



REDUCING HEALTH INEQUALITIES: A CHALLENGE FOR OUR TIMES



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REDUCING **HEALTH INEQUALITIES**: A CHALLENGE FOR OUR TIMES
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RÉDUCTION DES **INÉGALITÉS EN SANTÉ** : UN DÉFI DE NOTRE TEMPS

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WHAT ARE HEALTH INEQUALITIES?

Canada has one of the highest life expectancies in the world and most Canadians enjoy excellent health. But some groups are at a greater risk of poor health and experience poorer overall health than the general population.

These differences in health status are called *health inequalities*.

Beyond our *individual choices*

Our health depends on the choices we make every day about healthy behaviours—what we eat, how active we are and whether or not we smoke. But the choices we make are influenced by a complex web of social and economic factors that include our incomes, jobs, education and the neighbourhoods we live in. Further, some research has shown that things like income have an influence on our health regardless of behaviours such as diet and exercise.

IMPORTANT TERMS TO KNOW

- » **Health inequality** refers to differences in the health status of individuals and groups. The reasons for these differences range from biology and genetics to broad social and economic factors. For example, in 2001, the life expectancy for First Nations was 6.6 years less than the life expectancy for the average Canadian population.
- » **Health inequity** refers to health inequalities that are generally considered to be *unfair or unjust and modifiable*. For example, Canadians who live in remote or northern regions do not have the same access to nutritious foods, such as fruits and vegetables, as other Canadians.
- » **Health equity** is the *absence* of unfair systems and policies that cause health inequalities. Health equity seeks to reduce inequalities and to increase access to opportunities and conditions conducive to health for all.
- » **Population health approach** focuses on the spectrum of factors that affect the health and well-being of the overall population, as well as inequalities.
- » **Determinants of health** are the broad range of personal, social, economic and environmental factors that determine individual and population health.
- » **Social determinants** of health refer to a specific group of socio-economic factors within the broader determinants of health that relate to an individual's place in society, such as income, education or employment.

DETERMINANTS OF HEALTH

Health inequalities are linked to the broad range of personal, social, economic and environmental factors. These factors are called **determinants of health**.

These health determinants can have a profound influence on how healthy we will be.

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture

WHAT CAUSES HEALTH INEQUALITIES?

According to the World Health Organization (WHO), there are five main causes of health inequalities:

1. Different levels of power and resources.

Different groups in our society have different access to resources, power and influence which, in turn, affects their degree of personal control over their life circumstances.

2. Different levels of exposure to health hazards.

Some people are at greater risk of experiencing factors that can negatively affect their health, such as poor housing or working conditions that are unsafe, have high demands or offer little personal control.

3. Different impacts of exposure to health hazards.

Even when everyone is exposed to the same health risks, their health may not be affected in the same way.

4. Different impacts of being sick.

Illness and chronic disease can have a harsher impact on some groups in our society.

5. Different experiences in early childhood.

Disadvantage early in our lives can accumulate and lead to poor health throughout adulthood and old age.

IN CANADA, WHICH GROUPS ARE MOST VULNERABLE TO HEALTH INEQUALITIES?

Health inequalities exist for many populations in Canada. Here are some examples of significant health inequalities among five key groups:

People living on low-income

- » Based on most recent data, people living in Canada's highest income urban neighbourhoods live an average of three years longer than those in the lowest income neighbourhoods.
- » The poorest 20 per cent of Canada's population have more than double the chance of having two or more chronic conditions, including heart disease and diabetes, than the richest 20 per cent.
- » For the most part, the differences in health status between the highest and lowest income groups have been decreasing over time, but there have been notable exceptions.
 - » For example, in the last 10 years, the difference in death from diabetes between highest and lowest income groups increased by 40 per cent. Possible reasons for this increase include:
 - Lower income Canadians are less likely to be able to afford prescription medications and are less likely to be tested and diagnosed early.





Aboriginal peoples (First Nations, Inuit, Métis)

- » Healthy life expectancy has been improving over time for Canada's Aboriginal peoples, but significant health gaps remain—in particular, rates of unintentional and intentional injury, diabetes and infectious disease remain unacceptably high when compared to the rest of Canada.
- » Nearly one in five adults from First Nations communities has been diagnosed with diabetes—four times the rate of the general population.
- » The rate of First Nations youth suicide (10 to 19 years) was 4.3 times greater than for Canada in 2000. The suicide rate for Inuit regions (1999-2003) is 11.6 times higher than for the rest of Canada.
- » According to a recent study, 28.8 per cent of First Nations adults sustained an injury serious enough to require medical care, compared to the Canadian average of 13.1 per cent.
- » Aboriginal peoples experience higher housing overcrowding and higher tuberculosis (TB) rates than the overall Canadian population. In 2006, 31 per cent of all Inuit and 26 per cent of First Nations on-reserve lived in crowded homes, compared with 3 per cent of non-Aboriginal populations in Canada. The rate of TB in Inuit Regions was 17.9 times higher than the Canadian population.
- » In 2006, just over half of all Métis aged 15 and over reported they had been diagnosed with a chronic condition. Almost double the percentage of Métis reported asthma (14 per cent) and diabetes (7 per cent) as compared with the total population (8 per cent and 4 per cent respectively).

Canadians living in rural parts of Canada

- » 57.2 per cent of rural Canadians aged 20-64 report being overweight or obese compared to 46.9 per cent of their urban counterparts.
- » Infant mortality rates are 30 per cent higher in rural areas compared to the national average.

Immigrant groups

- » Most immigrants arrive in good health, but this diminishes over time—a pattern known as *the healthy immigrant effect*.
- » For every year in Canada, certain immigrant populations have a greater risk of developing specific chronic diseases. People of South Asian ancestry are more likely to develop cardiovascular disease while depression is more prevalent amongst Chinese immigrants, and diabetes amongst immigrants of African and South Asian descents.
- » Studies show that immigrant women do not use cervical and breast cancer screening programs as regularly as Canadian-born women. Some reasons for this can include lack of culturally and linguistically appropriate information and services, and experiences of racism in the healthcare system.

Vulnerable men and women

- » Women are more than twice as likely as men to report suffering from depression. Men are at greater risk of suicide than women in all age groups.
- » More women than men live in poverty, earning on average only 71 per cent of what men earn. Low-income can mean greater chance of premature death for men than for women.

Greater health equality has the potential to contribute to healthier children, a more productive workforce and a more sustainable healthcare system. Most importantly, it means a more equitable and just society, where *all* Canadians have the opportunity to live longer and healthier lives.

Health inequalities are linked to our position in society.

One way to think about health inequalities is to picture a social staircase:

AT THE TOP—People have access to education, nutritious food and good housing, and have the most control over their circumstances.

People at the top live longer and in better health than everyone else.

IN THE MIDDLE—People have adequate resources and control over life circumstances.

People in the middle are less healthy and live shorter lives than those higher up.

AT THE BOTTOM—People have lower education, poorer quality food, inadequate housing and little control over their circumstances.

People at the bottom are twice as likely to have a serious illness and die prematurely than those at the top.

WHAT CAN BE DONE ABOUT HEALTH INEQUALITIES?

Reducing health inequalities in Canada needs to be a shared goal. Almost every sector, each level of government, private and not-for-profit organizations, communities and individuals can contribute to reducing health inequalities and all can benefit.

The WHO recommends the following actions to reduce health inequalities:

- » **Improve living and working conditions.** Enhance supports for early childhood development and education, and ensure social protection for workers, the unemployed, the elderly and people living with disabilities.
- » **Tackle the inequitable distribution of power, money and resources.** Promote gender equity, political empowerment and human rights.
- » **Measure and understand the problem and assess the impact of action.** Collaborate at the national and international levels to evaluate the impact of policy and action on health inequalities. Train policy-makers and health practitioners, and increase public understanding through awareness campaigns.
- » **Enhance health promotion and disease prevention policies to meet the needs of disadvantaged populations including:**
 - » Improving access to health services;
 - » Reducing risks and boost protective factors such as coping skills; and
 - » Creating environments in which the healthy choice is the easy choice—for everyone.





THE PUBLIC HEALTH AGENCY OF CANADA'S COMMITMENT TO REDUCE HEALTH INEQUALITIES

The Public Health Agency of Canada's actions on health inequalities can be grouped into three overarching categories:

- 1. Mobilize collaborative action in Canada**—across governments, the community and non-profit sectors and the private sector. Collaborative, targeted policies and programs support children, seniors, Aboriginal Peoples, immigrants and groups at high-risk for chronic and infectious diseases.
- 2. Strengthen public health systems and capacity**—to focus on vulnerable groups and health determinants, and share knowledge from Canadian and international sources. The Public Health Agency of Canada equips public health practitioners and networks with evidence, training and tools on determinants of health and inequalities. The Agency ensures that health inequality reduction remains a top internal priority that is integrated into the organizational culture, policies, programs and procedures.
- 3. Global partnerships for change**—to share current knowledge and experience and advance global action to reduce health inequalities. In addition, globalization and related factors are increasingly important considerations for domestic policy and action. The WHO is a key partner.

► For more information, go to www.phac-aspc.gc.ca

“We cannot rate our collective health and well-being by looking only at those who are healthiest. We must also consider those left behind.”

– Dr. David Butler-Jones, Chief Public Health Officer of Canada



FIND OUT MORE ABOUT **HEALTH INEQUALITIES**

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