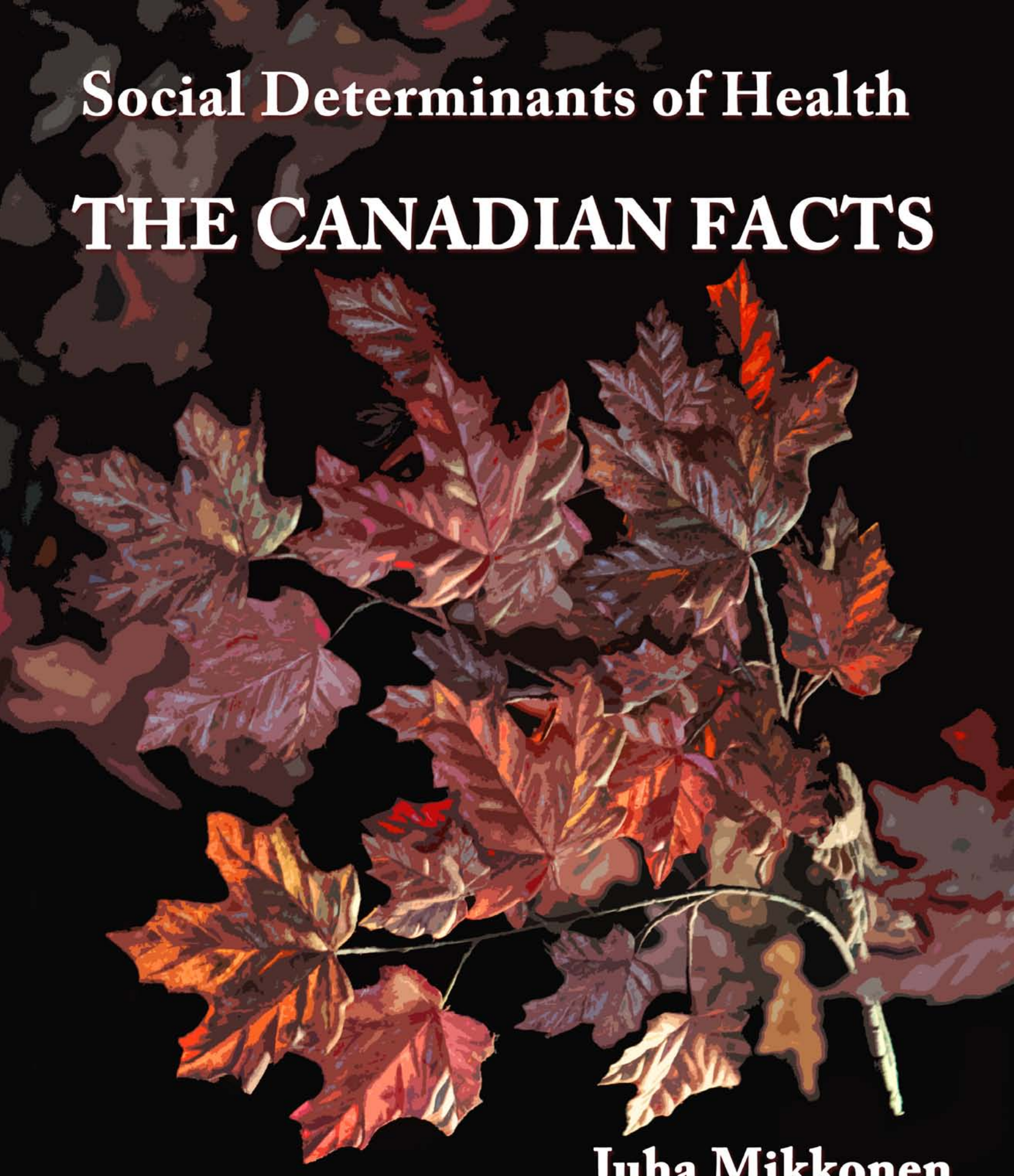
Social Determinants of Health

THE CANADIAN FACTS



Juha Mikkonen

Dennis Raphael

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Social Determinants of Health: The Canadian Facts

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Social Determinants of Health: The Canadian Facts

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Foreword by the Honourable Monique Bégin

AUTHORS

Juha Mikkonen (Helsinki, Finland) has worked with numerous non-governmental organizations in Europe. Currently he is a vice-president of the European Anti-Poverty Network Finland (EAPN-Fin). At the international level, he is a member of the executive committee of the European Anti-Poverty Network. He has held positions in many decision-making bodies at the University of Helsinki, the Finnish Student Health Services and the Finnish Youth Co-operation Allianssi, which is an umbrella organization for 112 Finnish youth NGOs. In addition, he has been a member of the board of the Gaudeamus – Helsinki University Press Ltd.

He is the editor of *Arkipäivän kokemuksia köyhyydestä*, 2007 (*Everyday Experiences of Poverty*) and *Rikas runo*, 2009 (*Rich/Wealthy Poems;* an anthology of poems about poverty). He was one of the organizers of the writing contest "*Everyday Experiences of Poverty*" which collected over 800 autobiographical writings from people living in low-income situations. Currently he is working in the areas of health inequalities, marginalization, political advocacy, health policy, and the social determinants of health. His most recent publication *Terve Amis!* (2010) provides 50 recommendations for reducing health inequalities among vocational school students in Finland. **Contact: mikkonen@iki.fi**

Dennis Raphael (Toronto, Canada) is a professor of health policy at the School of Health Policy and Management at York University. Over the course of his career he has carried out research in child and adolescent development, student mathematics and science achievement, health promotion and quality of life, social exclusion, and public policy and the social determinants of health. Currently he is working on the social determinants of the incidence and management of type II diabetes in vulnerable communities and the impacts of globalization on the health of Canadians.

He is the editor of *Social Determinants of Health: Canadian Perspectives* (2009, 2nd edition) and *Health Promotion and Quality of Life in Canada: Essential Reading*s (2010); co-editor of *Staying Alive: Critical Perspectives on Health, Illness, and Health Care* (2010, 2nd edition); and the author of *About Canada: Health and Illness* (2010) and *Poverty and Policy in Canada* (2007). Dr. Raphael has published 170 scientific papers and has made 214 public presentations since he began working on quality of life issues in 1993. He manages the 1240 member Social Determinants of Health Listserv at York University. **Contact: draphael@yorku.ca**

Printed and bound colour copies of this document are available.

Details are provided at www.thecanadianfacts.org

FOREWORD

We have known for a very long time that health inequities exist. These inequities affect all Canadians but they have especially strong impacts upon the health of those living in poverty. Adding social sciences evidence – the understanding of social structures and of power relationships – we have now accumulated indisputable evidence that "*social injustice is killing people on a grand scale.*"

When the World Health Organization's Commission on Social Determinants of Health published its final report (containing the quote above) that demonstrated how the conditions in which people live and work directly affect the quality of their health, we nodded in agreement. Everyone agrees that populations of Bangladesh, Sierra Leone or Haiti have low life expectancy, are malnourished, live in fearful and unhealthy environments, and are having a terrible time just trying to survive.

But what does that have to do with us in Canada?

For years, we bragged that we were identified by the United Nations as "the best country in the world in which to live". We have since dropped a few ranks, but our bragging continues. We would be the most surprised to learn that, in all countries – and that includes Canada – health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The truth is that Canada – the ninth richest country in the world – is so wealthy that it manages to mask the reality of poverty, social exclusion and discrimination, the erosion of employment quality, its adverse mental health outcomes, and youth suicides. While one of the world's biggest spenders in health care, we have one of the worst records in providing an effective social safety net. What good does it do to treat people's illnesses, to then send them back to the conditions that made them sick?

This wonderful document, *Social Determinants of Health: The Canadian Facts,* is about us, Canadian society, and what we need to put faces and voices to the inequities – and the health inequities in particular – that exist in our midst. Only when we see a concrete description of these complex and challenging problems, when we read about their various expressions in all the regions of the country and among the many sub-groups making up Canada, can we move to action.

A document like this one, accessible and presenting the spectrum of existing inequities in health, will promote awareness and informed debate, and I welcome its publication. Following years of a move towards the ideology of individualism, a growing number of Canadians are anxious to reconnect with the concept of a just society and the sense of solidarity it envisions. Health inequities are not a problem just of the poor. It is **our** challenge and it is about public policies and political choices and our commitments to making these happen.

I find it an honour to write this Foreword to *Social Determinants of Health: The Canadian Facts*, a great initiative of our Canadian advocate for population health, Dennis Raphael, and his colleague from Finland, Juha Mikkonen.

The Hon. Monique Bégin, PC, FRSC, OC

Member of WHO Commission on
Social Determinants of Health

Former Minister of
National Health & Welfare

WHAT PEOPLE ARE SAYING ABOUT THE CANADIAN FACTS

"Congratulations on this most valuable contribution to Canadians' understanding of what really needs to change in order to improve population health. My hope is that it also sends a strong yet accessible message to those of us in the Canadian health system about how we need to change our practice."

– Penny Sutcliffe, MD, MHSc, FRCPC, Chief Executive Officer, Sudbury & District Health Unit

"Juha Mikkonen and Dennis Raphael have created a resource that is at once educational, easy to read, evidence-based, and a powerful call to action. I hope to see this document open on the desks of policy makers, public health professionals, students, and front line health providers. This important contribution to the dialogue around social determinants of health in Canada offers both an accessible resource, and a straightforward guide to what we need to do to reduce inequities in health."

– Gary Bloch, Family Physician, St. Michael's Hospital, Toronto; Assistant Professor, University of Toronto

"This is a superb document for getting the message out there regarding the politics of health. There is nothing like it in Canada. The text and the graphs will enlighten even the skeptics. The cover art is great. The layout is engaging and the whole thing is entirely readable. I'll be using it in every class I teach."

– Dr. Elizabeth McGibbon, St. Francis Xavier University

"Under the International Covenant on Economic, Social and Cultural Rights, everyone has rights 'to an adequate standard of living' and 'the enjoyment of the highest attainable standard of physical and mental health.' Nonetheless, the evidence for comprehensive action on the social determinants of health is overwhelming. Like highly skilled trial lawyers, Juha Mikkonen and Dennis Raphael have assembled this evidence, concisely, clearly and compellingly, into a single document. As a result, the prospect of realizing the rights that constitute an international standard for a decent human life is that much brighter. Bravo!"

– Rob Rainer, Executive Director, Canada Without Poverty

"The Canadian Facts so succinctly described in this readable little book are not nice ones. But beneath the intersecting pathways by which social injustices become health inequalities lies the most sobering message: Things are getting worse. We have lived through three decades where the predatory greed of unregulated markets has allowed (and still allows) some to accumulate ever larger hordes of wealth and power while denying others a fair share of the resources they need to be healthy. This book is a fast-fact reference and an invitation for Canadian health workers to join with social movement activists elsewhere to reclaim for the public good some of these appropriated resources. "

– Ronald Labonté, Professor and Canada Research Chair, Globalization and Health Equity, University of Ottawa

"With unusual clarity and insight, this informative resource will help change the way readers think about health. It renders visible how underlying social and economic environments influence health outcomes even more than personal behaviors, genetic profiles, or access to healthcare. Solutions, it reminds us, lie not in new medical advances or even 'right choices' but in the political arena: struggling for the social changes that can provide every resident the opportunity to live a healthy and fulfilling life."

– Larry Adelman, creator and executive producer, "Unnatural Causes: Is Inequality Making Us Sick?"

1. INTRODUCTION

A health care system – even the best health care system in the world – will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair.

– The Honourable Roy Romanow, 2004

The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health. The importance to health of living conditions was established in the mid-1800s and has been enshrined in Canadian government policy documents since the mid-1970s. In fact, Canadian contributions to the social determinants of health concept have been so extensive as to make Canada a "health promotion powerhouse" in the eyes of the international health community. Recent reports from Canada's Chief Public Health Officer, the Canadian Senate, and the Public Health Agency of Canada continue to document the importance of the social determinants of health.

But this information – based on decades of research and hundreds of studies in Canada and elsewhere – tells a story that is unfamiliar to most Canadians. Canadians are largely unaware that our health is shaped by how income and wealth is distributed, whether or not we are employed, and if so, the working conditions we experience. Furthermore, our well-being is also determined by the health and social services we receive, and our ability to obtain quality education, food and housing, among other factors. And contrary to the assumption that Canadians have personal control over these factors, in most cases these living conditions are – for better or worse – imposed upon us by the quality of the communities,

housing situations, our work settings, health and social service agencies, and educational institutions with which we interact.

There is much evidence that the quality of the social determinants of health Canadians experience helps explain the wide health inequalities that exist among Canadians. How long Canadians can expect to live and whether they will experience cardiovascular disease or adult-onset diabetes is very much determined by their living conditions. The same goes for the health of their children: differences among Canadian children in their surviving beyond their first year of life, experiencing childhood afflictions such as asthma and injuries, and whether they fall behind in school are strongly related to the social determinants of health they experience.

Research is also finding that the quality of these health-shaping living conditions is strongly determined by decisions that governments make in a range of different public policy domains. Governments at the municipal, provincial/territorial, and federal levels create policies, laws, and regulations that influence how much income Canadians receive through employment, family benefits, or social assistance, the quality and availability of affordable housing, the kinds of health and social

services and recreational opportunities we can access, and even what happens when Canadians lose their jobs during economic downturns.

These experiences also provide the best explanations for how Canada compares to other nations in overall health. Canadians generally enjoy better health than Americans, but do not do as well as compared to other nations that have developed public policies that strengthen the social determinants of health. The World Health Organization sees health damaging experiences as resulting from "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics".

Despite this evidence, there has been little effort by Canadian governments and policymakers to improve the social determinants of health through public policy action. Canada compares unfavourably to other wealthy developed nations in its support of citizens as they navigate the life span. Our income inequality and poverty rates are growing and are among the highest of wealthy developed nations. Canadian spending in support of families, persons with disabilities, older Canadians, and employment training is also among the lowest of these same wealthy developed nations.

Social Determinants of Health: The Canadian Facts provides Canadians with an introduction to the social determinants of our health. We first explain how living conditions "get under the skin" to either promote health or cause disease. We then explain, for each of 14 key social determinants of health:

1) Why it is important to health;
2) How we compare on the social determinant of health to other wealthy developed nations;
3) How the quality of the specific social determinant can be improved.

Key sources are provided. We conclude with a section that outlines what Canadians can do to improve the quality of the social determinants of health.

Social Determinants of Health: The Canadian Facts is a companion to two other information sources about the social determinants of health. *Social Determinants of Health: Canadian Perspectives* (2009) is an extensive and detailed compilation of prominent Canadian scholars and researchers' analyses of the state of the social determinants of health in Canada. *About Canada: Health and Illness* (2010) provides this information in a more compact and less academic presentation.

Improving the health of Canadians is possible but requires Canadians think about health and its determinants in a more sophisticated manner than has been the case to date. The purpose of *Social Determinants of Health: The Canadian Facts* is to provide a foundation to these efforts.

Juha Mikkonen
Dennis Raphael

Suggested readings

Raphael, D. (Ed.). (2009). Social Determinants of Health: Canadian Perspectives. 2nd edition. Toronto: Canadian Scholars' Press Incorporated.

Raphael, D. (Sept., 2010). About Canada: Health and Illness. Halifax: Fernwood Publishers.

World Health Organization. (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: World Health Organization.

Figure 1.1 A Model of the Determinants of Health

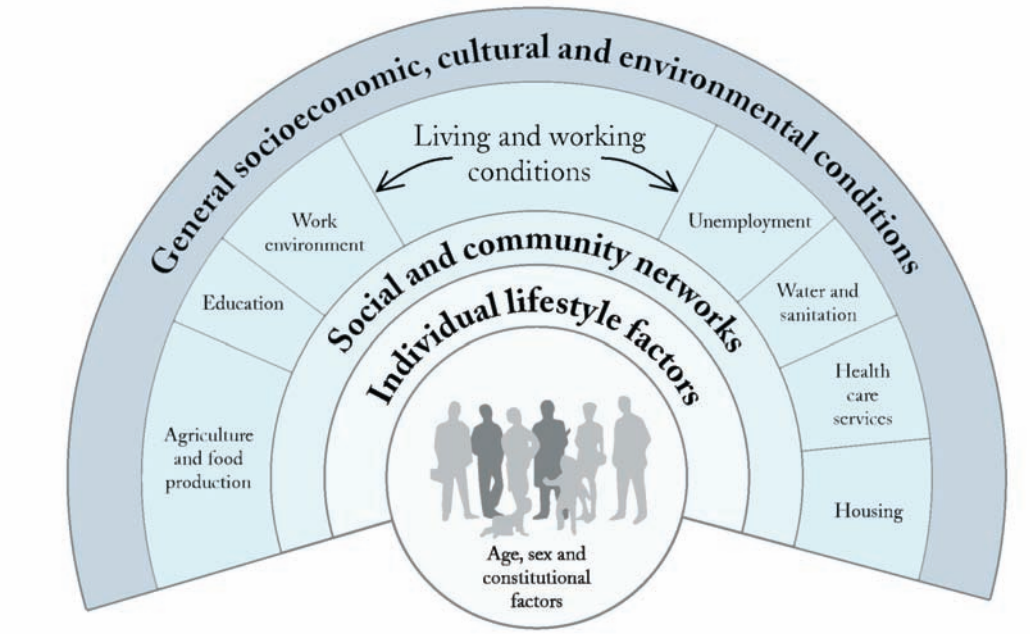


Figure shows one influential model of the determinants of health that illustrates how various health-influencing factors are embedded within broader aspects of society.

Source: Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

Box 1.1 Social Determinants of Health

Among the variety of models of the social determinants of health that exist, the one developed at a York University Conference held in Toronto in 2002 has proven especially useful for understanding why some Canadians are healthier than others. The 14 social determinants of health in this model are:

Aboriginal status
disability
early life
education
employment and working conditions
food insecurity
health services
gender
housing
income and income distribution
race
social exclusion
social safety net
unemployment and job security

Each of these social determinants of health has been shown to have strong effects upon the health of Canadians. Their effects are actually much stronger than the ones associated with behaviours such as diet, physical activity, and even tobacco and excessive alcohol use.

Source: Raphael, D. (2009). Social Determinants of Health: Canadian Perspectives, 2nd edition. Toronto: Canadian Scholars' Press.

2. STRESS, BODIES, AND ILLNESS

Prolonged stress, or rather the responses it engenders, are known to have deleterious effects on a number of biological systems and to give rise to a number of illnesses.

– Robert Evans, 1994

Why Is It Important?

People who suffer from adverse social and material living conditions also experience high levels of physiological and psychological stress. Stressful experiences arise from coping with conditions of low income, poor quality housing, food insecurity, inadequate working conditions, insecure employment, and various forms of discrimination based on Aboriginal status, disability, gender, or race. The lack of supportive relationships, social isolation, and mistrust of others further increases stress.

At the physiological level, chronic stress can lead to prolonged biological reactions that strain the physical body. Stressful situations and continuing threats provoke "fight-or-flight" reactions. These reactions impose chronic stress upon the body if a person does not have enough opportunities for recovery in non-stressful environments. Research evidence convincingly shows that continuous stress weakens the resistance to diseases and disrupts the functioning of the hormonal and metabolic systems. Physiological tensions provoked by stress make people more vulnerable to many serious illnesses such as cardiovascular and immune system diseases, and adult-onset diabetes.

At the psychological level, stressful and poor living conditions can cause continuing feelings of shame, insecurity and worthlessness. In adverse living

conditions, everyday life often appears as unpredictable, uncontrollable, and meaningless. Uncertainty about the future raises anxiety and hopelessness that increases the level of exhaustion and makes everyday coping even more difficult. People who experience high levels of stress often attempt to relieve these pressures by adopting unhealthy coping behaviours, such as the excessive use of alcohol, smoking, and overeating carbohydrates. These behaviours are generally known to be unhealthy but they are effective in bringing momentary relief. Damaging behaviors can be seen as responses to adverse life circumstances even though they make the situation worse in the long run.

Stressful living conditions make it extremely hard to take up physical leisure activity or practice healthy eating habits because most of one's energy is directed towards coping with day-to-day life. Therefore, taking drugs – either prescribed or illegal – relieves only the symptoms of stress. Similarly, healthy living programs aimed at underprivileged citizens are not very efficient in terms of improving health and the quality of life. In many cases, individually-oriented physical activity and healthy eating program do not address the social determinants of health that are the underlying causes of many serious illnesses.

Policy Implications

- The focus must be on the source of problems rather than dealing with symptoms. Therefore, an effective way to reduce stress and improve health is by improving the living conditions people experience.

- Elected representatives and decision-makers must commit themselves to implementing policy that ensures good quality social determinants of health for every Canadian.

Key sources

Brunner, E. & Marmot, M. G. (2006). 'Social Organization, Stress, and Health'. In Marmot M. G. & Wilkinson, R. G. (Eds.) (2006). Social Determinants of Health (pp. 6-30). 2nd edition. Oxford, UK: Oxford University Press.

Raphael, D. (2009). 'Social Structure, Living Conditions, and Health'. In Raphael, D. (Ed.), Social Determinants of Health: Canadian Perspectives (pp. 20-36). 2nd edition. Toronto: Canadian Scholars' Press.

Figure 2.1 Social Determinants of Health and the Pathways to Health and Illness

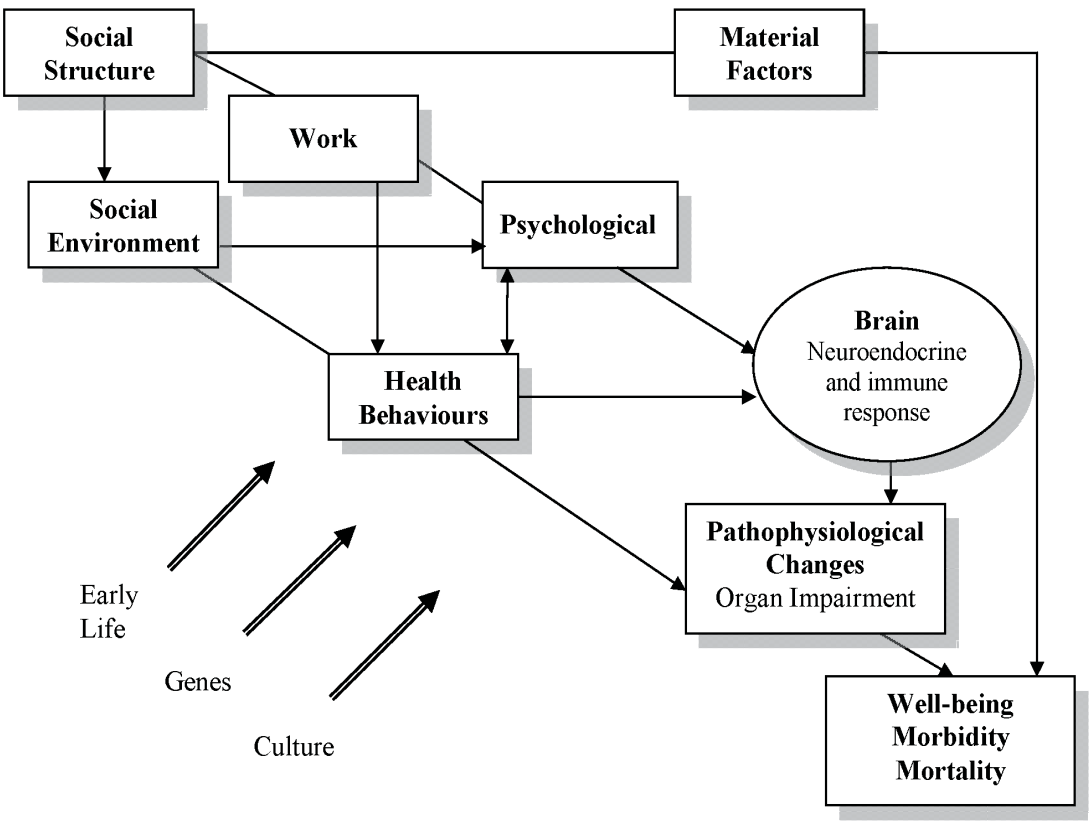


Figure shows how the organization of society influences the living and working conditions we experience that then go on to shape health. These processes operate through material, psychosocial, and behavioural pathways. At all stages of life, genetics, early life, and cultural factors are also strong influences upon health.

Source: Brunner, E., & Marmot, M. G. (2006). 'Social Organization, Stress, and Health.' In M. G. Marmot & R. G. Wilkinson (Eds.), Social Determinants of Health. Oxford: Oxford University Press, Figure 2.2, p. 9.

3. INCOME AND INCOME DISTRIBUTION

Health researchers have demonstrated a clear link between income and socio-economic status and health outcomes, such that longevity and state of health rise with position on the income scales.

– Andrew Jackson, 2009

Why Is It Important?

Income is perhaps the most important social determinant of health. Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use. In Canada, income determines the quality of other social determinants of health such as food security, housing, and other basic prerequisites of health.

The relationship between income and health can be studied at two different levels. First, we can observe how health is related to the actual income that an individual or family receives. Second, we can study how income is distributed across the population and how this distribution is related to the health of the population. More equal income distribution has proven to be one of the best predictors of better overall health of a society.

Income comes to be especially important in societies which provide fewer important services and benefits as a matter of right. In Canada, public education until grade 12, necessary medically procedures, and libraries are funded by general revenues, but childcare, housing, post-secondary education, recreational opportunities, and resources for retirement must be bought and paid for by individuals.

In contrast, in many wealthy developed nations these services are provided as citizen rights.

Low income predisposes people to material and social deprivation. The greater the deprivation, the less likely individuals and families are able to afford the basic prerequisites of health such as food, clothing, and housing. Deprivation also contributes to social exclusion by making it harder to participate in cultural, educational, and recreational activities. In the long run, social exclusion affects one's health and lessens the abilities to live a fulfilling day-to-day life.

Researchers have also found that men in the wealthiest 20% of neighbourhoods in Canada live on average more than four years longer than men in the poorest 20% of neighbourhoods. The comparative difference for women was found to be almost two years (Figure 3.1). This Canadian study also found out that those living in the most deprived neighbourhoods had death rates that were 28% higher than the least deprived neighbourhoods.

The suicide rates in the lowest income neighbourhoods were found to be almost twice those seen in the wealthiest neighbourhoods. Additionally, a host of studies show that adult-onset diabetes and heart attacks are far more common among low-income Canadians.

A recent report by the Organisation for Economic Co-operation and Development (OECD) identified Canada as being one of the two wealthy developed nations (among 30) showing the greatest increases in income inequality and poverty from the 1990s to the mid-2000s. Canada is now among the OECD nations with higher income inequality (Figure 3.2).

As a result of these trends, from 1985 to 2005, the bottom 60% of Canadian families experienced an actual decline in market incomes in constant dollars while the top 20% of Canadian families did very well.

Increasing income inequality has also led to a hollowing out of the middle class in Canada with significant increases from 1980-2005 in the percentages of Canadian families who are now poor or very rich. The percentage of Canadian families who earned middle-level incomes declined from 1980 to 2005 while the percentage of very wealthy Canadians increased as did those near the bottom of the income distribution.

The increases in wealth inequality in Canada are even more troubling. Wealth is probably a better indicator of long-term health outcomes as it is a better measure of financial security than income. From 1984 to 2005 the bottom 30% of Canadian families had no net worth and over this period they moved into even greater debt. In contrast, the net worth of the top 10% of Canadian families in 2005 was $1.2 million, an increase of $659,000 in constant dollars from 1984.

Policy Implications

- There is an emerging consensus that income inequality is a key health policy issue that needs to be addressed by governments and policymakers.
- Increasing the minimum wage and boosting assistance levels for those unable to work would provide immediate health benefits for the most disadvantaged Canadians.
- Reducing inequalities in income and wealth through progressive taxation is a highly recommended policy option shown to improve health.
- A greater degree of unionized workplaces would most likely reduce income and wealth inequalities in Canada. Unionization helps to set limits on the extent of profit-making that comes at the expense of employees' health and wellbeing.

Key sources

Auger, N., & Alix, C. (2009). 'Income, Income Distribution, and Health in Canada'. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (pp. 61-74). 2nd edition. Toronto: Canadian Scholars' Press.

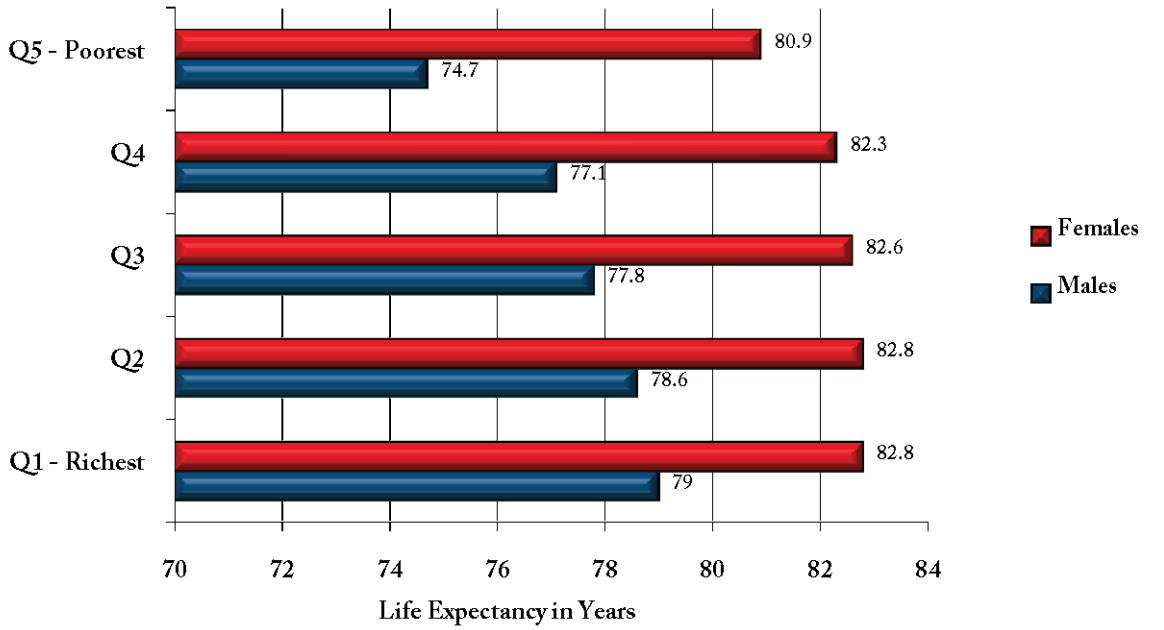
Curry-Stevens, A. (2009). 'When Economic Growth Doesn't Trickle Down: The Wage Dimensions of Income Polarization'. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (pp. 41-60). 2nd edition. Toronto: Canadian Scholars' Press.

Organisation for Economic Co-operation and Development. (2008). Growing Unequal: Income Distribution and Poverty in OECD Nations. Paris: Organisation for Economic Co-operation and Development.

Wilkins, R. (2007). Mortality by Neighbourhood Income in Urban Canada from 1971 to 2001. HAMG Seminar, 16 January 2007. Ottawa: Statistics Canada.

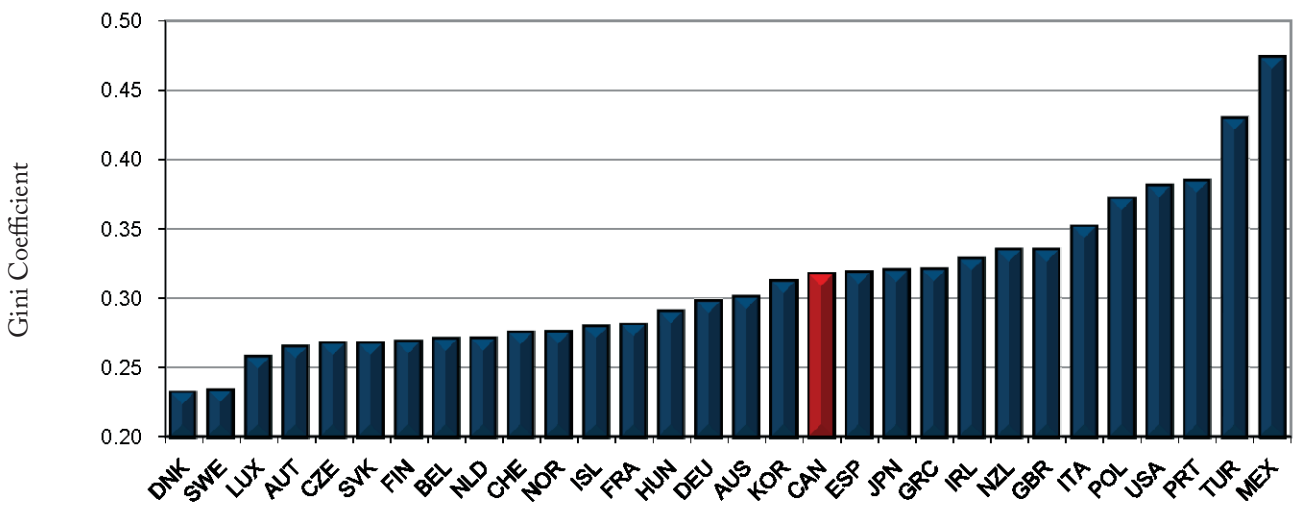
Wilkinson R. G. & Pickett K. (2009). The Spirit Level - Why More Equal Societies Almost Always Do Better. London, UK: Allen Lane.

Figure 3.1 Life Expectancy of Males and Females by Income Quintile of Neighbourhood



Source: Wilkins, R. (2007). Mortality by Neighbourhood Income in Urban Canada from 1971 to 2001. Ottawa: Statistics Canada, Health Analysis and Measurement Group.

Figure 3.2 Income Inequality in OECD Countries, mid-2000s



Note: Countries are ranked, from left to right, in increasing order in the Gini coefficient. The income concept used is that of disposable household income in cash, adjusted for household size.

Source: Organisation for Economic Co-operation and Development. (2008). Growing Unequal: Income Distribution and Poverty in OECD Nations. Paris: OECD.

4. EDUCATION

Canada as a whole performs well on national and international assessments, but disparities exist among populations and regions that do not seem to be diminishing with time.

– Charles Ungerleider, Tracey Burns, and Fernando Cartwright, 2009

Why Is It Important?

Education is an important social determinant of health. People with higher education tend to be healthier than those with lower educational attainment. There are various pathways by which education leads to better health. First, level of education is highly correlated with other social determinants of health such as the level of income, employment security, and working conditions. Viewed in this light, education helps people to move up the socioeconomic ladder and provides better access to other societal and economic resources.

Second, higher education makes it easier to enact larger changes in the Canadian employment market. Better educated citizens have more opportunities to benefit from new training opportunities if their employment situation suddenly changes. Furthermore, education facilitates citizens' possibilities for civic activities and engagement in the political process. In other words, people attain better understanding of the world and they become more able to see and influence societal factors that shape their own health.

Finally, education increases overall literacy and understanding of how one can promote one's own health through individual action. With higher education, people attain more sophisticated skills to evaluate how behaviors they adopt might be harmful or beneficial to their health. They achieve greater ability and more resources to allow attainment of healthier lifestyles.

On the other hand, it is important to remember that lack of education in itself is not the main factor causing poorer health. The manner by which education influences the population's health is shaped by public policies. For instance, if adequate income and necessary services such as childcare could be available to all, the health-threatening effects of having less education would be much less.

In international comparisons, the overall state of education in Canada is good (Figure 4.1). About 50 percent of the population has some post-secondary education. However, the troubling aspect in Canada is that children whose parents do not have post-secondary education perform notably worse than children of more educated parents. It has been suggested that the link between children's educational performance with their parents education levels would be reduced if there was affordable and high quality early learning programs in Canada. The lack of these programs has a major influence on many children's intellectual and emotional development.

High tuition fees influence whether children of low-income families can attain college or university education. In Scandinavian countries that provide free post-secondary education, the link between family background and educational attainment is weaker than is the case in Canada. For example, Swedish children whose parents did not complete secondary school usually outperform children on language and mathematical skills from other nations – including Canada – whose parents did complete secondary school.

Policy Implications

- Elected representatives must commit themselves to adequately funding the Canadian education system so that schools are able to provide well-developed curricula for students.

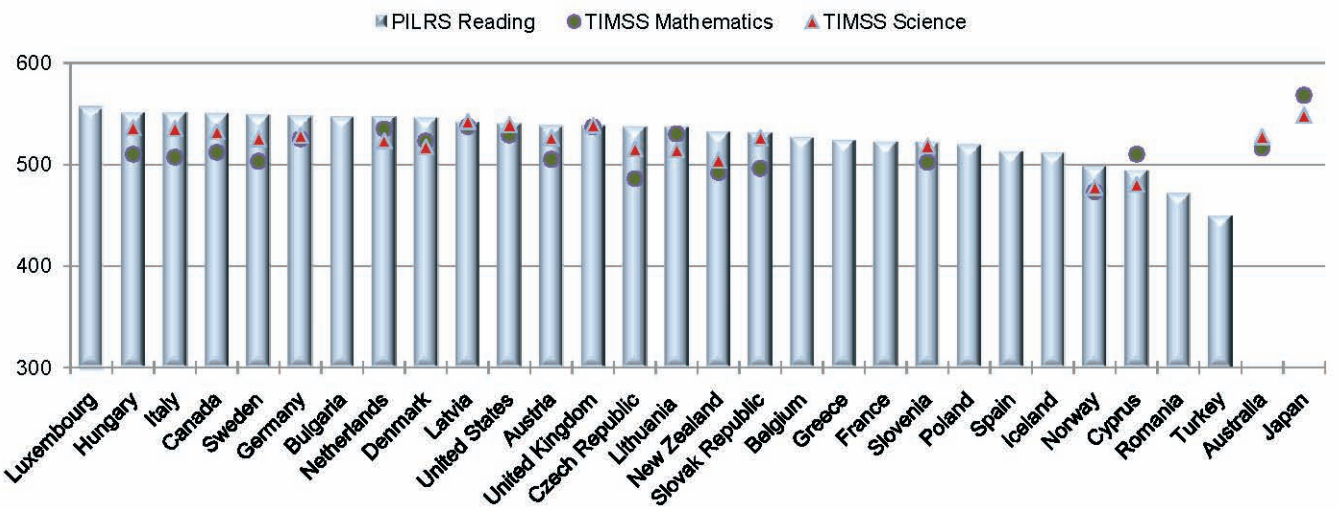
- Tuition fees for university and college education must be better controlled by Canadian governments so that fees do not exclude children of low-income families from higher education.

Key sources

Ronson, B., & Rootman, I. (2009). 'Literacy and Health Literacy: New Understandings about their Impact on Health'. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (pp. 170-186). 2nd edition. Toronto: Canadian Scholars' Press.

Ungerleider, C., Burns, T., & Cartwright, F. (2009). 'The State and Quality of Canadian Public Elementary and Secondary Education'. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (pp. 156-169). 2nd edition. Toronto: Canadian Scholars' Press.

Figure 4.1 Canadian Test Scores in Comparative Perspective



Source: Progress in International Reading Literacy Study (PIRLS, 2006) and Trends in International Mathematics and Science Study (TIMSS, 2007).

5. UNEMPLOYMENT AND JOB SECURITY

Workers are not only more uncertain about the likelihood that they will be retained in their current job, they are also uncertain about whether they will be able to find another job that meets their needs.

– Emile Tompa, Michael Polanyi, and Janice Foley, 2009

Why Is It Important?

Employment provides income, a sense of identity and helps to structure day-to-day life. Unemployment frequently leads to material and social deprivation, psychological stress, and the adoption of health-threatening coping behaviours. Lack of employment is associated with physical and mental health problems that include depression, anxiety and increased suicide rates.

Job insecurity has been increasing in Canada during the past decades (Figure 5.1). Currently, only half of working aged Canadians have had a single full-time job for over six months or more. Precarious forms of work include arrangements such as working part-time (18%), being self-employed (14%), or having temporary work (10%). The OECD calculates an employment protection index of rules and regulations that protects employment and provides benefits to temporary workers. Canada performs very poorly on this index achieving a score that was ranked 26th of 28 nations (Figure 5.2).

The number of people having part-time work expanded during the past two decades. Researchers suggest that the trend is associated with more intense work life, decreased job security and income polarization between the rich and the poor.

Six percent of Canadians have had their current job fewer than six months and five percent have more than one job.

Unemployment is related to poor health through various pathways. First, unemployment often leads to material deprivation and poverty by reducing income and removing benefits that were previously provided by one's employer. Second, losing a job is a stressful event that lowers one's self-esteem, disrupts daily routines, and increases anxiety. Third, unemployment increases the likelihood of turning to unhealthy coping behaviours such as tobacco use and problem drinking.

Often, insecure employment consists of intense work with non-standard working hours. Intense working conditions are associated with higher rates of stress, bodily pains, and a high risk of injury. Excessive hours of work increase chances of physiological and psychological problems such as sleep deprivation, high blood pressure, and heart disease. Consequently, job insecurity has negative effects on personal relationships, parenting effectiveness, and children's behavior.

Women are over-represented in precarious forms of work. While women constitute just over 40%

of full-time workers, they represent 75% of part-time permanent workers and 62% of part-time temporary workers. In 1975, 13.6% of women were working part-time and that figure has increased to 27.3% in 2000. In contrast, in 1975 only 3.6% of men were part-time workers and that figure increased to 10.3% by 2000.

Policy Implications

- National and international institutions need to be legally mandated to make agreements that provide the basic standards of employment and work for everyone.

- Power inequalities between employers and employees need to be reduced through stronger legislation governing equal opportunity in hiring, pay, training, and career advancement.

- Unemployed Canadians must be provided access to adequate income, training, and employment opportunities through enhanced government support.

- Workers, employers, government officials, and researchers need to develop a new vision of what constitutes healthy and productive work.

- More policy-relevant research must be pursued to support government's decision-making and to have an accurate and up-to-date picture of job security in Canada.

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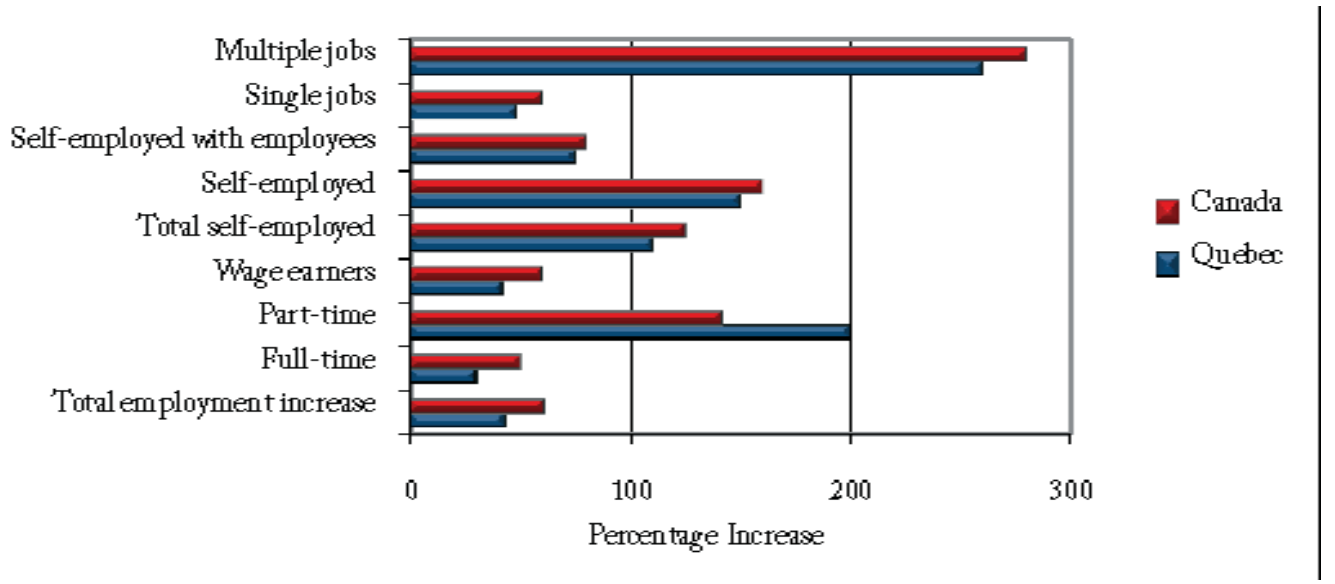
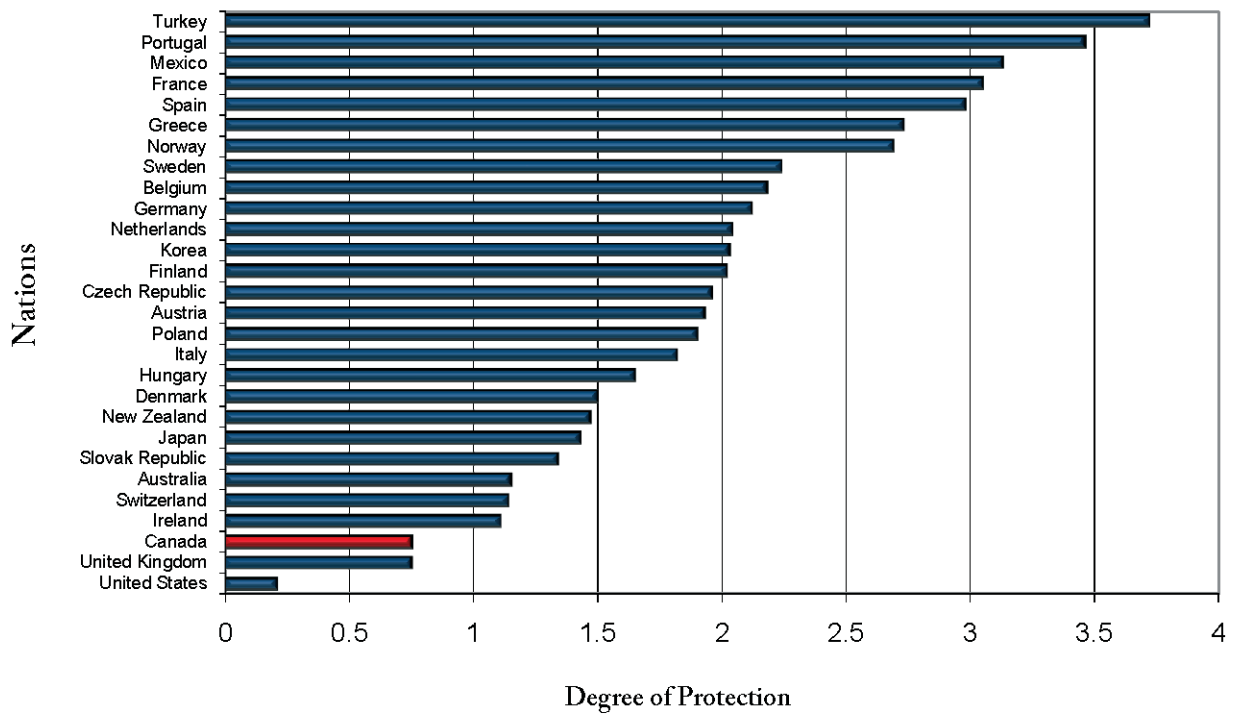
Figure 5.1 Increase in Various Forms of Employment for 15-64 Year Olds, Quebec and Canada, 1976-2003



Source: Tremblay, D. G. (2009). 'Precarious Work and the Labour Market.' In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (2nd ed., pp. 75-87). Toronto: Canadian Scholars' Press, Figure 5.1.

Figure 5.2 Employment Protection, OECD Nations, 2007



Source: Source: OECD (2010). Strictness of Employment Protection. Online at: http://stats.oecd.org/Index.aspx

6. EMPLOYMENT AND WORKING CONDITIONS

The relationship between working conditions and health outcomes is an important public health concern.

– Peter Smith and Michael Polanyi, 2009

Why Is It Important?

Working conditions are an important social determinant of health because of the great amount of time we spend in our workplaces. People who are already most vulnerable to poor health outcomes due to their lower income and education are also the ones most likely to experience adverse working conditions.

Researchers have identified a host of work dimensions which shape health outcomes. The dimensions include factors such as: 1) employment security; 2) physical conditions at work; 3) work pace and stress; 4) working hours; 5) opportunities for self-expression and individual development at work. High-stress jobs predispose individuals to high blood pressure, cardiovascular diseases, and development of physical and psychological difficulties such as depression and anxiety.

Research evidence has also shown that imbalances between demands (e.g., time pressures, responsibility) and rewards (e.g., salary, respect from supervisors) often lead to significant health problems. When workers perceive that their efforts are not being adequately rewarded, they are more likely to develop a range of physical and mental afflictions (Figure 6.1).

Similarly, increased health problems are seen among workers who experience high demands but have little control over how to meet these demands. These high-strain jobs are much more common

among low-income women working in the sales and service sector. Canadian women scored higher than men in reporting high stress levels from "too many hours or too many demands."

Statistics Canada also found that in 2000, over one third of Canadian workers (35%) reported experiencing work-related stress from "too many demands or too many hours." This figure is up from the figure of 27.5% reported in 1991. Another survey with a somewhat different question found in 2005 that one in three workers (32.4%) reported that most days at work were stressful. Women scored higher (37%) than men (32%) on an item assessing high stress levels from "too many hours or too many demands."

With respect to job control, 1994 data found that just 4 in 10 Canadian workers said they had a lot of freedom over how to work," which is much lower than the 54% figure seen in 1989. Men have more control (43%) than women (38%) and professionals and managers report (51%) more control than skilled workers (35%) and unskilled workers (35%). One authority concludes: "To summarize, while we lack detailed information on changes in the overall incidence of work involving high demands and low worker control, high-stress work is common and likely on the increase."

In Canada, workplace injuries are most likely under-reported as there are significant costs to both employers and employees in reporting these accidents. About 30 percent of Canadian workers feel that their employment puts their health and safety at risk. In Canada, about 33% of men and 12% of women work more than 40 hours per week. On the contrary, full-time workers in the European Union generally work less than 40 hours per week and some countries such as France, the Netherlands, and Germany are now close to a 35-hour per week norm. Holidays and vacation time are much greater in European nations than in Canada (Figure 6.2).

Collective bargaining helps to equalize the balance between employers and employees. Union members working under a collective agreement have a greater likelihood of receiving higher wages, benefits, and more opportunities to influence their working conditions. The union advantage is especially great for blue-collar and lower wage private services. For instance, Canadian women in unionized workplaces earn wages 36% higher than women in non-unionized workplaces.

Policy Implications

- Government policies must support Canadians' working life so that demands upon workers and their rewards are balanced.

- Special focus should be on improving conditions of employees in high-strain low-income jobs.

- Collective and organized action through unionization of workplaces is an important means of balancing power between employers and employees.

- Working conditions can be made better when employees are provided with opportunities to influence their work environment.

- More quantitative and qualitative research on working conditions in Canada is urgently needed.

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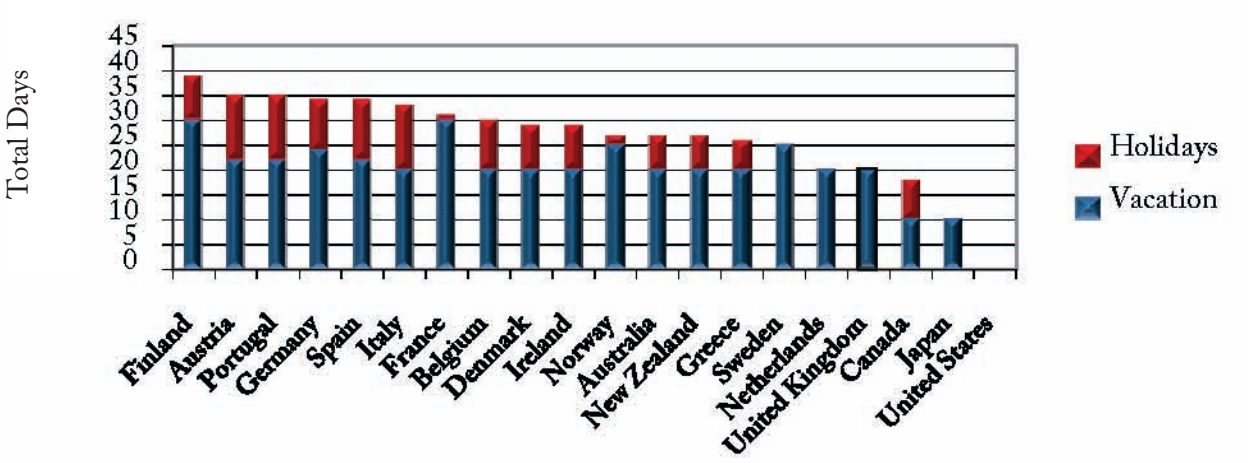
Figure 6.1 Employment Strain and Health

Components	Control / Demand / Effort	Measures
1. Employment relationship uncertainty	Control over access to work, where work is performed, the work schedule, setting terms and conditions of work	Employment uncertainty Earnings uncertainty Scheduling uncertainty
2. Employment relationship workload	Effort required to find work, balance demands associated with multiple work places and employers, keep work	Effort getting work Effort associated with multiple jobs Effort keeping work
3. Employment relationship support	Availability of help with a job, assistance if worker is stressed, presence of union and level of support provided by it	Report of support from co-workers (e.g., personal interest, are friendly, helpful, and competent) Support from supervisors (concerned about workers, pay attention, helpful, successful)
4. Household Insecurity	Adequacy of household earnings and benefits	Individual and household earnings Household benefit coverage Presence of children under 18

Source: Lewchuk, W., de Wolff, A., King, A., and Polanyi, M. (2006). 'The Hidden Costs of Precarious Employment: Health and the Employment Relationship.' in Vosko, L.F. (ed.), Precarious Employment: Understanding Labour Market Insecurity in Canada (pp. 141-162). Montreal: McGill-Queen's University Press.

Figure 6.2 Mandated Holidays and Vacation Time, OECD Nations, 2006

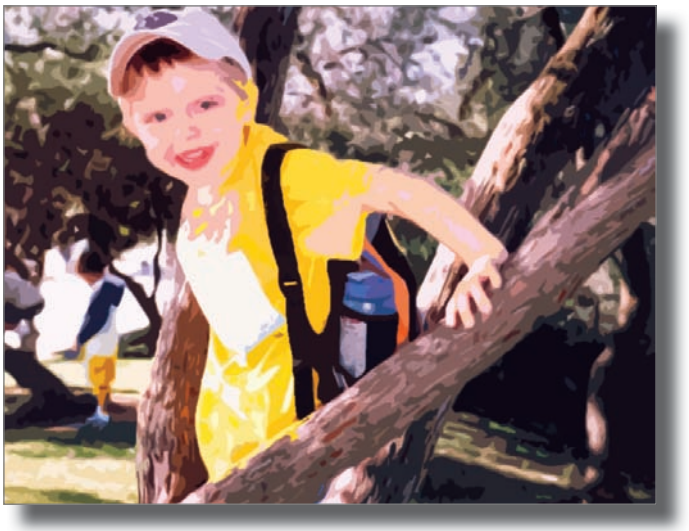


Source: Ray, R. and Schmitt, J. (2007). No-Vacation Nation. Washington DC: Center for Economic and Policy Research.

7. EARLY CHILDHOOD DEVELOPMENT

There is strong evidence that early childhood experiences influence coping skills, resistance to health problems and overall health and well-being for the rest of one's life.

– Federal/Provincial/Territorial Advisory Committee on Population Health, 1996



Why Is It Important?

Early childhood experiences have strong immediate and longer lasting biological, psychological and social effects upon health.

"Latency effects" refer to how early childhood experiences predispose children to either good or poor health regardless of later life circumstances. For example, low birthweight babies living in disadvantaged conditions are generally more susceptible to health problems than babies of advantaged populations. These latency effects result from biological processes during pregnancy associated with poor maternal diet, parental risk behaviours, and experience of stress. Health effects may also result from early psychological experiences that create a sense of control or self-efficacy.

"Pathway effects" refer to a situation when children's exposures to risk factors at one point do not have immediate health effects but later lead to situations that do have health consequences. For instance, it is not an immediate health issue if young children lack readiness to learn as they enter school. But limited learning abilities can lead to experiences that are harmful to one's health in later life such as lower educational attainment. One way to weaken the relationship between parents' socioeconomic status and children's developmental outcomes is the provision of high quality early child education regardless of parents' wealth.

"Cumulative effects" suggest that the longer children live under conditions of material and social deprivation, the more likely they are to show adverse health and developmental outcomes. Accumulated disadvantage can lead to cognitive and emotional deficits such as incompetence and emotional immaturity. In addition, adverse childhood experiences can create a sense of inefficacy – or learned helplessness – which is a strong determinant of poor health.

The state of early child development in Canada is, however, cause for concern. The most obvious indicator of the situation is whether children are living under conditions of material and social deprivation. In Canada the best measure of this is the percentage of children living in "straitened living circumstances" or below Statistic Canada's low income cut-offs (LICOs). LICOs identify Canadians spending significantly more resources on necessities of housing, clothing, and food than the average.

The child poverty figure of 15% provided by Statistics Canada's pre-tax LICO is identical to those

provided by international organizations such as the OECD and the Innocenti Research Centre of the United Nations International Children Emergency Fund. These organizations define child poverty as living in families which have access to less than 50% of the median family income of that nation. In these comparisons, 15% of Canadian children are living in poverty which gives Canada a rank of 20th of 30 wealthy developed nations (Figure 7.1).

In regards to access to regulated childcare – an important contributor to child well-being – only 17% of Canadian families have access to regulated child care. Even in Quebec where an extensive effort is underway to provide regulated high quality childcare, only 25 percent of families have access to it. The Organisation for Economic Co-operation and Development (OECD) published a report that rates Canada as last among 25 wealthy developed nations in meeting various early childhood development objectives. Canada is also one of the lowest spenders on early childhood education (Figure 7.2). A comprehensive OECD report ranked Canada 12th of 21 nations in children's health and well-being using a wide range of health indicators.

The quality of early childhood development is shaped by the economic and social resources available to parents. Government can provide a range of supports and benefits to children through family-friendly public policies. Researchers have even stated that establishing a comprehensive early childhood education program in Canada would be the single best means of improving Canadian health outcomes.

Policy Implications

- Governments must guarantee that affordable and quality child care is available for all families regardless of wealth or income level.

- Providing support and benefits to families through public policies forms a base for healthy childhood development. Providing higher wages and social assistance benefits would reduce child poverty and be one of the best means to improve early childhood development.

- All Canadians would benefit from improved early childhood development in terms of improved community quality of life, reduced social problems, and improved Canadian economic performance.

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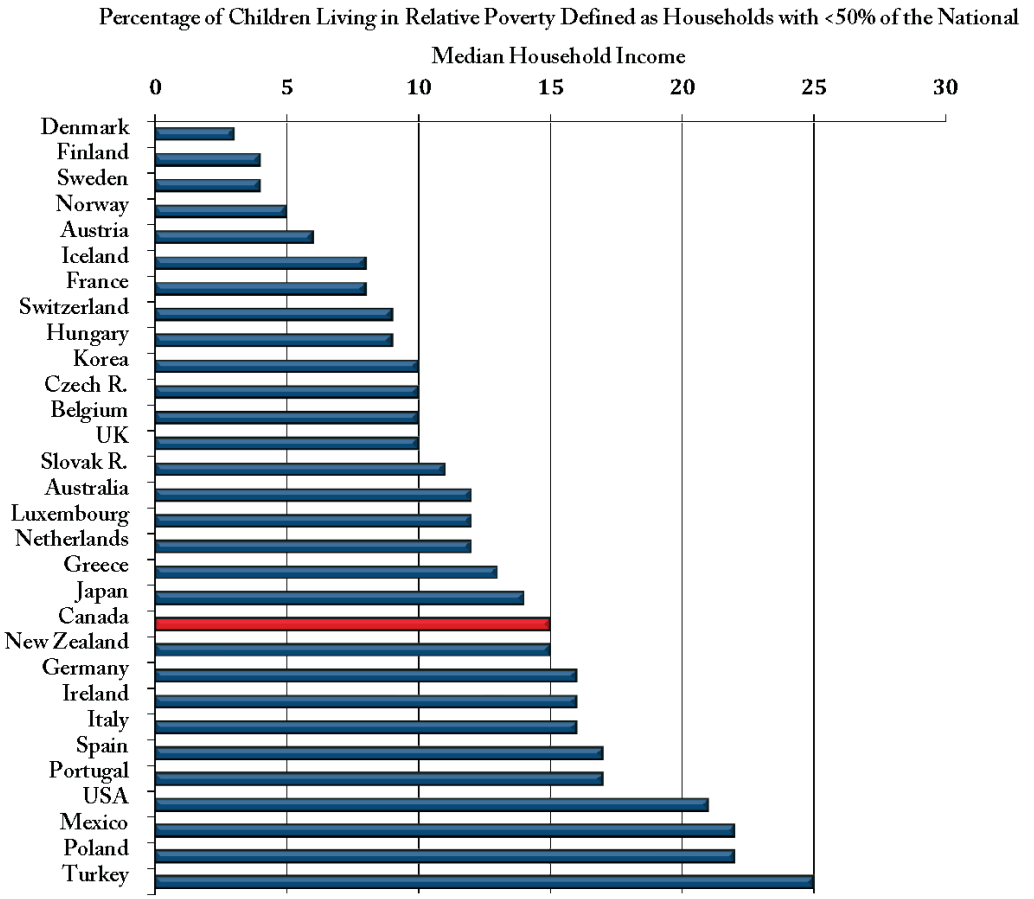
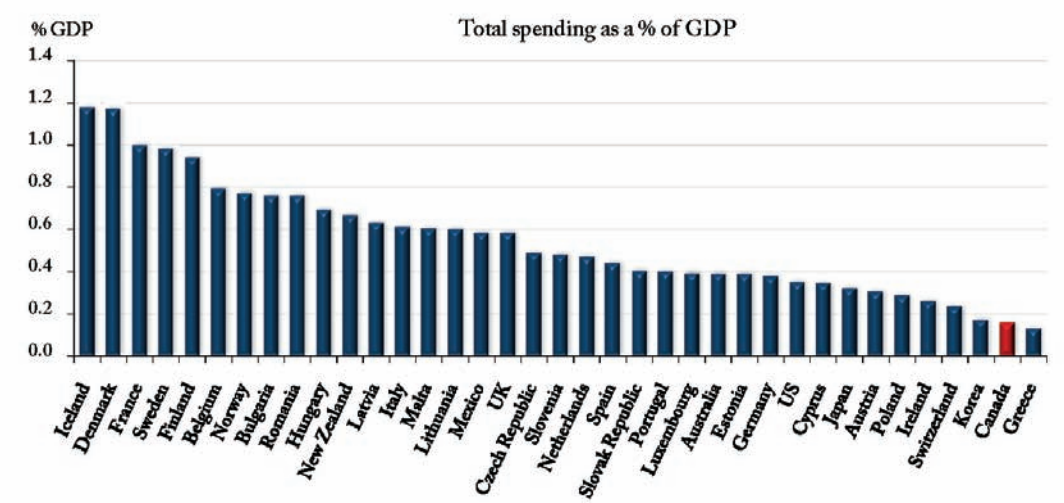
Figure 7.1 Child Poverty in Wealthy Nations, Mid-2000s



Source: Adapted from Organisation for Economic Co-operation and Development (2008). Growing Unequal: Income Distribution and Poverty in OECD Nations, Table 5.2, p. 138. Paris: Organisation for Economic Co-operation and Development.

Figure 7.2 Public Expenditure on Childcare and Early Education Services (% of GPD), 2005.



Source: Social Expenditure Database 1980-2005; OECD Education Database; Eurostat.

8. FOOD INSECURITY

A very brief social history of food insecurity in Canada would read simply: Poverty increased, then it deepened. Food insecurity emerged, then it increased in severity.

– Lynn McIntyre and Krista Rondeau, 2009

Why Is It Important?

Food is one of the basic human needs and it is an important determinant of health and human dignity. People who experience food insecurity are unable to have an adequate diet in terms of its quality or quantity. Food insecure citizens are uncertain if they are able to acquire food in socially acceptable ways. Food insecurity is a barrier to adequate nutritional intake. People experiencing food insecurity consume fewer servings of fruits and vegetables, milk products, and vitamins than those in food-secure households.

It is estimated that about 9 percent or 1.1. million Canadian households – representing 2.7 million Canadians – experience food insecurity. Among families with children, 5.2% reported child-level food insecurity. The risk of food insecurity is especially great in lone-parent families and families receiving social assistance.

The Canadian Community Health Survey found that food insecurity is more common in households that contain children (10.4%) than in those without children (8.6%). It also found that food insecurity is especially common in households led by lone mothers (25%). Aboriginal households – with and without children – are more likely to be food insecure than non-Aboriginal households.

A study identified many events that move a Canadian family into experiencing hunger. Hunger was found to result from a family acquiring another mouth to feed either through birth or family melding; a change in the number of parents in the home; loss of a job; change in employment hours; or the health of an adult or a child declining. Getting out of hunger only happened under one condition: the mother began a full-time job, with the family's income rising.

Dietary deficiencies – more common among food insecure households – are associated with increased likelihood of chronic disease and difficulties in managing these diseases. Heart disease, diabetes, high blood pressure, and food allergies are more common in food insecure households even when factors such as age, sex, income, and education are taken in account. Additionally, food insecurity produces stress and feelings of uncertainty that have health-threatening effects.

Malnutrition during childhood has long-term effects on a child's physiological and psychological development. Often mothers try to protect their children from the nutritional effects of food insecurity by cutting back their own food intake to allow their children to have an adequate diet.

However, parents are often unable to protect their children from the negative psychological impacts of household food insecurity.

In addition, household food insecurity is also an excellent predictor of Canadians reporting poor or fair health as compared to good, very good, or excellent health, experiencing poor functional health (e.g., pain, hearing and vision problems, restricted mobility, etc.), multiple chronic conditions, and major depression or distress (Figure 8.1).

More specifically, these food insufficient households were 80% more likely to report having diabetes, 60% more likely to report high blood pressure, and 70% more likely to report food allergies than households with sufficient food. Finally, increasing numbers of studies indicate that children in food insecure households are more likely to experience a whole range of behavioural, emotional, and academic problems than children living in food secure households.

Food banks provide last resort support to food insecure households and exist as a consequence of failed public policies. In March of 2009, almost 800,000 Canadians made use of food banks (Figure 8.2.). Almost always, food insecurity is caused by lack of economic resources. Therefore, public policies that reduce poverty are the best means of reducing food insecurity.

Policy Implications

- Governments must reduce food insecurity by increasing minimum wages and social assistance rates to the level where an adequate diet is affordable.

- Governments must assure that healthy foods are affordable (e.g., milk, fruits, and foods high in fiber).

- Providing affordable housing and childcare would reduce other family expenses and leave more money for acquiring an adequate diet.

- Facilitating mothers' employment through job supports, making available affordable childcare, and providing employment training would serve to reduce food insecurity among the most vulnerable Canadian families.

- Better monitoring systems must be designed and implemented to produce up-to-date accounts of food insecurity in Canada.

Key sources

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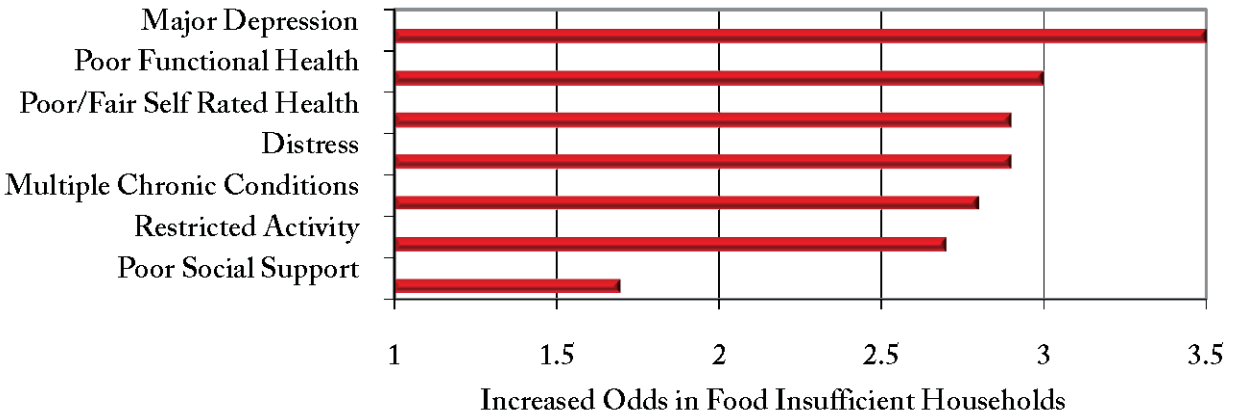
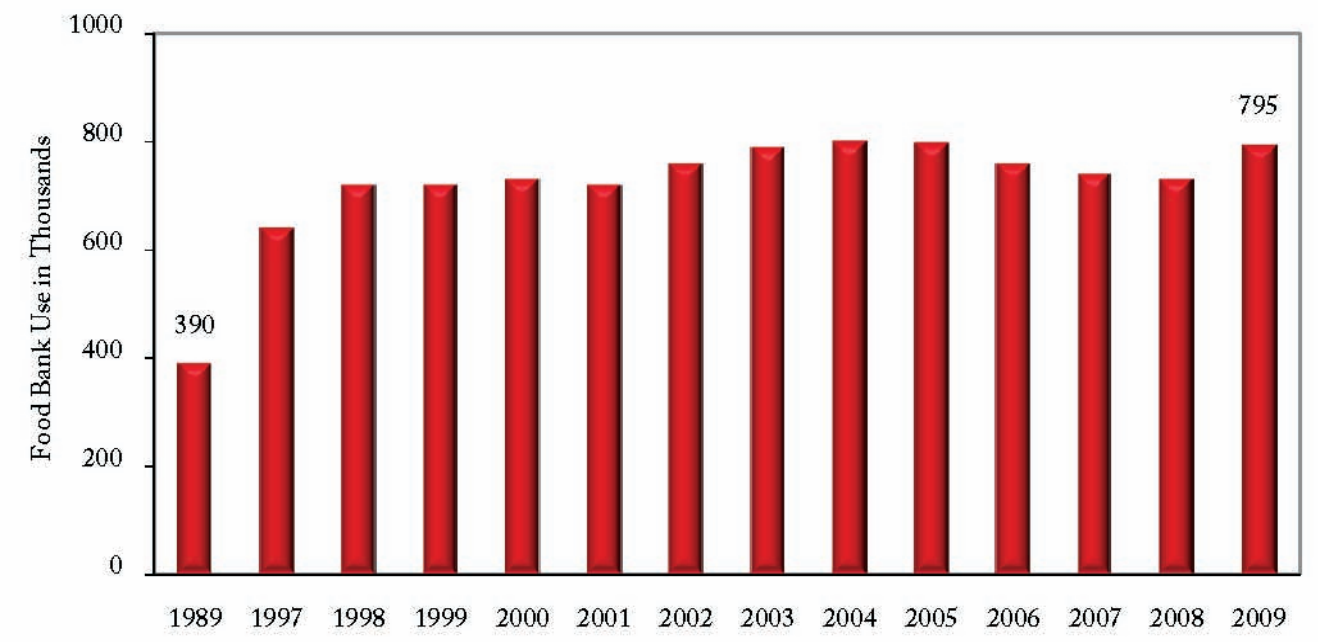
Figure 8.1 Odds of Individuals in Food Insufficient Households Reporting Poor General, Physical, Mental or Social Health and Multiple Chronic Conditions (1996-1997)



Source: Vozoris, N., & Tarasuk, V. (2003). Household Food Insufficiency is Associated with Poorer Health. Journal of Nutrition, 133, 120-127.

Figure 8.2 Number of People Assisted by Food Banks in Canada, 1989-2009 (March of each Year, in Thousands)



Source: Food Banks Canada. (2009). Hungercount 2009. Toronto: Food Banks Canada.

9. HOUSING

It would hardly seem necessary to argue the case that housing—and homelessness in particular—are health issues, yet surprisingly few Canadian studies have considered it as such.

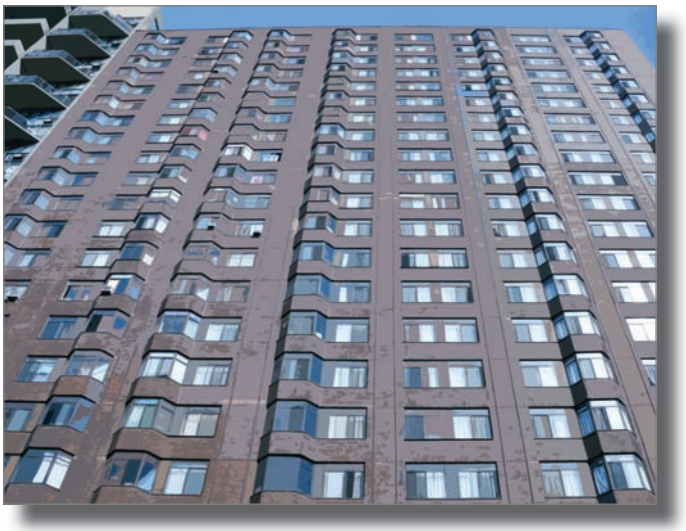
– Toba Bryant, 2009

Why Is It Important?

Many studies show that poor quality housing and homelessness are clear threats to the health of Canadians. Housing is an absolute necessity for living a healthy life and living in unsafe, unaffordable or insecure housing increases the risk of many health problems. Lack of economic resources is the prime reason many Canadians experience housing problems.

Housing is a public policy issue because governments have a responsibility to provide citizens with the prerequisites of health. Canada is signatory to numerous international human rights agreements that guarantee the provision of shelter. Canada is routinely identified by international authorities as not fulfilling these commitments (Box 9.1).

Housing influences health in many ways. People experience qualitatively different material environments depending on their housing quality. Overcrowding allows for transmission of respiratory and other illnesses. Some Canadian homes, especially on Aboriginal reserves, lack even clean water and basic sanitation – a fundamental public health risk. Housing provides a platform for self-expression and identity. High housing costs reduce the resources available to support other social determinants of health. Living in poor housing creates stress and unhealthy means of coping such as substance abuse.



The presence of lead and mold, poor heating and draft, inadequate ventilation, vermin, and overcrowding are all determinants of adverse health outcomes. Children who live in low quality housing conditions have a greater likelihood of poor health outcomes in both childhood and as adults. Dampness, for example, causes respiratory illness and makes pre-existing health conditions worse. It is not easy to separate the effects of housing from other factors since poverty, poor housing and pre-existing illnesses often go together, but studies that have separated them show poor housing conditions to be independent causes of adverse health outcomes.

Canada is experiencing a housing crisis. Over the past 20 years, rents have risen well beyond the cost of living and this is especially so in cities. In addition, the proportion of tenants spending more than 30% of total income on rent – the definition of unaffordable housing used by the Canadian government – has risen (Figure 9.2) and is very high in Canadian cities (43% in Vancouver, 42% in Toronto, and 36% in Montreal). The proportion spending more than 50% — putting them at risk of imminent homelessness is also very high (22% in Vancouver, 20% in Toronto, and 18% in Montreal).

Most low-income Canadians are among the one-third of Canadians who are renters and rents are increasing faster than renter household incomes. Canada's social housing sector remains stagnant at about 5% of the overall housing stock and little new non-profit or co-operative housing have been created since the national program to fund new affordable homes was cancelled in the 1990s.

A homelessness emergency exists in many Canadian cities. Homeless people experience a much greater rate of a wide range of physical and mental health problems than the general population. Likelihood of early death among homeless people is 8-10 times greater than the general population.

Contributing factors to the crisis are lack of affordable rental accommodation and growth of part-time and precarious employment that are both low paying and insecure. Canada has one of the highest levels of low-paying jobs at 23 percent and among the highest family poverty rates among Western nations. The result is increasing numbers of families and individuals with insecure housing. Growing numbers of Canadians are under-housed, living in motels, dependent on the shelter system, or living on the street.

Housing insecurity is linked to income insecurity which is, in turn, leads to illness and premature death. "Three Cities" research by Dr. David Hulchanski and colleagues at the University of Toronto finds that housing and income insecurity, racial identity, and health status are linked in Canada's largest city. They are probably similarly linked in other major urban areas.

Policy Implications

- Housing policy needs to be more explicitly linked to comprehensive income (including a jobs strategy), public health, and health services policy.

- Housing policy must make affordable and quality housing available for all Canadians. Provinces should provide their matching share for housing provision as defined in the Affordable Housing Framework Agreement of 2001.

- The federal government must increase funding for social housing programs targeted for low-income Canadians. Housing policies should support mixed housing as an antidote for urban segregation.

- Public support and advocacy is needed to create the political will to establish housing initiatives. An initiative called the 1% Solution proposes that Canadian governments can solve the housing crisis by increasing their budgetary allocation for housing by 1% of overall spending (http://tdrc.net/1-solution.html).

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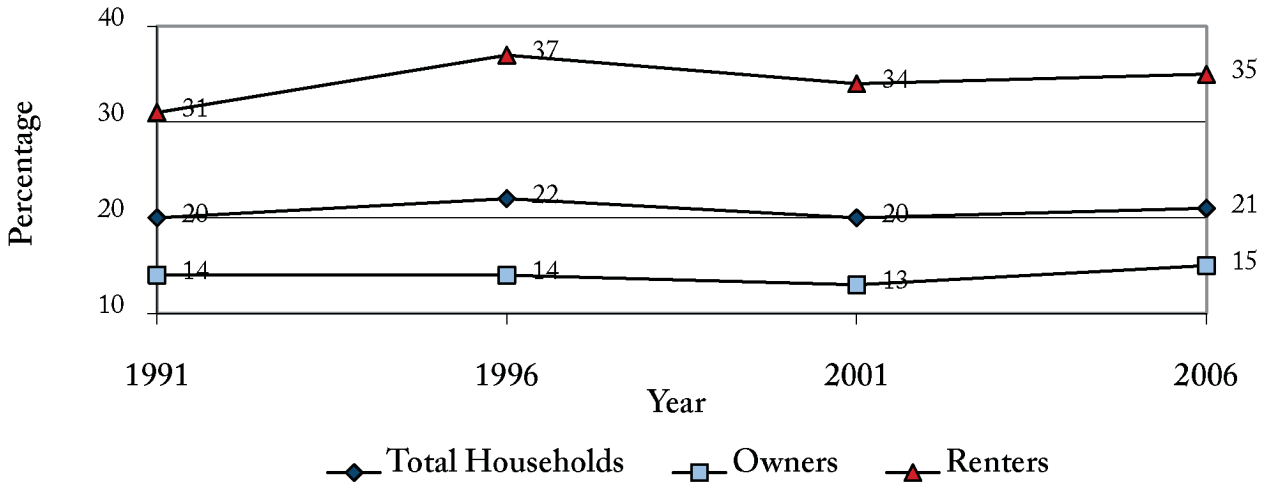
Box 9.1 International Attention to Canada's Housing Crisis

Everywhere that I visited in Canada, I met people who are homeless and living in inadequate and insecure housing conditions. On this mission I heard of hundreds of people who have died, as a direct result of Canada's nation-wide housing crisis. In its most recent periodic review of Canada's compliance with the International Covenant on Economic, Social and Cultural Rights, the United Nations used strong language to label housing and homelessness and inadequate housing as a "national emergency." Everything that I witnessed on this mission confirms the deep and devastating impact of this national crisis on the lives of women, youth, children and men.

Source: Miloon Kothari (2007). Preliminary Observations of Mission to Canada. United Nations: Special Rapporteur on the Right to Adequate Housing.

Figure 9.1 Percentage of Canadian Households Spending More than 30% of Income on Shelter Costs, 1991-2006



Source: Canada Mortgage and Housing Corporation (CMHC) (2009). Housing in Canada Online. Available online at http://data.beyond2020.com/CMHC/. Ottawa: CMHC.

10. SOCIAL EXCLUSION

Social exclusion is an expression of unequal relations of power among groups in society, which then determine unequal access to economic, social, political, and cultural resources.

– Grace-Edward Galabuzi, 2009

Why Is It Important?

Social exclusion refers to specific groups being denied the opportunity to participate in Canadian life. In Canada, Aboriginal Canadians, Canadians of colour, recent immigrants, women, and people with disabilities are especially likely to experience social exclusion. Many aspects of Canadian society marginalize people and limit their access to social, cultural and economic resources. Socially excluded Canadians are more likely to be unemployed and earn lower wages. They have less access to health and social services, and means of furthering their education. These groups are increasingly being segregated into specific neighborhoods. Excluded groups have little influence upon decisions made by governments and other institutions. They lack power.

There are four aspects to social exclusion. *Denial of participation in civil affairs* is a result of legal sanction and other institutional mechanisms. Laws and regulations prevent non-status residents or immigrants from participation. Systemic forms of discrimination based on race, gender, ethnicity or disability status, excludes people. New Canadians are frequently unable to practice their professions due to a myriad of regulations and procedures that bar their participation. *Denial of social goods* such as health care, education, housing, income security, and language services is common. Socially excluded groups earn lower incomes than Canadians.

They lack affordable housing and experience less access to services.

Exclusion from social production is a lack of opportunity to participate and contribute to social and cultural activities. Much of this results from the lack of financial resources that facilitate involvement. *Economic exclusion* is when individuals cannot access economic resources and opportunities such as participation in paid work. All of these forms of exclusion are common to Aboriginal Canadians, Canadians of colour, recent immigrants, women, and people with disabilities.

The social exclusion of recent immigrants to Canada is well documented. Their unemployment rates are higher (6.7% for Canadian-born workers, 7.9% for all immigrants, and 12.1% for recent immigrants) and their labour force participation is lower (80.3% for Canadian-born workers, 75.6% for all immigrants, and 65.8% for recent immigrants). The specific situations of Canadians of Aboriginal status, Canadians of colour, persons with disabilities, and women are considered in later sections of this document.

Social exclusion creates the living conditions and personal experiences that endanger health. Social

exclusion also creates a myriad of educational and social problems. Social exclusion creates a sense of powerlessness, hopelessness and depression that further diminish the possibilities of inclusion in society.

The presence of social exclusion and its impact upon health is dramatically illustrated in Box 10.1. Maps of neighbourhoods in the City of Toronto are provided that detail the varying concentrations of poverty, diabetes, and visible minorities in these neighbourhoods. The correspondence among poverty rates, prevalence of diabetes, and concentration of visible minorities is striking.

These findings are consistent with studies that find that marginalization and exclusion of individuals and communities from mainstream society constitute a primary factor leading to adult-onset diabetes and a range of other chronic diseases such as respiratory and cardiovascular disease. Social exclusion is also related to a range of social problems that include educational underachievement and crime.

It appears that the restructuring of Canada's economy and labour market toward flexible labour markets has served to accelerate these processes of social exclusion. The quality of jobs is increasingly being stratified along racial lines, with a disproportionate proportion of low-income sector employment being taken by Canadians of colour and recent immigrants. And these Canadians of colour and recent immigrants are less represented in high-income sectors and occupations. Social exclusion is increasing therefore as a result of both the increasing precariousness of employment and the fact that these precarious jobs are increasingly being filled by Canadians of colour and recent immigrants.

Policy Implications

- Governments at all levels must revise laws and regulations and develop programs that will allow new Canadians to practice their professions in Canada.

- Governments must enforce laws that protect the rights of minority groups, particularly concerning employment rights and anti-discrimination.

- Attention must be directed to the health needs of immigrants and to the unfavourable socio-economic position of many groups, including the particular difficulties many new Canadians face in accessing health and other care services.

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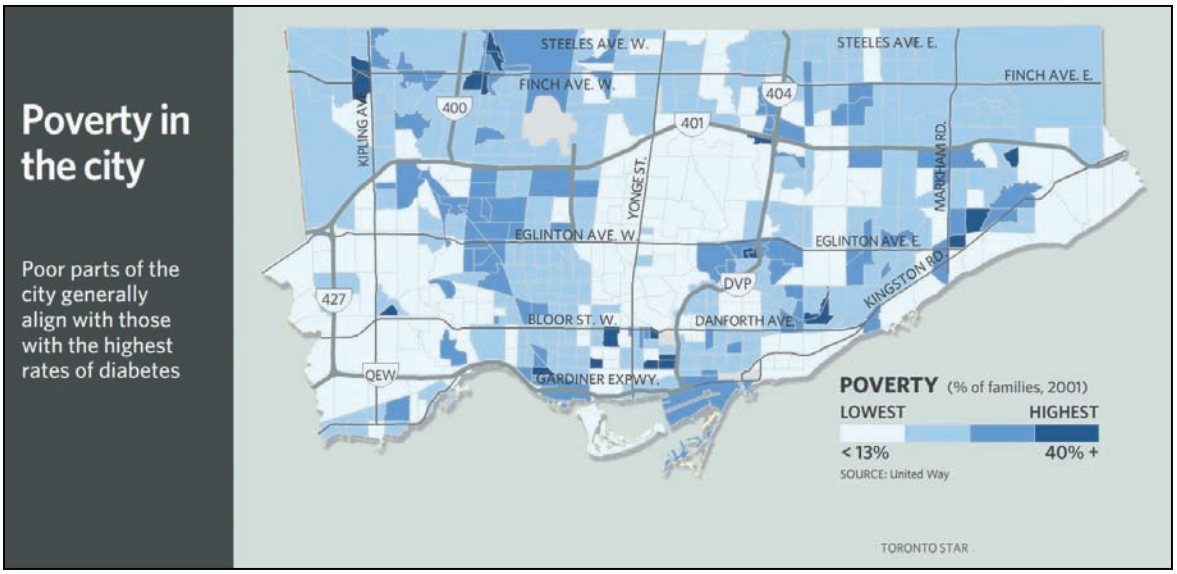
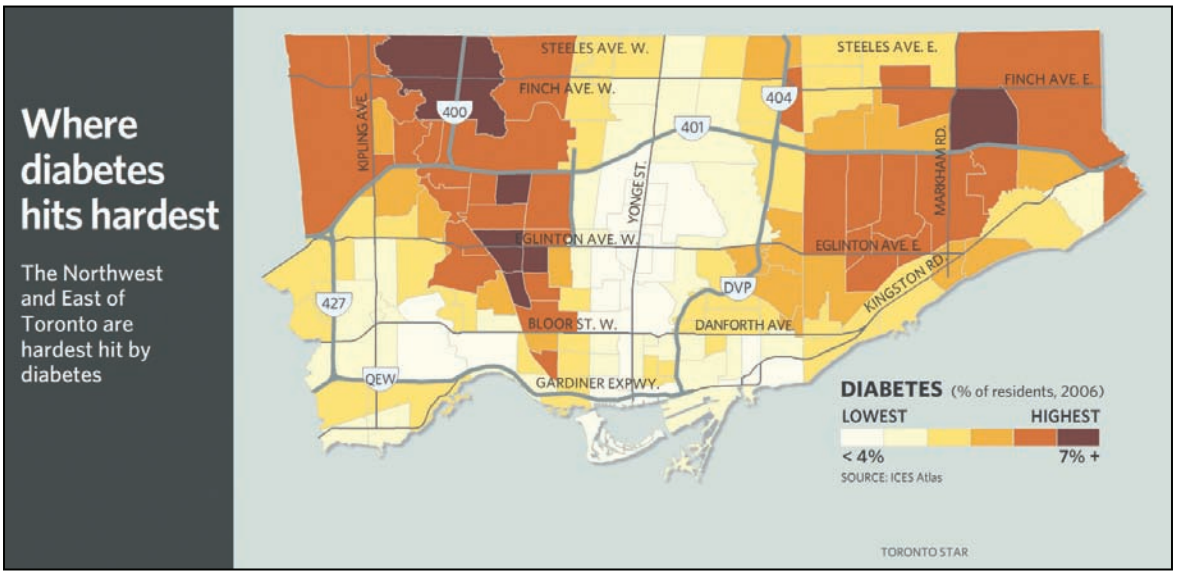
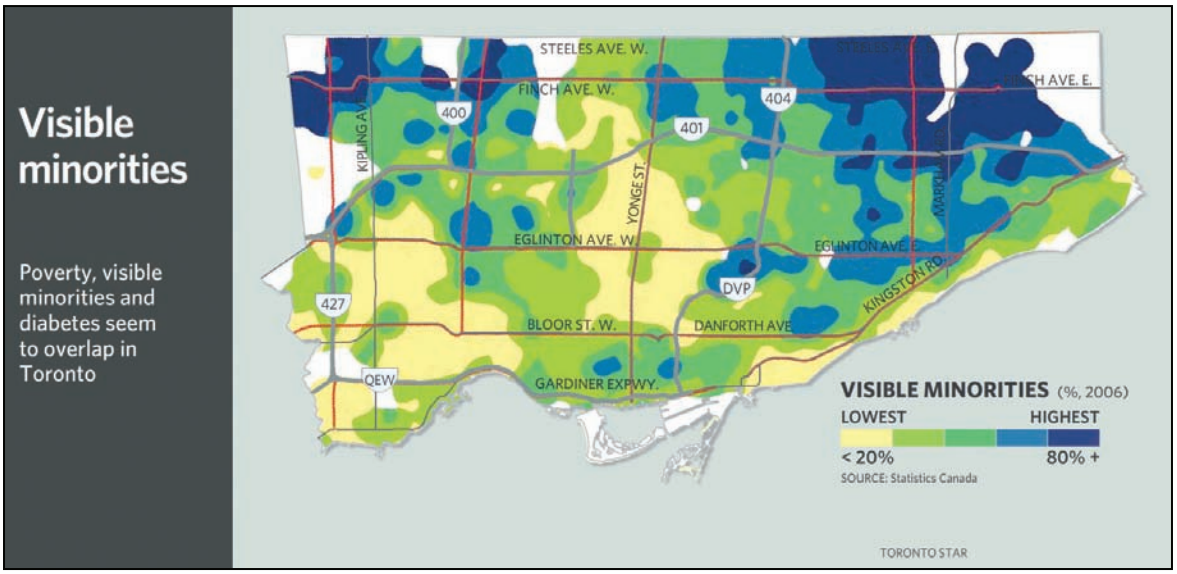
Source (Box 10.1):
Toronto Star, http://www.thestar.com/staticcontent/772097 using data from the United Way of Greater Toronto (poverty), Institute for Clinical Evaluation Sciences (diabetes), and Statistics Canada (visible minorities). Retrieved April 8, 2010.

Box 10.1 Poverty, Diabetes, and Visible Minorities in Toronto







11. SOCIAL SAFETY NET

We need to examine a host of policy changes by federal and provincial governments, policies that not only took apart the social safety net erected by the welfare state in previous decades, but contributed to a fundamental reduction in the role and scope of the state.

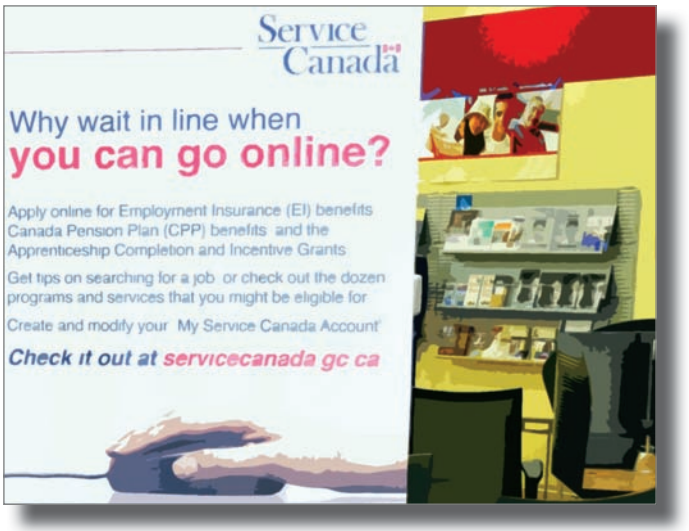
– David Langille, 2009

Why Is It Important?

The social safety net refers to a range of benefits, programs, and supports that protect citizens during various life changes that can affect their health. These life changes include normal life transitions such as having and raising children, attaining education or employment training, seeking housing, entering the labour force, and reaching retirement.

There are also unexpected life events such as having an accident, experiencing family break-ups, becoming unemployed, and developing a physical or mental illness or disability that can affect health. The primary way these events threaten health is that they increase economic insecurity and provoke psychological stress, all important determinants of health.

In Canada, becoming unable to work through unemployment or illness and experiencing family break-ups are good predictors of coming to experience poverty. These events are usually outside of an individual's control. All wealthy developed nations have created systems – usually termed the welfare state – to offer protection and supports to its citizens to help deal with these threats. These include family allowances, childcare, unemployment insurance, health and social services, social assistance and disability benefits and supports, home care and retirement pensions.



The protections and supports offered by Canadian governments are well below those provided by most other industrialized wealthy nations (Figures 11.1 and 11.2). The Organisation for Economic Co-operation and Development (OECD) publishes extensive statistics on social safety net spending amongst its 30 member nations. Canada ranks 24th of 30 countries and spends only 17.8 percent of gross domestic product (GDP) on public expenditures. Among OECD countries for which data is available, Canada is amongst the lowest public spenders on early childhood education and care (26th of 27), seniors' benefits and supports (26th of 29), social assistance payments (22nd of 29), unemployment benefits, (23th of 28), benefits and services for people with disabilities (27th of 29), and supports and benefits to families with children (25th of 29).

As one example of Canada's frayed social safety net, employment insurance is available to people who are without employment and who meet the eligibility requirements. Recent changes to eligibility, however, have significantly reduced the percentage of Canadians who are eligible for such payments. In fact, only 40% of working Canadians are eligible to receive benefits even though they have been paying into it.

A well-functioning social safety net is not only about providing financial benefits. It also includes services such as counseling, employment training and community services. For instance, active labour policy refers to supporting unemployed citizens by providing training opportunities and resources for finding new jobs. Canada ranks 21st of 30 OECD countries on such spending. Volunteer-based activities and peer support offer a valuable extension of social safety net provision by Canadian governments. However, voluntary action cannot eliminate the need for basic security and protection provided by governmental institutions.

Canadian citizens require protection when markets fail to provide basic security and adequate income. Sole reliance on the private market system increases insecurity among the population. A weak social safety net turns citizens against communal action and decreases social cohesion. These have health-threatening effects. Citizens experience better physical and mental health when they have a secure base for living a productive life.

Policy Implications

- The social safety net provided by Canadian federal, provincial/territorial, and municipal governments needs to be strengthened. Canada's spending in support of citizens lags far behind many other developed economies. Current benefits do not provide adequate income for life transitions.

- Canadian decision-makers must reevaluate whether minimizing government intervention is an ethical and sustainable approach to maintaining health, promoting social well-being, and increasing economic productivity.

- Strong political and social movements are needed to pressure governments into creating public policy that will strengthen Canada's social safety net.

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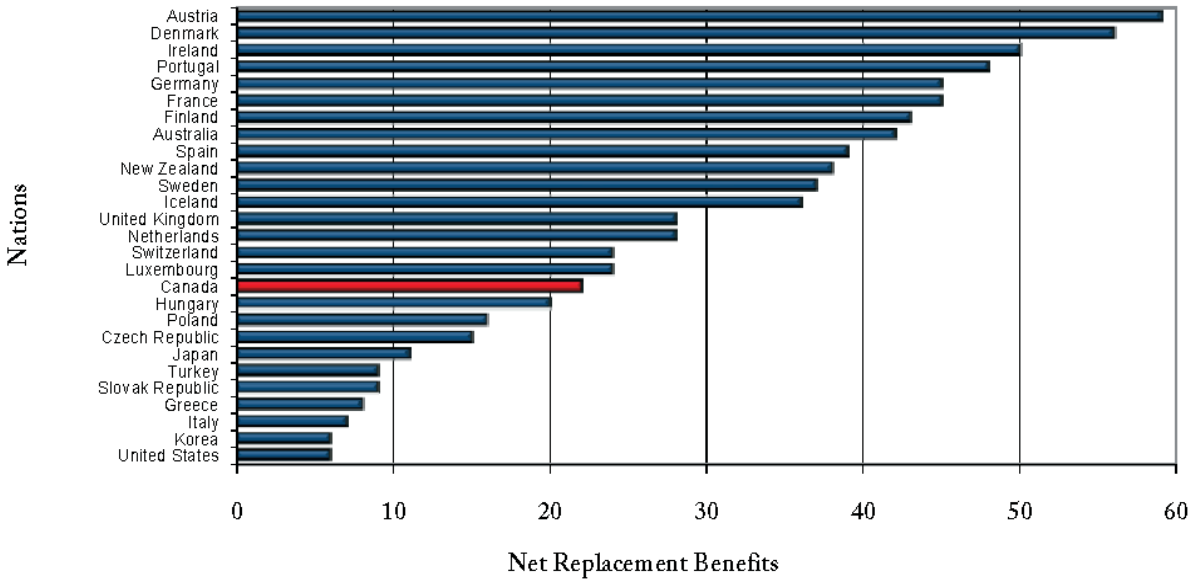
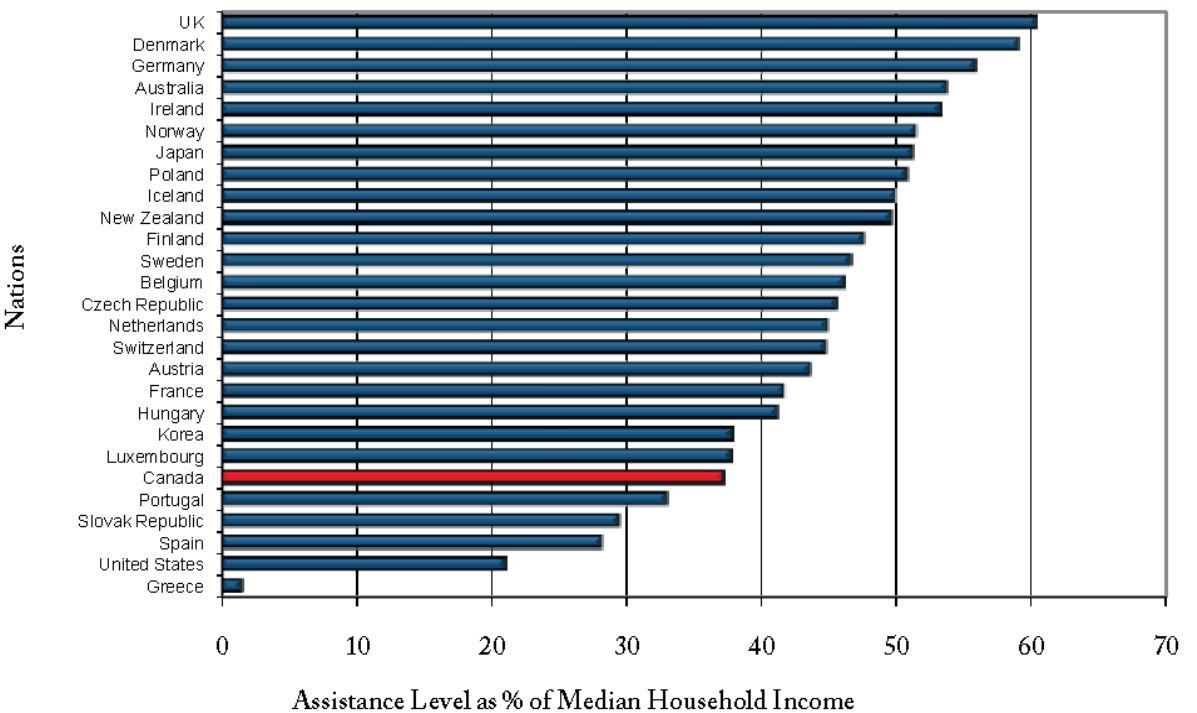
Figure 11.1 Unemployment Replacement Benefits over a Five Year Period as a Percentage of Median Income, OECD Nations, 2007



Source: Organisation for Economic Co-operation and Development. (2009). Generosity of Unemployment Benefits. Available at http://dx.doi.org/10.1787/706364844714.

Figure 11.2 Social Assistance Levels as a Percentage of Median Household Income, Lone Parent with Two Children, OECD Nations, 2007



Source: Organisation for Economic Co-operation and Development. (2009). Net Incomes of Social Assistance Recipients in Relation to Alternative Poverty Lines, 2007. Available at http://dx.doi.org/10.1787/706265650677

12. HEALTH SERVICES

The health sector has been relatively slow in grasping the connections among human rights, social injustice, and how everyday life unfolds for patients.

– Elizabeth McGibbon, 2009

Why Is It Important?

High quality health care services are a social determinant of health as well as a basic human right. The main purpose of a universal health care system is to protect the health of citizens and spread health costs across the whole society. A universal health care system is especially effective in protecting citizens with lower incomes who cannot afford private health care insurance.

The Canada Health Act (1984) sets out requirements provincial governments must meet through their public health-care insurance plans. These are: public administration, comprehensiveness, universality, portability, and accessibility. The "single payer" concept describes the concept of health care administration by a public authority (public administration).

The Canadian Health Act requires provinces provide all "medically necessary" services on a universal basis (comprehensiveness). All residents are provided access to public health-care insurance on equal terms and conditions (universality). However, provincial governments have great discretionary power because the Act does not provide a detailed list of insured services. Therefore, the range of insured services varies among provinces.

Provinces provide health services to Canadian citizens when they are temporarily absent from their home province or out of country (portability). The Canadian Health Act states every Canadian has to

be provided uniform access to health services in a way that is free of financial barriers (accessibility). No one should be discriminated against on the basis of income, age, or health status.

Nevertheless, there are continuing issues of access to care. The bottom 33% of Canadian income earners are – as compared to the top 33% of income earners – 50% less likely to see a specialist when needed, 50% more likely to find it difficult to get care on weekends or evenings, and 40% more likely to wait five days or more for an appointment with a physician.

There are also issues related to medicare coverage. While Canada is in the mid-range of public spenders on health care (14th of 30 OECD nations), it is amongst the lowest in its coverage of total health care costs (Figures 12.1 and 12.2). Medicare covers only 70% of total health care costs – the rest is covered by private insurance plans and out-of-pocket spending – which gives Canada a rank of 22nd of 30 OECD nations for public coverage of health care costs. Medicare does not cover drug costs, and coverage of home care and nursing costs varies among provinces. In many other wealthy developed nations these costs are covered by the public health care system.

As a result, Canadians with below-average incomes are three times less likely to fill a prescription due to cost and 60% less able to get a needed test or treatment due to cost than above average income earners. Even average-income Canadians are almost twice as likely to have problems getting prescriptions filled and paying medical bills than above average-earners.

While a pharmacare program has long been recommended by Royal Commissions for both its promotion of health equity and its ability to control costs, it has not been put into practice. This is of particular concern as the fastest-rising health expenditure in Canada is pharmaceuticals. Drug costs accounted for 9 percent of total health expenditures in 1975 and, by 2005, these expenditures had doubled (18%). Drug costs now are the second largest expenditure surpassing payments to physicians. Hospital costs remain first. Home care will also become increasingly important with the aging of the population. There is little evidence of reform in this area as well.

Dental plans are available to only 26% of low-income workers. Among the 74% of these lower income workers without plans, only 39% visit a dentist on an annual basis. In many Europeans nations dental care is part of national health plans.

Policy Implications

- District health authorities and health policymakers must direct attention to existing inequities in access to health care and identify and remove barriers to health care.

- Governments must implement a pharmacare program and increase public coverage of home care and nursing home costs.

- The medicare system must be strengthened and governments should resist the increasing involvement of for-profit companies in the organization and delivery of health care.

- Health authorities must find means of controlling the use of costly but ineffective new treatments (e.g., pharmaceuticals and screening technologies) that are being marketed aggressively by private corporations.

- As the Commission on the Future of Health Care in Canada concluded, Canadians need to accept the notion that the medicare system is "as sustainable as we want it to be".

- Consideration should be given to providing dental care to families living on low incomes.

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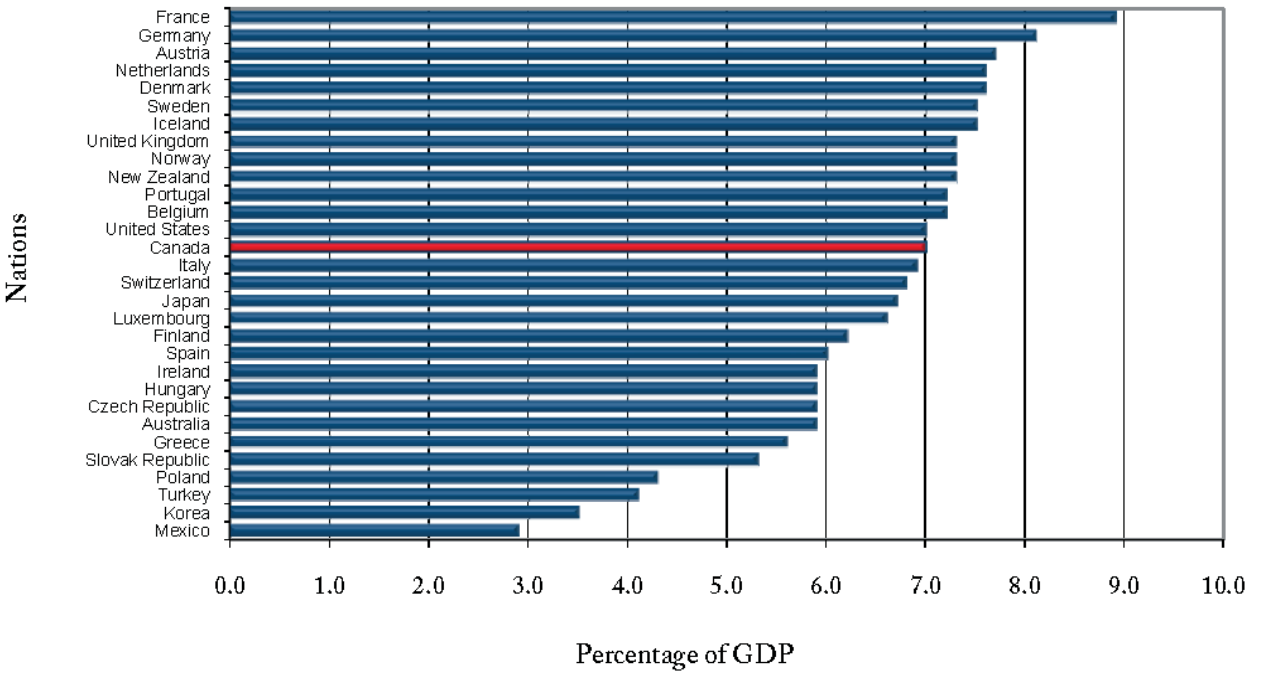
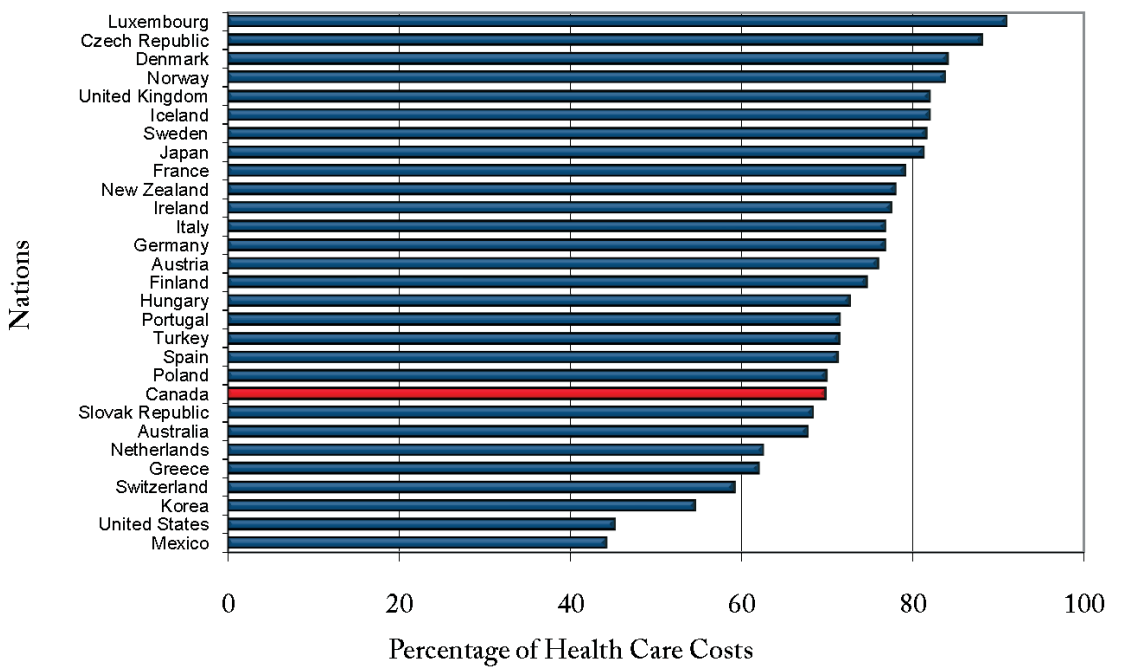
Figure 12.1 Public Spending on Health Care as a Percentage of GDP, OECD Nations, 2006



Source: OECD Health Data 2009- Version: June 09.

Figure 12.2 Public Spending on Health Care as Percentage of Total Health Care Spending, OECD Nations, 2006



Source: OECD Health Data 2009 - Version: June 09.

13. ABORIGINAL STATUS

As one of the richest countries in the world, Canada is well placed to right past wrongs and ensure that all Canadians, including Canada's First Peoples, are able to enjoy living conditions that promote health and well-being.

– Janet Smylie, 2009

Why Is It Important?

Aboriginal peoples in Canada – First Nations, Dene, Metis, and Inuit – number 1.2 million and constitute 3.8% of the Canadian population. The health of Aboriginal peoples in Canada is inextricably tied up with their history of colonialization. This has taken the form of legislation such as the Indian Act of 1876, disregard for land claims of Metis peoples, relocation of Inuit communities, and the establishment of residential schools. The result has been adverse social determinants of health and adverse health outcomes.

The average income of Aboriginal men and women in 2001 was $21,958 and $16,529 respectively, which is 58% of the average income of non-Aboriginal men and 72% of the average income of non-Aboriginal women. For Aboriginal Canadians living on reserves, their respective figures as a percentage of non-Aboriginal incomes were for men, 40% and for women, 61%.

Figures were somewhat better for those living off-reserve, but still well below incomes of non-Aboriginal Canadians. In 2001, 26% of Aboriginal households had incomes below the low income cut-offs in contrast to the 12% figures for households that were not Aboriginal. In 2001, the Aboriginal unemployment rate was 14%, double the rate of non-Aboriginal households. For First Nations Canadians

living on reserve the figure was 28%, twice the rate for Aboriginals living off reserve.

Education levels differ widely between Aboriginal and other Canadians. Among First Nation people living on reserve, 40% of men and 43% of women attain high school education. The figures are better for First Nation people living off-reserve; 56% for men and 57% for women. Figures for Inuit peoples are 43% for both men and women and for Metis, 65% for men and 63% for women. But these figures compare unfavourably to non-Aboriginal Canadians where 71% of men and 70% of women attain high school education.

Aboriginal Canadians living off reserve are four times more likely to experience food insecurity than non-Aboriginal Canadians. Thirty-three percent of off-reserve Aboriginal households experienced moderate or severe food insecurity in 2004 as compared to 8.8% of non-Aboriginal households. Fourteen percent of Aboriginal households experienced severe food insecurity as compared to 2.7% of non-Aboriginal households. On-reserve food is equally insecure. In a Cree community of Fort Severn, Ontario, for example, two thirds of households experienced food insecurity in 2002. A 1997 study in the northern communities of Repulse Bay and Pond Inlet found about 50% of each

community's families reported not having enough to eat in the past 30 days.

Aboriginal peoples are four times more likely to be living in crowded housing than non-Aboriginal Canadians. Thirty-eight percent of Inuit in Innuit Nunatt live so as compared to 11% of Aboriginal Canadians and three percent of the non-Aboriginal population. Life expectancies of Aboriginal peoples are five to 14 years less than the Canadian population, with Inuit men and women showing the shortest lives. Infant mortality rates are 1.5 to four times greater among Aboriginal Canadians than the overall Canadian rate.

Rates of numerous infectious and chronic diseases are much higher in the Aboriginal population than the non-Aboriginal Canadian population. Suicide rates are five to six times higher and Aboriginal peoples have high rates of major depression (18%), problems with alcohol (27%), and experience of sexual abuse during childhood (34%). Table 13.1 provides an analysis that places Aboriginal Canadians' situation in comparative perspective. Using the United Nations Human Development Index – consisting of life expectancy, education, and economic well-being – the Canadian Aboriginal population ranks 33 among nations. Canada itself has a rank of 8.

The United Nations Declaration of the Rights of Indigenous Peoples, approved by the UN General Assembly in 2007, identifies numerous areas in which national governments could work to improve the situation of Aboriginal peoples. The Declaration include articles concerned with improving economic and social conditions, the right to attain the highest levels of health, and the right to protect and conserve their environments. Canada was one of four nations (Australia, Canada, New Zealand, US) to vote against its adoption. One hundred and forty three nations voted in favour.

Policy Implications

The 1996 Royal Commission on Aboriginal Peoples made a number of recommendations, virtually all of which have not been implermented.

- Recognition of an Aboriginal order of government with authority over matters related to the good government and welfare of Aboriginal peoples and their territories.

- Replacement of the federal Department of Indian Affairs with two departments, one to implement a new relationship with Aboriginal nations and one to provide services for non-self-governing communities.

- Creation of an Aboriginal Parliament.

- Initiatives to address social, education, health, and housing needs, including the training of 10,000 health professionals over a 10-year period, the establishment of an Aboriginal peoples' university, and recognition of Aboriginal nations' authority over child welfare.

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United Nations (2007). The Declaration on the Rights of Indigenous Peoples. Available at http://www.un.org/esa/socdev/unpfii/en/declaration.html

Table 13.1 Selected International and Aboriginal HDI scores, 2001

HDI Rank	Country	HDI Score
Selected Countries with High Human Development		*(0.800–1)*
1	Norway	.944
2	Iceland	.942
3	Sweden	.941
4	Australia	.939
5	Netherlands	.938
6	Belgium	.937
7	United States	.937
8	**Canada**	**.937**
9	Japan	.932
13	United Kingdom	.930
16	Austria	.929
17	France	.925
19	Spain	.925
20	New Zealand	.917
23	Portugal	.896
30	Republic of Korea	.879
31	U.S. American Indian and Alaska Native	.877
32	Czech Republic	.861
33	**Canadian Aboriginal Population**	**.851**
34	Argentina	.849
42	Costa Rica	.831
43	Chile	.831
52	Cuba	.806
53	Belarus	.804
54	Trinidad and Tobago	.802
55	Mexico	.800
Selected Countries with Medium Human Development		*(0.500 – 0.799)*
73	Saudi Arabia	.769
74	New Zealand Maori	.767
75	Ukraine	.766
85	Philippines	.751
94	Dominican Republic	.737
102	Cape Verde	.727
103	Australian Aboriginal and Torres Strait Islanders	.724
104	China	.721
105	El Salvador	.719
120	Egypt	.648

Source: Cooke, M. et al (2007). Indigenous Well-being in Four Countries: An Application of the UNDP'S Human Development Index to Indigenous Peoples in Australia, Canada, New Zealand, and the United States. BMC International Health and Human Rights, 7:9.

14. GENDER

Gender matters in health and care. The point may seem obvious, but it has only recently been acknowledged in health policy and research.

– Pat Armstrong, 2009

Why Is It Important?

Women in Canada experience more adverse social determinants of health than men. The main reason for this is that women carry more responsibilities for raising children and taking care of housework. Women are also less likely to be working full-time and are less likely to be eligible for unemployment benefits. In addition, women are employed in lower paying occupations and experience more discrimination in the workplace than men. For these reasons, almost every public policy decision that weakens the social safety net has a greater impact on women than on men.

Women tend to earn less than men regardless of occupation. For example, among women working in management, women earn on average $956 a week compared to $1261 earned by men. Women work fewer hours than men and their hourly wages are only 80% of the wages of men. Jobs which are more dominated by men tend to pay more, and even when women work in these fields, they tend to get paid less. Figure 14.1 shows the gender gap in earnings between men and women is not lessening and even seemed to have increased from 2004 to 2005. These differences are apparent for all men and women, those working full time/full year and even for those working full time/full year with university degrees.

International comparisons (Figure 14.2) show that Canada is among the nations with the greatest gap

between men and women's earnings. Canada ranks 19th of 22 OECD nations in reducing the earnings gap between men and women. Combating discrimination in the workplace would eliminate various forms of gender-based discrimination. The gap between Canadian men's and women's wages is smaller and the provision of benefits more generous in workplaces that are unionized.

In Canada, the other major concern in terms of gender inequality is the lack of affordable and high quality daycare. This forces women to stay at home more and take care of family responsibilities. Making affordable childcare available would increase women's possibilities to participate in working life. Single mothers are especially at high risk of entering poverty because of the lack of affordable childcare services and women's generally lower wages.

Women have a life expectancy of 79 years as compared to men's 76.3 years. However, the higher mortality rate and lower life expectancy of men does not mean that women enjoy superior health. Women have more episodes of long-term disability and chronic diseases than men. On the other hand, men are more prone to accidents and extreme forms of social exclusion which reduce their overall life expectancy.

There are specific aspects of gender that pertain to men's health. Men experience more extreme forms of social exclusion that manifests in homelessness and severe substance abuse. The suicide rate of men is four times higher than that of women. Men are also more likely to be perpetrators and victims of robbery and physical assault.

About 95% of Canada's prison population are men. Young males who experience disadvantage – in the forms of poverty, low educational attainment and unemployment – are more prone to anti-social behaviours and criminal offences than women. Moreover, men's health is sometimes influenced – for the worse – by unhealthy constructs of masculinity that idealize aggressiveness, dominance and excessive self-reliance.

There is also evidence that gay, lesbian, and transgendered Canadians experience discrimination that leads to stress that has adverse health effects. This is especially a problem during adolescence when gay and lesbian youth need to come to terms with their self-identity. Discrimination is also an ongoing problem when these Canadians enter the work world.

The health of both genders is shaped by the distribution of social and economic resources. Changing these distributions requires action that extends beyond the health care or community services sectors. Required actions include the provision of living wages and adequate social assistance benefits, affordable housing and childcare, and making it easier to qualify for employment insurance. Creation and enforcement of pay equity legislation and enforcement of anti-discrimination rules are essential.

Policy Implications

- Improving and enforcing pay equity legislation would improve the employment and economic situation of Canadian women.

- Providing a national affordable high quality childcare program would provide opportunities for women to engage in the workplace and improve their financial situations.

- Improving access to employment insurance for part-time workers would assist women who combine work and caregiving responsibilities.

- Creating policies that make it easier for workplaces to achieve collective agreements through unionization would be especially beneficial for Canadian women.

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Figure 14.1 The Pay Gap: Earnings of Women vs. Men

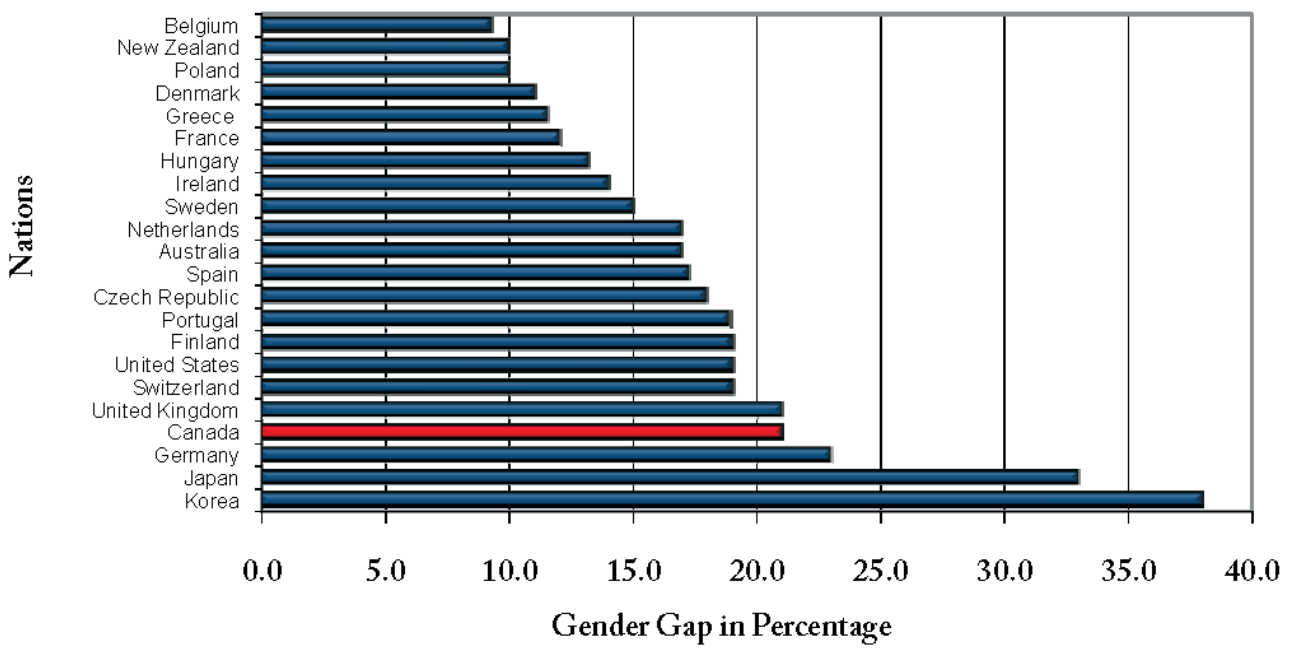
	2000	2001	2002	2003	2004	2005
Average Annual Earnings of Men Full Year / Full Time	$53,300	$54,400	$54,500	$54,300	$56,300	$55,700
Average Annual Earnings of Women Full Year / Full Time	$37,700	$38,000	$38,300	$38,100	$39,300	$39,200
Pay Gap	$15,600	$16,400	$16,200	$16,200	$17,000	$16,500

Average Annual Earnings of Women as % of Men

All	61.7	62.1	62.8	62.9	63.4	64.0
Full Vear/Full Time	70.6	69.9	70.2	70.2	69.9	70.5
Full Year/Full time with University Degree	68.6	65.5	69.0	69.0	65.6	67.9

Source: Canadian Labour Congress (2008). Women in the Workforce: Still a Long Way from Equality. Available at http://equalpaycoalition.org/cms/upload/CLC%20womensequalityreportEn.pdf.
Data Source: Statistics Canada (2008). Income Trends in Canada. Ottawa: Statistics Canada.
Income Data are in constant 2005$.

Figure 14.2 Gender Gap in Wages, OECD Nations, in Percentage, 2006



Source: Organisation for Economic Co-operation and Development. (2009). Gender Gap in Median Earnings of Full-time Employees. Available at www.oecd.org/dataoecd/1/35/43199347.xls.

15. RACE

Racialized and immigrant groups are disproportionately impacted by labour market segregation, unemployment and income inequality, poverty, and poor neighbourhood selection.

– Grace-Edward Galabuzi, 2009

Why Is It Important?

Canada prides itself on being a multicultural society. Since the 1960s over three quarters of immigrants to Canada have come from the Global South or developing nations and most are members of visible minority groups (i.e. racialized groups). One third of racialized Canadians are Canadian-born and the other two thirds are immigrants. Racialized Canadians experience a whole range of adverse living circumstances that threaten not only their health but also the overall health and well-being of Canadian society.

Racism can take three forms, all of which will have impacts on health. Institutionalized racism is concerned with the structures of society and may be codified in institutions of practice, law, and governmental inaction in the face of need. Personally mediated racism is defined as prejudice and discrimination, and can manifest itself as lack of respect, suspicion, devaluation, scapegoating, and dehumanization. Internalized racism is when those who are stigmatized accept these messages about their own abilities and intrinsic lack of worth. This can lead to resignation, helplessness, and lack of hope. These concepts are clearly applicable to Canadian society.

Canadian of colour in every province experience higher unemployment and under-employment rates, and lower incomes than Canadians of European

descent (Figure 15.1). This was less so in the 1970s when Canadians of non-European descent's employment levels and earned incomes were similar to Canadians of European descent.

Researchers at Statistics Canada attempted to identify the factors responsible for the deteriorating economic situation of immigrants – most of which are people of colour – and found that the increases in low-income status affected immigrants in all education and age groups, including the university educated. The study found that the economic returns to these recent immigrants of colour for their work experience and education that were common in the past were not happening now.

Also, past surveys found that the health status of European and non-European descent Canadians did not differ. In fact there was a "healthy immigrant effect" whereby immigrants to Canada showed superior health status to those born in Canada. However, recent data from the National Population Health Survey shows that the health of non-European immigrants – especially recent immigrants of colour – shows deterioration over time as compared to Canadian-born residents and European immigrants.

As compared to the Canadian-born population, recent non-European immigrants were twice as likely to report deterioration in health from 1993/94 to 2002/3 (Figure 15.2). Non-European immigrants were also 50% more likely to become frequent visitors to doctors than the Canadian-born population. These recent immigrants of colour are experiencing more mental health problems and greater incidence of housing and food insecurity than Canadians of European descent.

In addition, the increasing concentration in Canadian urban neighbourhoods of low-income Canadians of colour should be a concern. In the USA this concentration has been identified as a cause of many health and social problems.

Policy Implications

- Canadians institutions must recognize the existence of racism in Canada and develop awareness and education programs that outline the adverse effects of racism.

- Governments must enact laws and regulations that allow foreign-trained immigrants to practice their occupations in Canada.

- Authorities must strongly enforce anti-discrimination laws.

- Since people of colour are experiencing especially adverse living circumstances, governments must take an active role in improving their living conditions.

Key sources

Galabuzi, G. E. (2005). Canada's Economic Apartheid: The Social Exclusion of Racialized Groups in the New Century. Toronto: Canadian Scholars' Press.

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Jones, C. (2000). 'Levels of Racism: A Theoretic Framework and a Gardener's Tale.' American Journal of Public Health, 90(8), 1212-1215.

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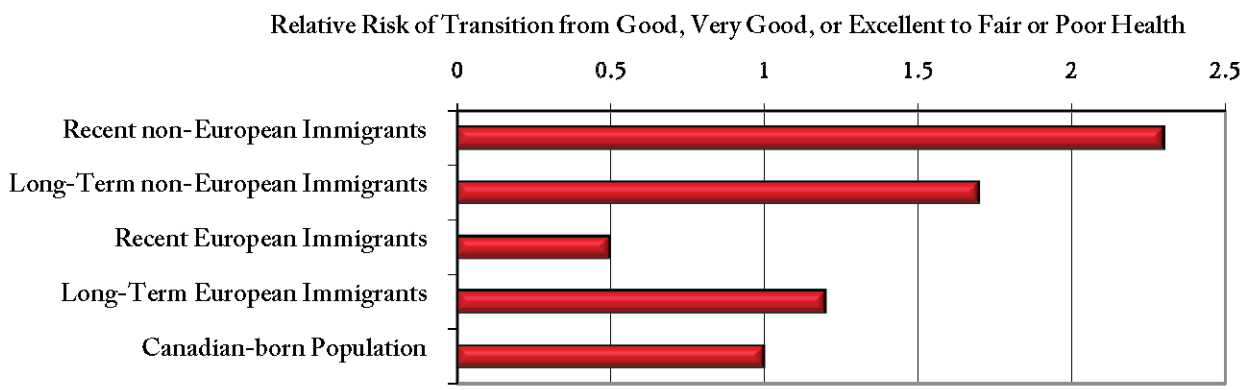
Figure 15.1 Average Income (all sources) by Selected Racialized Community, 2001

	Men	Women	Total
All Canadian earners	36,800	22,885	29,769
African community	27,864	19,639	23,787
Arab community	32,336	19,264	26,519
Caribbean community	29,840	22,842	25,959
Chinese community	29,322	20,974	25,018
Filipino community	27,612	22,532	24,563
Jamaican community	30,087	23,575	26,412
Haitian community	21,595	18,338	19,782
Japanese community	43,644	24,556	33,178
Korean community	23,370	16,919	20,065
Latin American community	27,257	17,930	22,463
South Asian community	31,396	19,511	25,629
Vietnamese community	27,849	18,560	23,190
West Asian community	28,719	18,014	23,841

Source: Statistics Canada. (2003). 2001 Census of Canada. 2001 Census Analysis Series. The Changing Profile of Canada's Labour Force. Catalogue no. 96F0030XIE2001009, February 2003. Ottawa: Statistics Canada.

Figure 15.2 Non-European Immigrants are more likely than the Canadian-born to Report a Deterioration in Health



Source: Ng, E. et al. (2005). Healthy Today, Healthy Tomorrow? Findings from the National Population Health Survey. Ottawa: Statistics Canada.

16. DISABILITY

Ameliorating disability is not simply a matter of intervening medically. It is about addressing the physical, social, civic, economic, and cultural rights violations experienced by people with disabilities.

– Marcia Rioux and Tamara Daly, 2010

Why Is It Important?

Too often disability is seen in medical rather than societal terms. While disability is clearly related to physical and mental functions, the primary issue is whether society is willing to provide persons with disabilities with the supports and opportunities necessary to participate in Canadian life. As compared to the other wealthy developed nations of the OECD, Canada's levels of benefits to persons with disabilities are very low, and its support for integration of persons with disabilities into society is below the OECD average.

The percentage of Canadians reporting a disability is 12.4%. Among children less than 14 years, the rate is less than five percent, but for adults aged 15 to 64 years, the rate rises to 11.5%. For those aged 65 and over, the rate is more than 40%. People with disabilities are less likely to be employed and, when they are employed, earn less than people without disabilities. Only 35% of men with disabilities were employed full-time/full-year in 2000 and the figure for women with disabilities was 23%. In contrast the figures for those without disabilities working full-time/full-year was 53% for men and 37% for women.

More troubling, 36% of men and 47% of women with disabilities did not work at all in 2000. The figures of those not working at all for those without disabilities were only 13% for men and 22% for

women. For those with disabilities who do work, in 2001, the average earnings were $32,385, whereas the average earnings of those without a disability were $38,677.

Over 40% of Canadians with disabilities are not in the labour force, forcing many of them to rely upon social assistance benefits. These benefits are very low in Canada and do not bring individuals even close to the poverty line in most cities. This should not be surprising as Canada is one of the most frugal OECD nations in its allocation of benefits to people with disabilities. In fact, Canada ranks 27th of 29 in public spending on disability-related issues.

The OECD carried out an extensive analysis of disability policy in its member nations. It created indices of compensation and integration for persons with disabilities. Each index consisted of ten measures of the extent to which governments provide benefits and supports to persons with disabilities.

Figure 16.1 shows that Canada, outside of Korea, provides the lowest compensations and benefits to its citizens with disabilities. Canada has some of the strongest restrictions on receiving benefits

and its levels of benefits are very low. Canada does somewhat better – but still falls below the OECD average – in efforts to integrate persons with disabilities into the workforce. Clearly, there is much work to be done in assisting persons with disabilities in Canada.

Many employment issues are related to the workplace being either unable or unwilling to accommodate to the needs of persons with disabilities. Many required modifications are rather minor and almost all of these would have annual costs of less than $1,500. For many persons with disabilities, an employer's reluctance to provide accommodation on the job can be extremely disheartening and frustrating.

Canada recently ratified the UN Convention on the Rights of Persons with Disabilities and therefore is now required to report on its progress in improving the situation. The Disability Rights Promotion International website provides further information on the Convention and its implications at http://www.yorku.ca/drpi.

Policy Implications

The Council of Canadians with Disabilities and the Canadian Association for Community Living outline the following necessary strategies. In the short-term, the federal government must:

- Commit to a framework that will assist individuals to meet the costs of disability-related supports; support family/informal caregivers; and enable community capacity to provide supports and inclusion.

- Make a 'down payment' on a transfer to enhance the supply of disability supports, and commit to a national program of disability supports.

- Commit to a 'disability dimension' in new initiatives, including Caregivers, Childcare, Cities and Communities, and the Gas Tax Rebate to enhance accessible transportation and other services.

- Commit to a study of poverty and disability for exploring an expanded role for the federal government in addressing income needs.

Longer-term strategies are:

- Explore a further role for the federal government in addressing poverty, by meeting individual costs of disability through an expenditure program, perhaps modeled after the National Child Benefit.

- Integrate the Caregiver Agenda into a Framework for Investment in Disability Supports.

Key sources

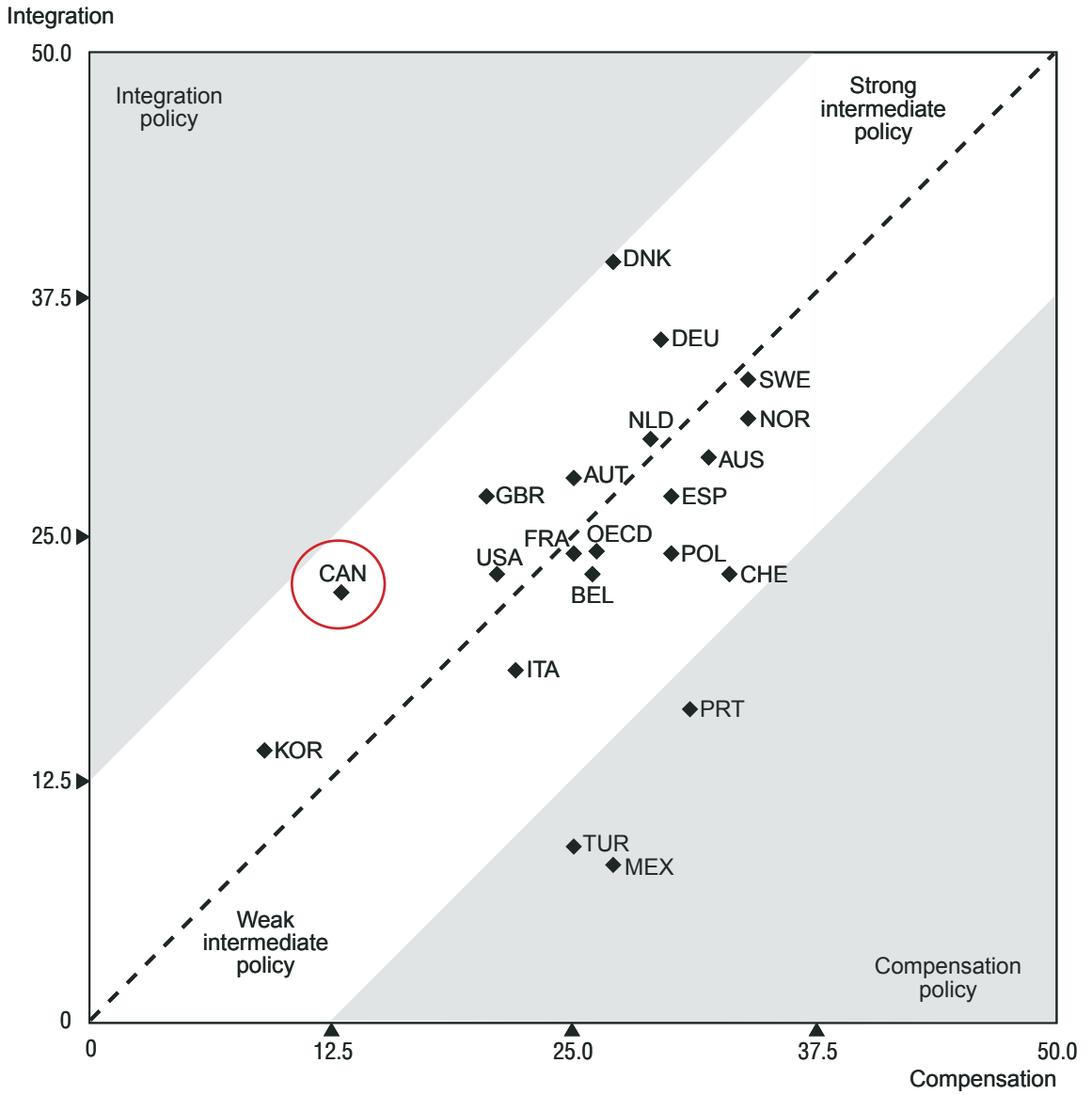
Council of Canadians with Disabilities (CCD) (2005). A Call to Combat Poverty and Exclusion of Canadians with Disabilities by Investing in Disability Supports. Ottawa: CCD.

Jackson, A. (2009). Work and Labour in Canada: Critical Issues. 2nd edition. Toronto: Canadian Scholars' Press.

Organisation for Economic Co-operation and Development (2003). Transforming Disability into Ability. Paris: OECD.

Rioux, M. and Daly, T. (2010). 'Constructing Disability and Illness'. In T. Bryant, D. Raphael, and M. Rioux (eds.). Staying Alive: Critical Perspectives on Health, Illness, and Health Care (pp. 347-370). 2nd edition. Toronto: Canadian Scholars' Press.

Figure 16.1 Canada Lags Behind Most other OECD Countries in its Provision of Benefits and Efforts to Integrate Persons with Disabilities into the Workforce



Source: Organisation for Economic Co-operation and Development (2003). Transforming Disability into Ability, Chart 6.1, p. 128. Paris: OECD,

17. WHAT YOU CAN DO

The profound structural change needed to secure investments in the social determinants of health in our complex federal system will occur only if we succeed in raising public awareness and developing political will.

– The Honourable Carolyn Bennett, 2009

The primary means of promoting the health of Canadians is through enactment of public policies that provide the living conditions necessary for good health. Public policies that would improve the quality of the social determinants of health are not pipe-dreams: they have been implemented in many wealthy industrialized nations – most of which are not as wealthy as Canada – to good effect. Not only can we look to other nations that apply a social determinants of health perspective, we can look to the time from the Great Depression to the period after World War II when Canada implemented medicare and public pensions, unemployment insurance, and federal and provincial programs that delivered affordable housing.

Canada has strayed from this tradition and has come to be a social determinants of health laggard among wealthy developed nations. Governments at all levels have neglected the factors necessary for health. Since it appears that elected representatives and policymakers are aware of these problems yet choose to not act, social and political movements must be developed that will pressure governments and policymakers to enact health-supporting public policy.

There are numerous ways of accomplishing this. One involves educating Canadians about the social determinants of health and having this knowledge translated into action. Canadians

should ask their elected representatives what is being done to address these issues (see Appendix I). Canadians should also raise these issues with agencies, organizations, and institutions whose mandates include promoting health and preventing illness.

Public health units, disease associations such as the Heart and Stroke Foundation, Canadian Cancer Society, and the Canadian Diabetes Association, and health care organizations such as hospitals and professional associations must educate themselves and their clients on how social determinants influence health. They should urge governments and policymakers to create and implement health promoting public policies. Canadians should ask these organizations what they are doing to educate Canadians about the social determinants of health and promote public policy action. Box 17.1 gives an example of what one health unit is doing to educate the public and influence public policy.

Another way to strengthen the social determinants of health is to support candidates of political parties that are receptive to the social determinants of health concept. Such candidates can be found in every political party, but are more likely to be found and influenced in some political parties than others.

Candidates who favour these ideas and the public policies that flow from them should be supported and those that currently do not, need to be pressured to adopt these positions. Evidence is abundant that in Canada and elsewhere, political parties of the left have been more likely to develop and implement public policies such as universal healthcare, public pensions, housing programs, and universal childcare that support the social determinants of health.

There is strong evidence that an essential aspect of improving the quality of the social determinants of health is making it easier for Canadians to unionize their workplace. In Canada, working under a collective agreement is related to higher wages, better benefits, and improved employment security and working conditions.

The strength of labour unions is also related to differences among developed nations in the quality of the social determinants of health experienced by citizens. Figure 17.1 shows that union density – or percentage of workers belonging to a union – and collective agreement coverage is strongly related to child poverty rate which is an aggregate of a number of social determinants of health.

Social democratic welfare states – Norway, Finland, Denmark, and Sweden – have the strongest unions and highest collective agreement rate and the lowest poverty rates; liberal welfare states – UK, USA, Canada, New Zealand, and Australia – have the opposite.

The Continental European nations are interesting in that while union membership is not as high as in the social democratic nations, there is a recognition on the part of business and government of the value of providing workers with various forms of security: their collective agreement rate is high and their poverty rates are moderate. Italy, Spain, and Portugal are less wealthy and less developed welfare states whose poverty rates are similar to the liberal welfare states.

Finally, Canadians can join and/or support organizations that work to strengthen the social determinants of health. Some of these organizations and additional sources of information are provided in the Appendix on resources and supports.

Courage my friends,
'tis not too late to build a better world.

– Tommy Douglas,
Father of Medicare in Canada

Key sources

Bennett, C. (2009). 'Foreword'. In D. Raphael (ed.) Social Determinants of Health Canadian Perspectives, (pp. xii-xiii). 2nd edition. Toronto: Canadian Scholars' Press.

Ontario Chronic Disease Prevention Alliance and Health Nexus (2008). Primer to Action: Social Determinants of Health. Toronto: Author. Online at http://www.healthnexus.ca/projects/primer.pdf.

Raphael, D. (Sept., 2010). About Canada: Health and Illness. Halifax: Fernwood Publishing.

Raphael, D. & Curry-Stevens, A. (2009). 'Surmounting the Barriers: Making Action on the Social Determinants of Health a Public Policy Priority'. In D. Raphael (ed.) Social Determinants of Health Canadian Perspectives (pp. 362-377). 2nd edition. Toronto: Canadian Scholars' Press.

Box 17.1 An Example of a Health Promotion Campaign Acknowledging Social Determinants of Health

The most important things you need to know about *your health* may not be as obvious as you think.

Health = A rewarding job with a living wage
Little control at work, high stress, low pay, or unemployment all contribute to poor health.
Your job makes a difference.

Health = Food on the table and a place to call home
Having access to healthy, safe, and affordable food and housing is essential to being healthy.
Access to food and shelter makes a difference.

Health = Having options and opportunities
The thing that contributes most to your health is how much money you have. More money means having more opportunities to be healthy.
Money makes a difference.

Health = A good start in life
Prenatal and childhood experiences set the stage for lifelong health and well-being.
Your childhood makes a difference.

Health = Community belonging
A community that offers support, respect, and opportunities to participate helps us all be healthy.
Feeling included makes a difference.

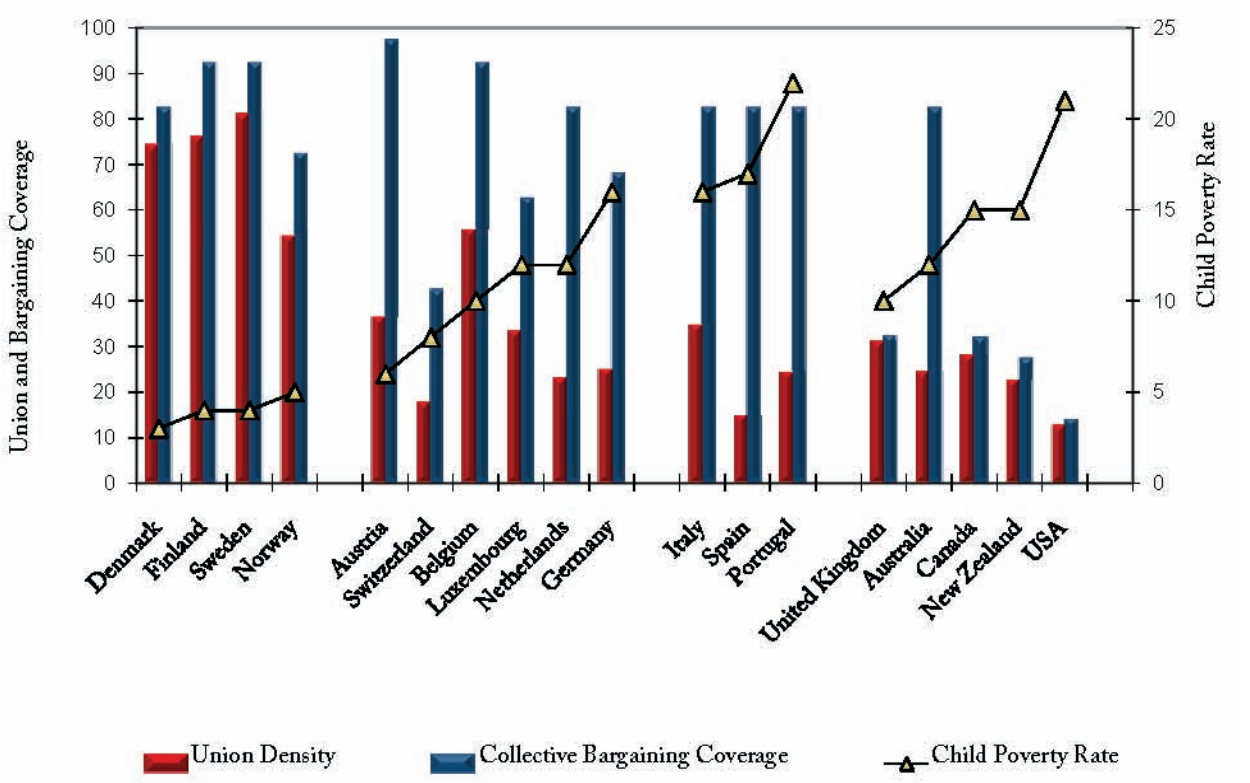
How can you make a difference?
Action to improve the things that make
ALL of us healthy depends on ALL of our support.

Start a conversation.
Share what you know.

To learn more, call the Sudbury & District Health Unit at (705) 522-9200, ext. 515 or visit www.sdhu.com.

Make it a Healthy Day!
Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

Figure 17.1 Union Density, Collective Agreement Coverage and Child Poverty, Early 00's (coverage rates) and Mid 2000s (poverty rates)



Source: Organisation for Economic Co-operation and Development (2006). Trade Union Members and Union Density. Available at http://www.oecd.org/dataoecd/8/24/31781139.xls and Organisation for Economic Co-operation and Development (2009). Growing Unequal: Income Distribution and Poverty in OECD Countries Figure 5.a2.1, p.154.

APPENDIX I. RESOURCES AND SUPPORTS

Resources on the Social Determinants of Health in Canada

Print Materials

Chronic Disease Alliance of Ontario (2008). Primer to Action: Social Determinants of Health. Toronto: Chronic Disease Alliance of Ontario.
– http://www.healthnexus.ca/projects/primer.pdf

BC Healthy Living Alliance (2009). Healthy Future for BC Families.
– http://www.bchealthyliving.ca/sites/all/files/BCHLA_Healthy_Futures_Final_Web.pdf

Raphael, D. (Sept., 2010). About Canada: Health and Illness. Halifax: Fernwood Publishers.

Raphael, D. (2009). Social Determinants of Health: Canadian Perspectives, 2nd edition. Toronto: Canadian Scholars' Press.

World Health Organization. (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: World Health Organization.
– http://tinyurl.com/czbkhg

Media Resources

Peterborough County-City Health Unit TV ads on Poverty and Health
– http://pcchu.peterborough.on.ca/PH/PH-social-ads.html

Poor No More (2010) – http://www.poornomore.ca/

Population Health: The New Agenda (2009) – http://tinyurl.com/l2x4d9

Sick People or Sick Societies? (2008) – http://tinyurl.com/432unj

Poverty Makes me Sick Video – http://tinyurl.com/y5vk3le

Unnatural Causes: Is Inequality Making us Sick? (2008) – http://www.unnaturalcauses.org/

Website Resources

Canadian Public Health Association Policy Statements – http://tinyurl.com/yactk3z

Dennis Raphael's Website – http://www.atkinson.yorku.ca/draphael

CHEO Health Research Institute – http://tinyurl.com/y6f6mpc

Public Health Agency of Canada – http://tinyurl.com/yddy6wr

Social Determinants of Health Commission – http://www.who.int/social_determinants/en/

Join the Social Determinants of Health Communication Network

Connect with 1250 others from around the world who are concerned about the social determinants by emailing the message:
subscribe SDOH yourfirstname yourlastname to listserv@yorku.ca

Policy and Advocacy Organizations Addressing the Social Determinants of Health

Progressive Public Policy Organizations

Canadian Centre for Policy Alternatives – http://www.policyalternatives.ca/

Caledon Institute of Social Policy – http://www.caledoninst.org/

Canadian Council on Social Development – http://www.ccsd.ca/home.htm

Wellesley Institute – http://wellesleyinstitute.com/

Aboriginal Health

National Aboriginal Health Organization – http://www.naho.ca/

Assembly of First Nations – http://www.afn.ca/

Childcare

Childcare Resource and Research Unit – http://www.childcarecanada.org/

Child Care Advocacy Association of Canada – http://www.ccaac.ca/

Disability Groups

Disabled Women's Network of Ontario – http://dawn.thot.net/

Council of Canadians with Disabilities – http://www.ccdonline.ca/

Employment and Working Conditions

Canadian Labour Congress – http://www.canadianlabour.ca/

Institute for Work & Health – http://www.iwh.on.ca/

Food Insecurity

Food Secure Canada – http://foodsecurecanada.org/

Food Banks Canada – http://foodbankscanada.ca/

Health Services

Canadian Health Coalition – http://www.healthcoalition.ca/

Canadian Doctors for Medicare – http://www.canadiandoctorsformedicare.ca/

Students for Medicare – http://studentsformedicare.com/

Health Providers Against Poverty – http://www.healthprovidersagainstpoverty.ca/

Housing and Homelessness

Centre for Urban and Community Studies, University of Toronto – http://www.urbancentre.utoronto.ca/

Homeless Hub – http://www.homelesshub.ca/

Cooperative Housing Federation – http://www.fhcc.coop/eng/pages2007/home.asp

Income

Canada without Poverty – http://www.cwp-csp.ca/

Campaign 2000 – http://www.campaign2000.ca/

Health Providers Against Poverty – http://www.healthprovidersagainstpoverty.ca/

Race

Colour of Poverty – http://www.colourofpoverty.ca/

National Anti-Racism Coucncil of Canada – http://www.narcc.ca/index.html/

Social Exclusion

Intraspec.ca – http://intraspec.ca/index.php

Metropolis Project – http://canada.metropolis.net/generalinfo/index_e.html

Women's Health

Canadian Women's Health Network – http://www.cwhn.ca/

Centres of Excellence for Women's Health – http://www.cewh-cesf.ca/en/index.shtml

Ontario Women's Health Network – http://www.owhn.on.ca/

Contacting Your Elected Officials and Health Associations about the Social Determinants of Health

Contact Governments

Find and Contact your Federal Member of Parliament – http://tinyurl.com/3dg9g3

Find and Contact your Provincial Representative – http://tinyurl.com/y8eda7x

Contact Federal Political Parties

Bloc Québécois – http://www.blocquebecois.org/

Conservative Party of Canada – http://www.conservative.ca/

Green Party of Canada – http://www.greenparty.ca/

Liberal Party of Canada – http://www.liberal.ca/

New Democratic Party of Canada – http://www.ndp.ca/

Contact Provincial Political Parties

http://canadaonline.about.com/od/elections/a/partieslist.htm

Contact Health Professional Associations

Canadian Medical Association – http://www.cma.ca/index.cfm/ci_id/3295/la_id/1.htm

Canadian Nurses Association – http://www.cna-aiic.ca/CNA/contact/default_e.aspx

Canadian Public Health Association – http://www.cpha.ca/en/contact.aspx

Provincial Public Health Associations – http://tinyurl.com/yzfdphs

Associations whose Focus is Strongly Related to Social Determinants of Health but Require some Persuasion to Move Forward

Canadian Cancer Society – http://www.cancer.ca/

Canadian Diabetes Association – http:// www.diabetes.ca/

Heart and Stroke Foundation – http:// www.heartandstroke.ca/

APPENDIX II. QUOTATION SOURCES

1. Introduction

Roy Romanow is a former Premier of Saskatchewan and was Commissioner of the Royal Commission on the Future of Health Care in Canada. The quotation is from his foreword to Social Determinants of Health: Canadian Perspectives.

2. Stress, Bodies, and Illness

Robert Evans is a professor of health economics at the University of British Columbia. The quotation is from the volume Why are some People Healthy and Others Not?

3. Income and Income Distribution

Andrew Jackson is national director of Social and Economic Policy with the Canadian Labour Congress. The quotation is taken from his chapter in Social Determinants of Health: Canadian Perspectives.

4. Education

Charles Ungerleider is professor of the Sociology of Education at the University of British Columbia and director of research and knowledge mobilization for the Canadian Council on Learning. **Tracey Burns** is a research and policy analyst in the Education Directorate of the Organisation for Economic Cooperation and Development in Paris. **Fernando Cartwright** is principal research scientist for the Canadian Council on Learning in Ottawa. The quotation is taken from their chapter in Social Determinants of Health: Canadian Perspectives.

5. Unemployment and Job Insecurity

Emile Tompa is a scientist at the Institute for Work & Health in Toronto. **Michael Polanyi** coordinates research, education, and advocacy on Canadian poverty and social justice issues at KAIROS: Canadian Ecumenical Justice Initiatives. **Janice Foley** is an associate professor in the Faculty of Business Administration at the University of Regina. The quotation is taken from their chapter in Social Determinants of Health: Canadian Perspectives.

6. Employment and Working Conditions

Peter Smith is a researcher at the Institute for Work & Health in Toronto. **Michael Polanyi** is at Kairos: Canadian Ecumenical Justice Initiatives. The quotation is taken from their chapter in Social Determinants of Health: Canadian Perspectives.

7. Early Childhood Development

The Federal/Provincial Territorial Advisory Committee on Population Health is responsible for advising governments on health policy and related issues. The quotation is from its 1996 Report on the Health of Canadians.

8. Food Insecurity

Lynn McIntyre is a professor in the Department of Community Health Sciences at the University of Calgary. **Krista Rondeau** is a research associate in the Department of Community Health Sciences at the University of Calgary. The quotation is taken from their chapter in Social Determinants of Health: Canadian Perspectives.

9. Housing

Toba Bryant is an assistant professor of health studies and associate of the Centre for Urban and Community Studies at the University of Toronto. The quotation is taken from her chapter in Social Determinants of Health: Canadian Perspectives.

10. Social Exclusion

Grace-Edward Galabuzi is an associate professor at Ryerson University in the Department of Politics and Public Administration. The quotation is taken from his chapter in Social Determinants of Health: Canadian Perspectives.

11. Social Safety Net

David Langille teaches Health Policy at the University of Toronto and is the executive producer of the film *Poor no More*. The quotation is taken from his chapter in Social Determinants of Health: Canadian Perspectives.

12. Health Services

Elizabeth McGibbon is an associate professor of nursing at St. Francis Xavier University. The quotation is taken from her chapter in Social Determinants of Health: Canadian Perspectives.

13. Aboriginal Status

Janet Smylie is a physician and research scientist at the Centre for Research on Inner City Health and associate professor in the Department of Public Health Sciences at the University of Toronto. The quotation is taken from her chapter in Social Determinants of Health: Canadian Perspectives.

14. Gender

Pat Armstrong is a professor in Sociology and Women's Studies at York University. The quotation is taken from her chapter in Social Determinants of Health: Canadian Perspectives.

15. Race

Grace-Edward Galabuzi is an associate professor at Ryerson University in the Department of Politics and Public Administration. The quotation is taken from his chapter in Social Determinants of Health: Canadian Perspectives.

16. Disability

Marcia Rioux is a professor at the School of Health Policy and Management at York University and director of the York Institute of Health Research. **Tamara Daly** is an assistant professor in the School of Health Policy and Management at York University. The quotation is taken from their chapter in Staying Alive: Critical Perspectives on Health, Illness, and Health Care.

17. What You Can Do

Carolyn Bennett is an assistant professor at the Department of Family and Community Medicine at the University of Toronto. She was Canada's first minister of state for public health from 2003–2006 and is currently the Member of Parliament for St. Paul's riding in Toronto. The quotation is from her foreword to Social Determinants of Health: Canadian Perspectives.