-income people are less likely to participate in community life. Affordable housing was deemed especially difficult to obtain by 96%, but other resources (obtaining healthy food, giving children a good start in life, and engaging in healthy behaviours) were also viewed as challenging by at least 70% of respondents.

- **Reutter, L.I., Marrison, M.J., Neufeld, A. (2002)**26 The purpose of this study was to examine public perceptions of the relationship between poverty and health and to identify demographic variables that predict support for the four explanations of the relationship between poverty and health (artifact, drift, behavioural, and structural) first identified in the Black Report in the United Kingdom. The majority of respondents believed that poverty leads to poor health. The explanation that health is influenced by the context in which individuals live (structural) received the most support.

- **Morris, E., Rosenbluth, D., Scott, D., Livingstone, T., Lix, L., McNutt, M., Watson, F. (2005)**27 Those who chose a structural explanation were more likely to support government spending than those who chose a behavioural explanation. The authors interpreted this as beliefs about the relationship between poverty and health.
influence support for policies. They assert that public health professionals have a role in increasing public awareness of the structural factors that influence health.

- Environics November 9, 2006: *In a poll conducted for the CBC, Canadians were asked what in their opinion is the most important issue facing the country today (people themselves listed themselves issues versus being prompted). Sixteen percent indicated the health care system (the top response), but poverty/homelessness/hunger and unemployment were tied for 6th place at 4% each and 2% of respondents indicated social issues/safety net/social programs.*

- *Alder Group & the Sudbury & District Health Unit. (2005)* Green lights for public health action were identified at this conference. Included in these green lights for action were local public health leadership and governance, relevant public health competencies and workforce readiness.

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**Strategies**

**NOW THEREFORE BE IT RESOLVED THAT** the Association of Local Public Health Agencies (alPHa) request that the Mandatory Health Programs and Services Guidelines be revised to include the Determinants of Health as a recognized health program and service area and planning framework for all Ontario boards of health; and

**AND FURTHER THAT** alPHa request Ontario’s Chief Medical Officer of Health to appoint an expert committee with intersectoral membership and strong public health representation to develop evidence-based goals, objectives, requirements, standards and evaluation framework, as well as a timely implementation strategy for this new Mandatory Program;

**AND FURTHER THAT** alPHa requests that the determinants of health be incorporated into the scope and function of the new Health Protection and Promotion Agency;

**AND FURTHER THAT** the alPHa Board encourage all Ontario boards of health to incorporate a broad determinants of health approach into organizational mission statements and strategic plans;

**AND FURTHER THAT** alPHa facilitates the identification of opportunities for advocacy on broad determinants of health and work with its members to enhance their role as effective change agents to address health disparities and improve health outcomes, recognizing the roles and responsibilities of other agencies, ministries and governments”.


**THEREFORE BE IT RESOLVED THAT** the OPHA request the Chief Medical Officer of Health for Ontario to engage in an inclusive process to examine the role of Ontario’s public health system in addressing social and broader determinants of health; and

**FURTHER THAT** this examination inform the current local public health capacity review process, the review and revision of the Mandatory Health Programs and Services
Guidelines, and the scope and role of the proposed Health Protection and Promotion Agency; and

FURTHER THAT a copy of this motion be forwarded to the Chief Medical Officer of Health for Ontario, the Ministers of Health and Long-Term Care, Children and Youth Services and Health Promotion, the Boards and constituent societies of OPHA and alPHa, and the Public Health Agency of Canada for their information and review.


The overall goal of this meeting is to assist the Ministries of Health Promotion, Health and Long-Term Care and Children and Youth Services to develop a comprehensive and coordinated strategy to reduce social inequities in health in Ontario thus improving the public's health overall.

We have mapped out a strategy framework that is consistent with the alPHa and OPHA motions quoted above and with the 2006 discussion paper, A framework to integrate social and economic determinants of health into the Ontario public health mandate. This strategy framework, called Towards a Comprehensive Strategy to Tackle Social Inequities in Health, is the basis upon which tangible provincial and local action on social inequities could be developed.

While the strategy framework is for provincial and local action, we recognize that this action must be positioned within a national and global context as the driving forces that generate social inequities in health are largely related to the macro-policy environment. These considerations are beyond the scope of this background document. However, we note their importance and point out that there are some very tangible recommendations in the literature on this subject.

Towards a Comprehensive Strategy to Tackle Social Inequities in Health draws heavily on work by the World Health Organization and the Canadian Population Health Initiative. It is organized around the layers of the determinants of health ‘rainbow’ diagram in Figure 1 above. However, it is also based on our professional experiences and those of our colleagues:
Towards a Comprehensive Strategy to Tackle Social Inequities in Health

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<tr>
<th>Provincial Government Strategies</th>
<th>Local Public Health Strategies (in partnership with, NGOs and community organizations)</th>
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<tr>
<td><strong>First Steps</strong></td>
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<tr>
<td>1. Establish principles for policy action. For example:</td>
<td>1. Adopt principles for policy action at the local level.</td>
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<td>a. Policies should strive to level up, not level down</td>
<td>2. Analyse local indicators with respect to provincial health equity targets.</td>
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<td>b. The three main approaches for reducing social inequities in health are interdependent and should build on one another (focus on people in poverty only; narrow the health divide; reduce social inequities throughout the whole population)</td>
<td>3. Analyse public health programs and services to ensure optimal alignment with the needs of those most disadvantaged. Programs and services should be based on a population health approach resulting in health gains for the population as a whole and a reduction in health inequities.</td>
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<td>c. Population health policies should have the dual purpose of promoting health gains in the population as a whole and reducing health inequities</td>
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<td>d. Actions should be concerned with tackling the social determinants of health inequities (i.e. not only on the social determinants of health, but also on the main determinants of the systematic differences in opportunities, living standards and lifestyles associated with the different positions in society – e.g. Aboriginal peoples)</td>
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<td>e. Stated policy intentions are not enough: the possibility of actions doing harm must be monitored</td>
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<td>f. Select appropriate tools to measure the extent of inequities and the progress towards goals</td>
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<td>g. Make concerted efforts to give a voice to the voiceless</td>
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<td>h. Wherever possible, social inequities in health should be described and analysed separately for men and women</td>
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<td>i. Relate differences in health by ethnic background or geography to socioeconomic background</td>
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<td>j. Health systems should be built on equity principles</td>
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<tr>
<td>2. Set national and provincial health equity targets</td>
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**Towards a Comprehensive Strategy to Tackle Social Inequities in Health**  
(Adapted from 31,32,33)

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<th>Provincial Government Strategies</th>
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<tr>
<td><strong>Layer 1: Individual lifestyle factors</strong></td>
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<td>The social and economic environments in which people live are of critical importance for shaping their lifestyles. Recognizing these structurally determined lifestyles highlights the importance of structural interventions in reducing social inequities in disease related to lifestyle factors. Interventions include fiscal policies that increase prices of harmful goods and legislation that limits access to these products. Equally important is the option of promoting healthier lifestyles by making it easier to choose the healthy alternatives.</td>
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<td>There is some cross over between provincial level and local level strategies for the lifestyle-related policies below.</td>
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<td>Local public health efforts in this layer of influence are largely downstream in that they are designed to lessen the negative health impacts of poverty and inequity.</td>
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<td>The following are examples of lifestyle-related policies through an equity lens:</td>
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**Tobacco control:**
- Keep the price of tobacco products high through taxation.
- Introduce comprehensive bans on advertising.

**Alcohol misuse:**
- Develop and maintain fiscal policies on price and access to alcohol.
- Analyse and report on the implicit unhealthy policies promoted by the alcohol industry.

**Nutrition, physical activity and obesity:**
- Conduct periodic assessments of the prevalence of unhealthy diets and lack of physical activity and rate of malnutrition and obesity by socioeconomic group.
- Increase the availability of fruits and vegetables and low fat products in low income areas. Raise the financial support given to low income families with children to make it possible for them to choose a healthier diet.
- Introduce and maintain strict rules and controls on advertising and promotions that target children and promote the consumption of foods considered to be less healthy.
- Prioritize public investments in recreational facilities for disadvantaged areas.

**Tobacco control:**
- Intensify tobacco-control efforts in disadvantaged areas.
- Promote the concept of smoke-free babies.
- Develop tailor-made cessation programs such that the effectiveness for diverse socioeconomic groups are considered.

**Alcohol misuse:**
- Identify upstream causes of alcohol misuse in society and develop social support systems at work and in the community to reduce the additional negative health impact of alcohol misuse typically experienced by lower socioeconomic groups.
- Analyse and report on the implicit unhealthy policies promoted by the alcohol industry.
- Develop tailored health education programs for those at greatest risk.

**Nutrition, physical activity and obesity:**
- Conduct periodic assessments of the prevalence of unhealthy diets and lack of physical activity and rate of malnutrition and obesity by socioeconomic group.
- Work with schools and community groups to provide free school lunches of a good quality and restrict access to less healthy foods and sweets on the premises of the school.
- Increase the availability of fruits and vegetables and low fat products in low income areas. Raise the financial support given to low income families with children to make it possible for them to choose a healthier diet.
### Towards a Comprehensive Strategy to Tackle Social Inequities in Health

(Adapted from 31,32,33)

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#### Layer 2: Social and community networks

At the individual level, there is strong evidence that certain types of social networks, social participation and supportive social relationships are good for a person's health. At the population level, there are features of the collective social context (e.g. neighbourhood, community), external to the individual that influence the level of health experienced by that population. Provincial policy options include bolstering individual social support and promoting horizontal and vertical interactions in populations.

The connectedness of local public health to municipal infrastructures, community groups and citizens means that local public health has a key role in fostering and supporting social and community networks for health.

Local public health efforts in this layer of influence are largely downstream (though not uniquely) in that they are designed to lessen the negative health impacts of poverty and inequity.

Interventions are primarily motivated by the desire to encourage a better environment for children in homes and communities and to increase understanding of conditions necessary to produce healthy children. However, they should be seen in the broader context of efforts to rebuild the social fabric of neighbourhoods in order to improve social support for all residents and reduce social exclusion.

- Provide additional health and social services to disadvantaged groups and communities that offer support to parents of young children and young mothers.
- Foster horizontal social interactions – between members of the same community or group to allow community dynamics to work. For example:
  - Community development initiatives that enable people to work collectively on their identified priorities for health
  - Build infrastructure in neighbourhoods to make it easier for social interactions to take place.
- Strengthen or develop systems that foster vertical social interactions on a society-wide basis:
  - Build inclusive social welfare and educational systems in which everyone contributes and everyone benefits
  - Employment policies that aim to integrate all groups in society into the labour market
  - Initiatives to strengthen the democratic process and make it easier for the disenfranchised to participate
- Mobilize communities and assist in building community coalitions.
- Foster horizontal social interactions – between members of the same community or group to allow community dynamics to work. For example:
  - Community development initiatives that enable people to work collectively on their identified priorities for health
  - Build infrastructure in neighbourhoods to make it easier for social interactions to take place
- Support communities and work to enhance community participation and cohesion
### Towards a Comprehensive Strategy to Tackle Social Inequities in Health

(Adapted from 31,32,33)

<table>
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<tr>
<th>Provincial Government Strategies</th>
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#### Layer 3: Living and working conditions

**Multisectoral actions** are required to combat inequities in health.

Local public health efforts in this layer of influence are largely downstream (though not uniquely) in that they are designed to lessen the negative health impacts of poverty and inequity. Public health must work in partnership with many community-based stakeholders in order to effect change in areas outside of its direct domain.

Multisectoral actions at the provincial and local levels are demonstrated in the following examples:

**Education:**

- The lower the adult educational achievement, the poorer the adult health status. Educational achievement is not distributed equally in society. Frequently it is the people living under disadvantaged circumstances that have both lower educational achievement and less access to good quality educational services.

- Identify and reduce economic, social and other barriers to gaining access to education at all levels and provide lifelong learning.
- Introduce comprehensive support programs for children in less privileged families to promote preschool development.
- Ensure that schools in less privileged areas receive extra resources to meet the greater needs for special support.
- Provide extra support to students from less privileged families; the goal should be that education achievements do not differ due to socioeconomic background.
- Provide extra support in the transition from school to work.
- Maintain and enhance healthy schools programs with a focus on equity (e.g. physical and psychosocial environments, free healthy lunches, physical activity promotion, teacher training re early warning signals).

**Working environment:**

- Workplace health promotion policy development and programming.

**Unemployment:**

- Improve the competence and capacity of the health sector to prevent the decline in health due to unemployment (e.g. outreach mental health services).
- Demonstration programs aimed at improving the employment prospects and earnings of parents on social assistance have shown positive results (e.g. including components of nurse home visiting, diet/nutrition, child development).

**Health care services:**

- Improve health care coverage, eligibility, geographic and cultural access and equitable resource allocation (preventing the ‘inverse care law’ – availability of good medical care tends to vary inversely with the need for it).
- Help alleviate the health damage caused by wider determinants of health (e.g. outreach services to homeless or other hard to reach groups living in poverty).
- Tackle wider determinants of health more directly (e.g. intensified outreach services through partnerships formed with agencies outside the health sector).
### Towards a Comprehensive Strategy to Tackle Social Inequities in Health

(Adapted from [31,32,33])

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| **Unemployment:**
  *Unemployment is an important determinant of social inequities in health. Efforts to reduce it should be given a high priority in any economic development strategy.*
  - Adopt targets for reducing unemployment and promote economic policies and legal frameworks that stimulate or further promote full employment (ensure policies to benefit those in the weakest position in the labour market).
  - Improve pathways that lead from unemployment back to work, including active systems of job seeking, training schemes and special resources such as subsidized wages and tax rebates for employing the long-term unemployed.
  - Strengthen Family Friendly Employment Policies including the availability of child care.
  - Improve the competence and capacity of the health sector to prevent the decline in health due to unemployment (e.g. outreach mental health services).
| **Health care services:**
  *Health care systems have a role in reducing the effects of poverty and inequity on health directly and through a multisectoral approach. A multisectoral perspective on health development recognizes that the health care sector is one of many determinants of health.*
  - Improve health care coverage, eligibility, geographic and cultural access and equitable resource allocation (preventing the ‘inverse care law’ – availability of good medical care tends to vary inversely with the need for it).
  - Prevent health services from causing poverty (financial burden of payment) by promoting taxation policies that secure adequate public funding.
  - Help alleviate the health damage caused by wider determinants of health (e.g. outreach services to homeless or other hard to reach groups living in poverty).
  - Tackle wider determinants of health more directly (e.g. intensified outreach services
| **Strengthen good informal care and self care.**
| **Promote multisectoral approaches:**
  - Collect and share information about the causes, magnitude and distribution of different health problems that are important for each sector to address
  - Develop and use different methods of equity-oriented health impact analyses
  - Engage in multisectoral actions for health
  - Engage in multisectoral collaboration to facilitate service provision to marginalized or difficult to reach groups

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Social Inequities in Health and Ontario Public Health
### Towards a Comprehensive Strategy to Tackle Social Inequities in Health

(Adapted from 31,32,33)

| Provincial Government Strategies | Local Public Health Strategies  
(in partnership with, NGOs and community organizations) |
|----------------------------------|----------------------------------------------------------|
| through partnerships formed with agencies outside the health sector).  
- Strengthen good informal care and self care.  
- Promote multisectoral approaches:  
  - Collect and share information about the causes, magnitude and distribution of different health problems that are important for each sector to address  
  - Develop and use different methods of equity-oriented health impact analyses  
  - Engage in multisectoral actions for health  
  - Engage in multisectoral collaboration to facilitate service provision to marginalized or difficult to reach groups  
  - Identify that the health care sector is one of many determinants of health |

#### Layer 4: General socioeconomic, cultural and environmental conditions

Policy options for addressing poverty as a cause of poor health lie in the provincial and national domains in Canada. The policy options need to be acted on in concert by both levels of government in order to be effective and mutually reinforcing/enabling.

Local public health efforts in this layer of influence are mostly related to informing public opinion, acting as a community catalyst or enabler and engaging in direct and indirect advocacy roles. These are upstream strategies in that they attempt to directly prevent or reduce poverty and inequality.

Provincial and local level strategies are highlighted below.

- Many of the strategies identified as provincial strategies have national application. The setting of overarching targets is a critical step:  
  - Set provincial targets for the reduction of income differences  
- Boost incomes of poor families by  
  - Equity-oriented economic growth and labour market policies  
  - Tax credits for low-income families  
  - Minimum salary levels that reduce the risk of being poor  
  - Reducing gender-specific income differences  
  - Securing or expanding child care or preschool care, increasing the possibilities for parents to earn an income from work outside the home  
  - Adult education or lifelong

- Engage in routine surveillance and reporting on local indicators of the social inequities in health:  
  - Community members and policy makers may be unaware of the magnitude and trends of existing inequities in health. Improving reporting on health inequities will assist with the problem of the invisibility of social inequities in health in everyday life (i.e. death and disease are perceived as hitting people randomly)  
  - Improve health information systems so that a much more sophisticated understanding of health inequities can be achieved (in collaboration with provincial level)  
  - Ensure that health information systems provide information about the distribution of different causes of death and
## Towards a Comprehensive Strategy to Tackle Social Inequities in Health

(Adapted from 31,32,33)

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<td><strong>opportunities to learn new skills</strong>&lt;br&gt;- Social welfare benefits to provide an adequate family income&lt;br&gt;- Old age pensions that secure a decent living standard for low income groups**&lt;br&gt;- Recognize that the possibilities of reducing poverty in high- and middle-income countries are related less to economic resources and more to political will and sense of solidarity and trust in the society as a whole. The political will can be rooted in self-interest as well as in genuine solidarity.<strong>&lt;br&gt;- Conduct health impact assessments of social and economic policy.</strong>&lt;br&gt;- Require the planning and development of built environment of communities such that they are support of the social determinants of health:&lt;br&gt;- Provision of excellent, affordable public transportation&lt;br&gt;- Community design that promotes walking and other forms of active transportation&lt;br&gt;- Mixed neighbourhoods with close proximity of work places and affordable health nutrition shopping to lower income residences&lt;br&gt;- Green spaces, and recreational facilities within walking or public transportation distance to lower income residences**&lt;br&gt;- Ensure safety considerations in neighbourhood design (such as separation of active transportation and recreation from traffic, sufficient lighting, police enforcement).**&lt;br&gt;</td>
<td><strong>perceived health problems by social background and not only by age and sex</strong>&lt;br&gt;- Engage in or intensify public education&lt;br&gt;- Develop a normative social marketing strategy regarding social inequities in health (e.g. quantify local health effects of determinants of inequities in health; ensure alternate views are included in local media re causes of disease and priority health issues; raise awareness of the social, economic and environmental determinants of health)<strong>&lt;br&gt;- Promote individual and community/collective actions that may lead to changes in social inequities in health.</strong>&lt;br&gt;- Make a concerted effort to give a voice to the voiceless:&lt;br&gt;- Seek the views of marginalized groups and increase their genuine participation (as opposed to token consultation)&lt;br&gt;- Provide administrative systems and information in a way that makes it easier for lay people to participate in decisions that affect their health**&lt;br&gt;- Ensure a strong health sector voice about the need for sustained political will and for government’s stewardship role to alleviate social inequities in health.<strong>&lt;br&gt;- Conduct and identify needs for local research related to social inequities in health&lt;br&gt;- Include qualitative approaches in local research to capture individuals at the level of their daily lived experience&lt;br&gt;- Include participatory action research approaches to foster community development&lt;br&gt;- Shift how research questions are formulated. This can be illustrated through the example of tobacco research. Traditionally, one would ask “Why do people smoke?” Through an equity lens, the question may be worded as “What social and economic factors (and policies) create conditions that make it more or less likely that people smoke?”</strong>&lt;br&gt;- Conduct health impact assessments of social and economic policies.</td>
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Next Steps

Reinforcement of fairness and equity as core values of Australian society is the responsibility of governments supported by civil society. The health sector should provide leadership and evidence of the impact of social determinants on health and equity. A National Health Equity Framework should be developed to encourage comprehensive and coordinated national action.


We began this background document by expressing our hopes that this meeting serves as the beginning of an earnest dialogue -- a dialogue toward finding an effective path forward to improving the health of all Ontarians, especially those who are most disadvantaged.

We are committed to this work and willing to contribute to next steps. Many of our public health colleagues share this commitment.

We do not underestimate the size of the task to be undertaken. We also do not underestimate the size of the health gains to be achieved.

The public health community’s voice needs to be heard as an advocate for sustained political will and for government’s stewardship role to be championed both within nation states and increasingly between them. Reducing public health to health education and promotion is misguided and regressive, as is a heavy reliance on health care systems to lead the paradigm shift where the pull of the acute sector remains powerful and likely always to drive out an upstream approach. Instead what is needed is much closer linkage between public health and sustainability so that health becomes a central integrating function of sustainable development strategies. But for this to happen, government action is unavoidable, combined with a clear commitment to a collective response. There are limits to markets and to viewing individuals as consumers exercising unfettered choice. It is time we acknowledged these and acted accordingly.

Appendices
Appendix 1: Definitions

**Advocacy**
Advocacy is the process of promoting and supporting a particular position, argument, policy or belief. It entails an intention to facilitate change towards a particular goal or objective. For anyone concerned with social justice, advocacy is the process of using information strategically and acting to change policies to improve the lives of disadvantaged people.\(^{34}\)

Determinants of health
These are factors that influence health positively or negatively. This report focuses on social, economic and lifestyle-related determinants of health – that is, factors that can be influenced by political, commercial and individual decisions – as opposed to age, sex and genetic factors, which also influence health but are not, on the whole, open to influence by political or other types of policy.\(^{35}\)

The Main Determinants of Health

Source: Dahlgren and Whitehead, 1993
Determinants of social inequities in health
These are social, economic and lifestyle related determinants of health that increase or decrease social inequities in health. These factors can always be influenced by political, commercial and individual choices/decisions.36

Downstream interventions
Interventions aimed at specific populations and designed to lessen the negative health impacts of poverty.37

Equity in health
This implies that, ideally, everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined factors.38

Equity-oriented health policies
These are policies that aim to reduce or eliminate social inequities in health.39

Public health
An organized activity of society to promote, protect, improve, and, when necessary, restore the health of individuals, specified groups, or the entire population. It is a combination of sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all the people. The term “public health” can describe a concept, a social institution, a set of scientific and professional disciplines and technologies, and a form of practice. It encompasses a wide range of services, institutions, professional groups, trades, and unskilled occupations. It is a way of thinking, a set of disciplines, an institution of society, and a manner of practice. It has an increasing number and variety of specialized domains, and it demands of its practitioners an increasing array of skills and expertise.40

In this background document, public health refers generally to government and non-governmental organizations whose collective mandates are as above. Local public health refers to local public health units/agencies/departments.

Social inequities in health
These are systematic differences in health status between socioeconomic groups, as measured by income, education and occupation. All systematic social inequities within a country are socially produced, modifiable and unfair.41

Socioeconomic status
Refers to position on the social hierarchy – social class, occupational group, educational level and income level; these characteristics relate to social stratification: individuals occupy a higher or lower position on the social hierarchy according to their occupation, education etc.42

Upstream interventions
Interventions that directly prevent or reduce poverty and inequality.43
Appendix 2: Resources


Canadian Population Health Initiative. (2004b). What have we learned studying income inequality and population health? Ottawa, ON: Canadian Institute for Health Information.


Endnotes

1 Ross, D. P. (2003). *Policy approaches to address the impact of poverty on health: A scan of policy literature*. Ottawa, ON: Canadian Institute for Health Information, Canadian Population Health Initiative.


7 Ibid.


10 Last, J. M. (Ed.). (2007). *A dictionary of public health*. Toronto, ON: Oxford University Press. The precautionary principle is explained as follows: In management of health risks, shaping of health policy, and all public policy decisions, this is the conservative, “better safe than sorry” approach that wisdom dictates should be the rule when there is any doubt about long-term consequences of irreversible decisions affecting control of the environment or a situation. It is a variation on the theme of the ethical principle of nonmaleficence, primum non nocere, or first do no harm (p. 298).


18 Ibid.

19 Ibid.


36 Ibid.


39 Ibid.


42 Ibid.