



Health inequalities in Canada: current discourses and implications for public health action

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ABSTRACT *Data concerning increasing economic inequality and its effects are increasingly becoming available in Canada. Warnings concerning the consequences of increasing economic inequality are primarily being raised within the social development sectors. The primary message is that economic inequality is creating poverty, a situation that should, on principle, be unacceptable to Canadians. The health effects of economic inequality and poverty are known to many public health professionals, but with few exceptions, public health responses are usually limited to the delivery of ameliorative programmes to those living in poverty. While federal, some provincial, and public health association documents include economic inequality as a determinant of health, discussions of the role that economic inequality plays in creating poverty, its impact upon community structures that support health, and the causes of increasing inequality are for the most part, isolated from public health discourse. Evidence of, and reasons for, resistance to such analyses and potential courses of action for addressing economic inequality and its health effects are presented.*

Introduction

There is a tradition of concern about health inequalities in Canada, but public health discussion of the explicit links among economic inequality, poverty, and health inequalities has been, and continues to be sporadic. Increased focus on these issues has been assisted by the availability of data documenting recent dramatic increases in Canada of both economic inequality and poverty. Much of the credit for highlighting these issues is due to the activities of social development organizations and progressive policy institutes with support by labour unions, rather than public health institutions. Canada also has a tradition of strong municipal involvement in community social service provision. This sector is now actively identifying the key elements of Canadian social infrastructure that support health. Yet, to date, these developments have had limited impact upon ongoing public health research and practice.

The lack of public health action on health determinants such as economic inequality and poverty is surprising given the strong health promotion tradition

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within Canada. Indeed, many government documents and statements include determinants of health concepts. Yet, most public health discourse and professional activity remains focused, with some notable exceptions, upon program delivery to low income individuals identified as being at high-risk for poor health outcomes. While there is potential for Canadian public health discourse to include the role of economic inequality in creating poverty and the sources of economic inequality, there are also potent attitudinal and structural barriers to moving in these directions.

In this paper, I consider the present state of knowledge concerning economic inequality and poverty levels within Canada, and their effects upon the health of Canadians in terms of various discourses. The state of public health involvement in these issues is considered through analysis of selected government and public health association documents and studies of public health practice. Some illustrative instances where public health has addressed structural issues related to health inequalities are presented. Means by which those concerned with economic inequality and its effect on health can move on this issue are presented.

Economic inequality, poverty, and health in Canada

Much of the information related to levels of economic inequality and poverty is collected and reported by Statistics Canada on an ongoing basis. The conceptual analysis and publicizing of these findings is usually carried out by social development organizations such as the Canadian Social Development Council, The Canadian Institute for Children's Health, the National Council of Welfare, and the child poverty advocacy organization Campaign 2000, among others.

A major recent contribution to the economic inequality debate was the researching and publication of *The Growing Gap: A Report On Growing Inequality Between the Rich and Poor in Canada* by the Toronto-based Centre for Social Justice.¹ Additional contributions have been made through the development and publicizing of measures of social health by both Statistics Canada² and The Canadian Centre for Policy Alternatives (CCPA),³ a progressive social policy think tank.

The CCPA recently published *Health and Wealth: How Social and Economic Factors Affect Our Health and Well-being*.⁴ This report brought together work on the determinants of health, the current poverty and economic inequality situation, and findings of decreasing social health in Canada. From another direction, Canadian journalist Linda McQuaig has played an important role in publicizing the role of government policy-making in creating economic inequality and poverty through best-selling books such as *Behind Closed Doors: How the Rich Won Control of Canada's Tax System – and Ended Up Richer*,⁵ *The Wealthy Banker's Wife: The Assault on Equality in Canada*,⁶ *Shooting the Hippo: Death by Deficit and other Canadian Myths*,⁷ and *The Cult of Impotence: Selling the Myth of Powerlessness in the Global Economy*.⁸ The importance of understanding the causes of inequality is a theme returned to later.

Public health discussion of economic inequality, poverty, and health has taken place primarily within government health promotion policy documents, a series

of publications by the Canadian Public Health Association⁹⁻¹¹ and other provincial health associations, and research and conceptual analyses by health sciences researchers at various Canadian universities. There is a curious disjunction however between the ideas contained within government statements and general public health practice. Some of this disjunction appears to be related to public health reluctance to become involved in social and health policy discussions, as well as the increasing influence of neo-liberal and neo-conservative ideologies on Canadian political life.

There are exceptions to this tendency as illustrated by the particularly well organized and presented report, *Social Inequalities in Health*, by the Director of Public Health for the Montreal Island health region.¹² Nevertheless, there has not been any single Canadian report focused on inequalities in health equivalent in scope or import to the *British Black, Health Divide*, or Acheson reports.^{13, 14} The recent series of papers by the Canadian National Forum on Health entitled *Canada Health Action: Building on the Legacy*¹⁵⁻¹⁸ contains extensive evidence of the importance of low income and poverty as a determinant of health yet these findings are diffused among many papers. The following section presents what is known about economic inequality and levels of poverty within Canada followed by a discussion of public health responses.

Poverty and economic inequality are increasing in Canada

Statistics Canada Low Income cut-offs are based on family and community size and identify individuals living in 'strained circumstances'. These cut-offs are often used to identify those living in poverty.¹⁹ By 1996, the poverty rate in Canada had risen to 18%, and child poverty reached a 17-year peak of 21%.²⁰ Child poverty has become somewhat of a policy focus in Canada and by 1996, 1.5 million Canadian children lived in poverty, up from 934,000 in 1989.^{21, 22} The most recent statistics from the 1996 Census indicates that provincial child poverty rates ranged from a low of 18.5% in Prince Edward Island to a high of 26.2% in Manitoba. Ontario, the wealthiest Canadian province according to gross personal product, experienced an increase in child poverty from 11% in 1989 to 20.3% in 1996. These increasing poverty levels have been well publicized with the Canadian newspaper of record, the *Toronto Globe and Mail*, carrying numerous reports documenting its increase.²³⁻²⁵

Poverty increases as economic inequality increases. I reanalyzed data from the Luxembourg Income Study²⁶⁻²⁷ and found that the relationship between degree of economic inequality within a nation as measured by the Gini index and child poverty for 16 industrialized Western nations was strong, positive, and reliable ($r=.77$).

The Growing Gap report¹ pointed out that by 1996, the 1973 21:1 pretax ratio of income between the richest 10% and the poorest 10% of families in Canada had increased to 314:1. Statistics Canada²² reported that during the 1980s the real income of most Canadians had decreased. In 1995, men reported average earnings of \$31, 917, down 5% from a high of \$33, 458 in 1980. Average income between 1990 and 1995 declined by 4% among husband and wife families and declined 8%

among lone-parent families. Yet the well off in Canada became wealthier. In Canada, the potential health-related effects of economic inequality had been kept in check by the presence of strong social programs, but since 1993 social programs have been weakened and the after taxes gap has begun to grow.⁴

Canadian studies of socio-economic status and health status

Evidence on the relationship between socio-economic status and health is sparse in Canada since socio-economic data on ill or deceased individuals is not routinely collected. What evidence is available is due to a series of analyses carried out on differences between residents of different neighbourhoods, children receiving or not receiving social assistance, and recent data from a longitudinal study of children's health.

Wilkins *et al.*²⁸ found individuals living within the poorest 20% of neighbourhoods to be more likely to die of just about every disease from which people can die, than the more well-off. These included cancers, heart disease, diabetes, and respiratory diseases among others. Wilkins and his colleagues used residence census tracts to estimate socio-economic income level. Even with the inevitable slippage that occurs since some poor people live in well-off neighbourhoods and vice versa, it was conservatively estimated that 22% of premature years of life lost in Canada could be attributed to income differences.

*The Health of Canada's Children Report*²⁹ documented the variation in health and well-being between poor and not-poor children. Some of the studies reported defined being poor as receiving social assistance, while in others it was income below the Statistics Canada low income cut-offs. Health differences were seen in incidence of illness and death, hospital stays, accidental injuries, mental health and well-being, school achievement and drop-out, family violence and child abuse, among others. In fact, poor children showed higher incidences of just about any health-related problem, however defined.

The most recent study by Ross and Roberts³⁰ brought together data from the National Longitudinal Survey of Children and Youth and the National Population Health Survey to provide evidence concerning children's health problems across the socio-economic range. They reported that children in low-income families (annual income < \$20,000) were twice as likely (25% compared to 12%) to be living in poorly functioning families as children in high-income families (annual income > \$80,000). The percentage of children in poorly functioning families also differed within the middle levels of incomes. These socio-economic differences were also seen for measures of chronic stress among parents, living in substandard housing, living within problem neighbourhoods, having less friendly neighbourhoods, and a very large number of other indicators of health and well-being.

Finally, 50% of parents earning < \$20,000 rated their children as not in excellent health; the figures for those earning > \$80,000 was 32%. In virtually every case, the incidence of difficulty was related to income across the total socio-economic range. Other evidence that bears upon the health of Canadians and its relationship

to economic inequality and poverty levels comes from studies of overall population social health.

Social health is declining in Canada

It has been argued that societies with high levels of economic inequality begin to show symptoms of societal disintegration.³¹ The form that societal disintegration takes in each society may be unique. In Britain these effects have included increased alcoholism, crime rates, deaths by road accidents and infectious diseases, lowered reading scores, drug offences, family functioning, and decreased voter turnout among others.³¹ In the US economic inequality among the states and between communities is related to levels of unemployment, incarceration, homicide, low birth weight, smoking, income assistance, use of food stamps, less spending on education, and disability.³² In Canada, relatively little attention has been paid to considering the economic inequality and health relationship beyond documenting the lower health status of those living in poverty. But there is evidence that health has been declining in Canada as economic inequality has increased.

Scores on a Social Health Index developed by the Canadian Government have been declining since the mid 1980s even as Gross Domestic Product increased during that same period.² This index of social health was developed based upon the Fordham Index of Social Health. The 15 Canadian measures include infant mortality, child abuse, child poverty, teen suicides, drug abuse, school drop-out, unemployment, average weekly earnings, persons 65 or over in poverty, out of pocket health expenses, homicides, alcohol-related fatalities, being on social assistance, access to affordable housing, and the gap between rich and poor.

While the GDP has been consistently growing in Canada from 112 billion in 1970 to 275 billion in 1995, the Social Health Index has been declining since 1979 such that by 1995 the index was at 1972 levels. Recovery in the GDP since 1982 has not been reflected in an increase in the Social Health Index. In the US the Social Health Index began to decline in 1977 and bottomed out in 1982 at a level below that of Canada. 'This raises speculation whether the social programs in Canada supported the growth (in the Social Health Index) in the seventies and whether they had a moderating effect, as the two countries have very similar contexts, except for these programs'.²

Stanford,³ in the report *Economic Freedom for the Rest of Us* commissioned by the Canadian Centre for Policy Alternatives, documented recent increases in economic inequality and decreases in equity and security in Canada and most provinces since 1990. His index is based on measures of employment, earnings, and equality and security.

Analysis of the impact of economic inequality upon community infrastructure

Federal program spending as a percentage of GDP has been decreasing since 1987 such that current federal spending is at 1950 levels.¹ These decreases have been necessitated by decreases in tax revenues resulting from modifications to the tax structure that have favoured the well-off.^{5,6} Analyses of the effects of reducing public expenditure upon community infrastructures are only beginning, but Raphael³³ has argued that one way economic inequality affects health is through reduction of services. In two community studies recently carried out in Toronto, the profound importance of community agencies and resources, and the effects of cutbacks were apparent.³⁴⁻³⁷ In *Dismantling the State: Downsizing to Disaster*, Stewart³⁸ considers the potential impact of reduced government spending on social infrastructure upon Canadian well-being.

Further analyses of the current and future states of Canadian social infrastructure should be assisted by the development of a Quality of Life Reporting System by the Federation of Canadian Municipalities (FCM).³⁹ The system was developed by the FCM and 16 large urban centres with the following rationale:

By providing a framework to monitor quality of life, the report is of value to Canadian communities and all orders of government as a tool to identify and raise awareness of issues affecting quality of life in Canadian communities; better target policies and resources aimed at improving quality of life; and to establish municipal governments as a strong and legitimate partner in public policy debate in Canada.³⁹

There were eight main indicator systems developed. These are described in this way:

1. **Population Resources Measures:** This is a profile of population characteristics, population growth, education levels, literacy levels, cultural diversity, immigration and the age structure of the population. It provides a basis for the monitoring of long-term demographic changes.
2. **Community Affordability Measures:** These measures compare levels of income with the cost of living. A higher affordability measure occurs when average incomes are relatively higher than average costs of living.
3. **Quality of Employment Measures:** These measures monitor employment dimensions and trends, such as the capacity of the labour market to provide opportunity, labour market efficiency, equity, and the distribution of employment, partial employment, and unemployment among population groups.
4. **Quality of Housing Measures:** These measures include the affordability of housing to rent and purchase (relative to prevailing incomes), percentage of homes in need of repair, and property taxes as a source of municipal revenue.
5. **Community Stress Measures:** These measures reflect social problems and they examine variables related to vulnerable groups. They include the incidence of

- low income, the number of homeless, the incidence of lone-parent families, and the incidence of various crises, including crisis calls, bankruptcies and suicides.
6. **Health of Community Measures:** These measures reflect the rate of premature deaths (before age 75) and why they occur, the incidence of and reasons for illness, the percentage of babies born in vulnerable health, and workdays lost due to illness or disability. Future revisions of the measure will include incidence of notifiable disease and will address self-rated health.
 7. **Community Safety Measures:** These measures reflect rates of crime and violence, youth crime, the rate of unintended injuries, and (in future) resident's subjective feeling of safety.
 8. **Community Participation Measures:** These measures reflect the involvement of citizens in their community, and include political participation (voter turnout), civic literacy as indicated by daily newspaper circulation, charitable giving, and support for community projects as measured by contributions to the annual United Way campaign.³⁹

These indicators are clearly consistent with emerging concepts of population health yet the connections with health have not explicitly been made by the FCM except for the health set of indicators. Findings of weakening community infrastructures through reduced public spending – a by-product of increasing economic inequality – and concomitant declines in health would be consistent with arguments that societies with greater economic inequality have weaker social safety nets,⁴⁰ an important determinant of health for all individuals, but especially the poor.⁴¹

Conceptually, Coburn⁴² has considered how both social cohesion and health effects described by Wilkinson should result from Canadian governments' increasing adherence to neo-liberal ideology and the retreat of the welfare state. Raphael³³ has built the argument that increasing economic inequality should result in decreased community infrastructure and poorer population health. Analysis of the costs of economic inequality in the areas of crime, education, productivity, and health such as those reported by Glyn & Miliband⁴³ have not yet been carried out in Canada. What has been public health responses to these developments?

Canadian discourses on economic inequality, poverty, and health

Various discourses can inform the analysis of the economic inequality, poverty, and health relationship.^{44, 45} Within Canada there are four ways by which the public health sector has framed these issues. The first discourse is a lifestyle focus whereby emphasis is placed upon the behaviours of the less well off. Labonte⁴⁶ has argued that this is the dominant public health approach towards health inequalities within Canada. This can play itself out through public health departments developing staff positions and programmes for tobacco use, physical activity, alcohol and other addictions, nutrition, sexual health, and violence prevention, among others.

The second public health discourse can be a poverty focus whereby the material and psychosocial deprivations experienced by the poor are considered.⁴⁷⁻⁵² A poverty focus can be associated with developing programs specifically directed to ameliorating the effects of poverty as well as identifying, and acting upon, the structural causes of poverty.

The third discourse considers the socio-economic and health gradient by which differences in health and well-being exist among individuals at differing levels of social class, income, or education. In this discourse the important role of public policy in sustaining and promoting economic inequality is acknowledged. The Canadian Public Health Association has been the foremost public health advocate in identifying how social and economic conditions affect health. In their *Action Statement for Health Promotion*⁵³ and *Health Impacts of Social and Economic Conditions: Implications for Public Policy*,¹¹ it brought together the most recent developments in population health and health promotion and articulated a clear, comprehensive statement of what is known about the role of the social determinants of health, including economic inequality, upon health. Interestingly, many government documents explicitly consider distribution of economic resources as a determinant of health.

The fourth way of considering the relationship between economic inequality and health is focused on how economic inequality, in addition to creating health problems for the poor and spreading the distribution of health unequally across the population, can have broad detrimental effects upon the health of communities and the entire population. In this latter analysis, economic inequality is seen as leading to societal effects that potentially injure health through a process that creates decreased social cohesion³¹ or alternatively weakens community infrastructures. Initial analyses within this discourse have been carried out by Coburn,⁴² Raphael,³³ and Townson.⁴ In light of these various means of considering the important issue of economic inequality and health, where does Canadian health policy and Canadian public health practice fall?

Canadian governments' focus upon health inequalities

Canada has a reputation as an innovator in health promotion theory and practice. In this section, I briefly review the forms within various documents that federal government concern with the issue of health inequalities has taken.

The 1974 Canadian government document *A New Perspective on the Health of Canadians*⁵⁴ was noteworthy for its introduction of the health field concept. The elements influencing the incidence of sickness and death in Canada were human biology, environment, lifestyle, and health care organization. While criticized as over-emphasizing the importance of individual choice upon lifestyle, the document was important in identifying health determinants other than the health care system.

Recommendations related to socio-economic issues were limited to assisting the 'less privileged' to improve their life style, yet it was recognized that '... economic circumstances, health education, attitudes, and facility of physical access

to health care, as well as improved pre-natal care, are the principal factors to be considered in lowering the rate of infant mortality'⁵⁴ and '... on the subject of environment, the number of economically deprived Canadians is still high, resulting in lack of adequate housing and insufficient or inadequate housing.'⁵⁴

The 1986 document *Achieving Health for All: A Framework for Health Promotion*⁵⁵ identified reducing inequities between low and high income groups as one of three major health challenges: 'The first challenge we face is to find ways of reducing inequities in the health of low- versus high-income groups in Canada.'⁵⁵ There was recognition of the greater health problems among low income groups, that 'poverty affects over half of single-parent families', and that 'more than one million children in Canada are poor'. An important means of improving health was through the co-ordination of healthy public policy, and health determinants potentially related to income differences were explicitly mentioned 'All policies which have a direct bearing on health need to be co-ordinated. The list is long and includes, among others, income security, employment, education, housing, business, agriculture, transportation, justice and technology'.⁵⁵

Current federal statements on 'population health promotion' recognize the latest developments concerning the effects of economic inequality upon health. The document 'Population Health Promotion: An Integrated Model of Population Health and Health Promotion'⁵⁶ states: 'It is not the amount of wealth but its relative distribution which is the key factor that determines health status. Likewise, social status affects health by determining the degree of control people have over life circumstances and, hence, their capacity to take action'.⁵⁶ Concern with income and social status as a determinant of health is also found in the document *Taking Action on Population Health: A Position Paper For Health Promotion and Programs Branch Staff*.⁵⁷

The most recent government statement on health was *The Statistical Report on the Health of Canadians*, released in September, 1999.⁵⁸ The report was commissioned by the Federal, Provincial and Territorial Advisory Committee on Population Health to provide a comprehensive and detailed statistical overview of the health status of Canadians and the major determinants of that status. The purpose of the report is to 'help policy-makers and program planners identify priority issues and measure progress in the domain of population health'.

The report continues the government's intellectual commitment to the role of the broader determinants of health on individual and social well being. An entire section of the report is devoted to The Social and Economic Environment and begins with the statement:

In the case of poverty, unemployment, stress, and violence, the influence on health is direct, negative and often shocking for a country as wealthy and as highly regarded as Canada.⁵⁸

Also of interest is the document's drawing upon, in a chapter on Low Income, much of the data on economic inequality, family income, and poverty levels initially publicized by social development organizations. Clearly, then, it is Canadian

government policy to consider income and social status, as well as economic inequality, as determinants of health. This emphasis upon income and social status are also found in provincial documents. In Saskatchewan, the document *A Population Health Framework for Saskatchewan Health Districts*⁵⁹ contains the statement:

While the list of these determinants of health is long and potentially overwhelming, consensus is growing that one general factor may be particularly important, and that is economic inequality. What this means is that the healthiest societies are those in which there is a relatively small gap between the best-off and the worst-off members.⁵⁹

In Prince Edward Island, the Health Promotion Framework⁶⁰ asks the questions: ‘What makes and keeps us healthy?’. Among its 11 determinants of health, the first listed is Income and Social Status followed by:

People are healthiest when they live in a society that can afford to meet everybody’s basic needs. Once basic needs are met, people’s health is also affected by how big a difference there is between the richest and poorest members of the society. When there are big differences in income in a society, there are also big differences in social status. This affects health because people with lower status have less control over their lives and fewer choices for themselves.⁶⁰

As is often the case however, as government documents have become more sophisticated in their presentation of economic inequality as a health issue, government actions frequently work at cross-purposes to these aims. The best single example is that of Ontario, Canada’s wealthiest province according to gross personal product. In a report entitled *Wealth and Health, Health and Wealth*,⁶¹ reanalysis of data from two studies obtained strong relationships between income adequacy – from the very poor to the wealthy – with self-rated health, health problems, and health service utilization. The report stated:

We conclude that efforts to create health in Ontario will not come from a narrow focus; both social and behavioural determinants must be addressed. Two sets of responses are required: policies that reduce poverty and policies that reduce the effects of poverty.⁶¹

That said, the current provincial government, first elected in 1995, brought in policies that seem designed to increase economic inequality and poverty. It froze social housing construction and ended rent controls.⁶² More significantly it managed a 22% cut in welfare payments combined with income tax cuts. Concerning these tax reductions, an analysis found those in the richest top half of 1% of families benefited by \$15, 586, while the poorest 10% of Ontario families received a benefit of \$150.¹ As a result of these policies, spending on social infrastructure has been reduced or frozen and homelessness and child poverty in Ontario have reached

unprecedented levels.⁶³ Nonetheless, economic inequality and poverty issues continue to be found within government policy documents. What then is known about public health practice as carried out by federal, provincial/territorial and local health departments and units in relation to economic inequality and poverty issues?

Current Canadian public health practice

Two recent studies considered the role of public health in addressing issues of health inequalities in general and poverty in particular. The first is a survey of current provincial public health emphases.⁶⁴ The second is an analysis of federal, provincial, and regional health projects that were specifically concerned with poverty within Canada.⁶⁵ A third study considered how public health workers, Canadian and others, respond to health inequalities.⁶⁶

Provincial ministries health practices

Sutcliffe *et al.*⁶⁴ surveyed public health practices in six Canadian provinces to determine if public health practice was consistent with Canada's perceived leadership role in the area of public health as typified by the Lalonde⁵⁴ and Epp⁵⁵ reports. Inquiry was made, through interviews with informants in Newfoundland, New Brunswick, Ontario, Manitoba, Saskatchewan, and Alberta, into the core public health functions within each province. The possible content areas and core strategies were 1) communicable disease control and health protection; 2) direct services; 3) health promotion/population health, and 4) other roles.

The survey revealed that 'Many provinces had no evidence of mandated programs that were explicitly health focused, that addressed broader determinants of health, or used multiple strategies'.⁶⁴ Communicable disease control and health protection were clearly the core businesses of public health and the population health discourse, however defined, had not resulted in mandated programming. This occurred even though all respondents recognized the importance of the broader determinants of health and identified the need for increased community input to address these issues.

Reasons given by provincial informants for this lack of public health focus included a lack of political commitment and the failure to allocate resources to population health issues. Informants expressed a concern that public health issues were being overshadowed by focus on acute and long term care services. The authors concluded:

Our findings suggest that despite the rhetoric of determinants of health, reality represents some backtracking and risks to Canada's reputation as a world leader. Careful scrutiny of appropriate mechanisms to ensure proper attention to the full array of core public health activities seems essential.⁶⁴

Study of federal, provincial and regional health projects concerned with poverty

Williamson & Grun⁶⁵ described 199 health sector initiatives that federal, provincial/territorial ministries of health, and health regions were undertaking to address poverty issues. Health Canada reported the presence of five initiatives, and the provincial/territorial ministries of health reported a total of 40 such programmes (there were 10 provinces and two territories in Canada at the time of this study). Responses were received from 98 health regions (71% response rate). Fifty of responding regions (51%) indicated they did not have any initiatives addressing poverty issues.

Four of the five federal projects addressed 'health-related issues of people in poverty (e.g., prenatal and postnatal support and education, nutrition education, early intervention)' with the other focussed on 'attending and addressing issues of poverty in planning (e.g., strategic plans, anti-poverty strategy)'. Among the provincial/territorial ministries of health, 40% of programmes were concerned with 'reducing barriers to health and/or economic burden (e.g. provision of dental care, extended health benefits, food coupons, food, clothing, housing, subsidized childcare)'. Twenty-five percent of provincial/territorial programmes focussed on 'addressing health-related issues of people' as described above. Twenty percent of provincial/territorial programmes were concerned with 'addressing and attending to poverty in planning'.

Among health regions, 37% of programmes were focused on 'addressing health related issues of people in poverty' and 29% on 'reducing barriers to health and or economic burden' as described above. Ten percent were concerned with 'addressing and attending to poverty in planning'.

Of particular interest were the number of initiatives focused on 'altering social and economic conditions contributing to poverty (e.g. job creation, lobbying to increase minimum wage, social assistance benefits)'. No federal or provincial/territorial initiatives were so oriented and only 6% of health regions addressing poverty issues reported such initiatives.

The authors categorized strategies associated with each initiative as being either organizational, community, or political. All five federal initiatives were organizational. Only five (12%) provincial/territorial initiatives were identified as involving political strategies such as the 'Ministry of Health working with other ministries to reduce poverty or its effects' or 'making policy recommendations to other ministries'. Only 7 (5%) of health region initiatives involved political strategies such as 'lobbying the government in regards to minimum wage, social assistance, affordable housing, and educating politicians regarding the determinants of health'. Williamson and Grun concluded:

Findings from this study provide evidence that the health sector is currently engaging in a variety of initiatives that address poverty. The vast majority of these initiatives focus on the consequences that poverty has for individuals and their families. While these initiatives likely play an important role in reducing the negative effects that poverty has on health,

they do little to alter the socioeconomic and political conditions that contribute to the poverty experienced by Canadians. Until these broad structural conditions are addressed and altered, efforts to improve the health of Canadians will be limited.⁶⁵

Labonte study of community health responses to health inequalities

Labonte⁶⁶ provides evidence from document analyses and key informant interviews that Canadian health workers are well aware that health inequalities are related to the presence of economic resources and related societal issues such as homelessness and unemployment. Yet, when asked as to the role of public health in addressing community health issues, responses are usually limited to lifestyle analyses and programmes.

Labonte points out that funding requirements usually limit funding to lifestyle issues. Additionally, health professionals usually see health inequalities in narrower ways than do community groups or individuals. Raphael⁶³ has argued that public health professionals are usually trained in clinical areas such as medicine or nursing and work within a discourse of individualism. Additionally public health departments and units appear, with some few significant exceptions, to be extremely reluctant to identify structural issues associated with health inequalities. This reluctance appears to have increased as a result of recent political changes.

Political influences upon public health practice

Canada has also been experiencing what has been called a 'hard right turn' in provincial governance.⁶⁷ This has been most especially striking in Alberta and Ontario. Within Ontario there have been specific consequences for public health practice. At the provincial level, public health has seen a retrenchment whereby the rhetoric of the broader determinants of health has been significantly diminished and the scope of public health practice narrowed. Additionally, some funding for public health has been transferred from the province to the municipalities with strong potential budget consequences. Public health must now compete with other city services such as policing, transportation, and roads for funding dollars.⁶³

At another level the City of Toronto, long known as a progressive leader in public health practice⁶⁸ and the source of many ideas about healthy cities,^{69, 70} has been forcibly amalgamated with the surrounding urban areas. This has been associated with a diminishing of the strong determinants of health and policy development approaches that the department had become known for. The new public health board has to date, not resumed the activist tradition of the old City of Toronto Board of Health whose chairs were usually politically progressive and sophisticated downtown city councillors.

Against the grain: public health addresses economic inequality and poverty

Nevertheless, there are some notable examples of public health efforts that address the role of poverty and, in some cases, economic inequality upon health. Most of these public health efforts are not in the published academic literature – which was reviewed in preparation for this paper – but were brought to my attention in response to a solicitation through a number of on-line listserves concerned with health promotion. The importance of these efforts is to illustrate means by which public health departments can begin to work on issues related to economic inequality and poverty issues.

City of Montreal report on social inequalities in health

In this document the director of public health presents an extensive discussion of the role that social inequalities, specifically economic resources, play in determining the health of Montrealers. ‘In actual fact, today’s socioeconomic context dictates our leading questions: What influence do living conditions, social environment and, more importantly, social inequalities have on health and well-being’.¹²

There is detailed analysis of the latest figures showing increases in poverty in Montreal, and the association of level of income with numerous indices of health and well being. Specific chapters are devoted to early childhood, youth, adults, and those over 65 years of age. In each case there is presentation of income data, the relationship of these data to health status, and means suggested for ameliorating the effects of low income upon health. As part of the section *Why Make an Issue of Poverty?* It is stated:

For anyone interested in public health, social inequalities in health must be a major concern. But we know that the solution is not to invest more in the health system or in new technologies. These inequalities must rather be met head-on; and well-targeted actions must be undertaken to ensure that they will not become worse.¹²

In the report’s final chapter, *Counteracting Poverty and its Consequences*, avenues of action open to the Department of Public Health are outlined. These actions include monitoring, research and evaluation, transmission of knowledge, regional programming, and strategic action. Concerning strategic action, this includes keeping decision-makers and public opinion informed of the department’s concerns about social issues important to the health and well being of residents. Of significance for the practice of public health in Canada is the introductory statement to this final chapter that reflects the general orientation of the entire report:

Having scanned the health and well-being of Montrealers from one end of the life cycle to the other, we note the important role played by poverty. Inequalities in health and well-being can be traced back to socioeconomic

inequalities, that is to the harsh living conditions which marginalize so many of our fellow citizens, not only limiting their access to essential goods, but depriving them as well of any meaningful role in social life.¹²

The Ontario health determinants partnership

This project is a partnership of the Association of Ontario Health Centres, Centre for Health Promotion of the University of Toronto, Ontario Prevention Clearinghouse, the Ontario Public Health Association, and the Registered Nurses Association of Ontario. An introductory letter to its *Making Connections*⁷¹ booklet states:

Our long-term goal is to build public capacity to understand and take action on conditions that make Ontarians healthy or unhealthy. Ultimately, this will lead to an increase in public pressure for healthy public policies and increased community action on the conditions that affect health in the settings where Ontarians live, learn, work, and play.⁷²

The document *Making Connections: Health is a Community Affair* highlights the importance of employment/working conditions, social support, income, housing, employment, and education/literacy for community health. It sets out community structures that support these determinants and urges community members to lobby governments to create healthy public policies. While poverty is highlighted, there is no explicit statement about the impact of economic inequality upon health.

Best start Barrie, Ontario anti-poverty initiatives

Best Start: Community Action for Healthy Babies⁷³ is a provincially funded population-based health promotion program aimed at reducing the incidence of low birth weight. While a number of community-based initiatives were seen by organizers as having an anti-poverty focus, only some had a specific dealing with the causes of poverty aspect. This information, gathered from their Internet site, indicates that a health determinants approach is part of these community-based activities.

The Municipal Tenants Network worked within a social determinants of health approach to increase residents' control over their environments. Best Start Barrie partnered with the Barrie Community Health Centre and tenants and staff of the Barrie Municipal Non-Profit Housing Corporation to develop a network primarily of tenants. Network members advocated for tenants, gained tenant involvement in management of their housing communities, and built partnerships with the housing corporation.

Think Again was developed with the Georgian Bay Coalition for Social Justice to implement a campaign to dispel myths about welfare. The campaign informed

people about the realities of poverty among the general population. Pamphlets and bus posters were placed in every city bus in Barrie during a four-month period. The campaign ended with a forum at Barrie City Hall, held on the International Day for the Eradication of Poverty.

Peel coalition against poverty

The Peel Coalition Against Poverty⁷³ worked with the Peel Social Planning Council and the Peel Health Department to develop a deputation to the regional government and a public vigil to gain the attention of political leaders who have promised to eradicate child poverty by the year 2000. The primary concern in the Peel project is to 'get at the root causes of poverty rather than deal with Band-Aid solutions'.

Nova Scotia pathways to health project

The Pathways to Building Healthy Communities in Eastern Nova Scotia Project⁷⁴ was developed by the Antigonish Women's Association, Eastern Regional Public Health Nursing Services, and the Extension Department of St. Francis Xavier University. The Pathways project adapts the story-telling technique developed by Labonte & Feather⁷⁵ for use by community members to identify components of, and the determinants of health. Community members are asked to tell stories that demonstrate some aspect of health based on personal experience. The convened group of community members then go on to summarize what happened in the story, why it happened, and what has been learned from this experience. This kind of information is used to identify relevant determinants of health, and then identify means of addressing these issues. An evaluation tool is designed to allow for assessment of success of such efforts. Analysis of stories is also carried out within the framework of determinants of health developed by Health Canada.

Building upon a recent one-day conference that explored economic inequality as a determinant of health,⁷⁶ St. Francis Xavier's University's Extension Department has organized a 'People's School on Health'. There are five workshops associated with the school entitled: Health and Empowerment; Globalization, Inequities and our Health; Health Public Policy: What it is and how can we influence it? Health Impact Assessment; and Towards Solutions.⁷⁷ To my knowledge it is the first systematic attempt to consider the origins and effects of economic inequality upon health within Canada.

Towards the future: implications for public health practice

Clearly then, there is a disjunction between Canada's tradition of progressive health promotion and ongoing public health practice. The conditions are such however,

that there is potential for increased attention to issues of economic inequality and its role in creating poverty and threatening the health of Canadians.

First, data is increasingly becoming available concerning levels of economic inequality and poverty and their effects upon health. Second, there is an active social development sector that is supported by progressive policy organizations bringing together evidence of the effects of increasing economic inequality and poverty. Third, government and public health association policy documents are increasingly highlighting the importance of economic and social factors upon health. Fourth, university researchers are increasingly analyzing the causes and consequences of economic inequality and poverty. Fifth, work by Canadian municipalities is identifying the key components of community infrastructure, many aspects of which should be related to economic inequality and health. Finally, as the effects of neo-liberal and neo-conservative policies upon Canadian community infrastructure and health become increasingly apparent, the lessons learned from experiences with such policies in the UK, New Zealand, and Australia should help in understanding and responding to these policies.

Moving on the economic inequality, poverty, and health agenda

A number of action areas can be outlined to move the economic inequality, poverty, and health agenda forward.

Develop communication between various sectors concerned with economic inequality

While there is some communication among the health, social development, policy organizations, and municipal sectors, more needs to occur. One example of such communication sees the Centre for Health Promotion of the University of Toronto's working with the Ontario Social Development Council on developing a Quality of Life Index for Ontario municipalities.⁷⁸

Additionally, Linda McQuaig, the author of many volumes on the causes of economic and social inequality in Canada, addressed the 1997 annual meeting of the Canadian Public Health Association in 1997 and the 1999 annual meeting of the Ontario Public Health Association. This year's annual meeting of the Ontario Public Health Association is being addressed by John Ralston Saul who, in his book *The Unconscious Civilization*⁷⁹ outlined the dangers associated with the rise of corporatism in Canada.

Other potential actions include the organization of interdisciplinary conferences and colloquia focused on the relationships among economic inequality, poverty and health, and the creation of collaborative working groups to highlight and publicize these issues. The Montreal Health Department's *Social Inequalities in Health* report contains many ideas for such collaborations.¹²

Contribute papers to academic and professional journals on developments in Canada and their potential for affecting the health of Canadians

There is to date little written about economic inequality and poverty effects upon health in the Canadian academic literature. This is beginning to change with increasing number of papers being published. Academics at the University of Alberta have been particularly productive in their analyses of the impact of poverty on health.⁴⁷⁻⁴⁹

At the University of Toronto, the Critical Social Science Interest Group has produced a series of papers that have examined various discourses on health including critiques of the notion of population health.^{44,80,81} Coburn⁴² has recently examined the impact of neo-liberalism on both economic inequality and health, while Raphael⁶² has outlined potential public health responses to health inequalities and considered the impact of economic inequality upon the health of Canadians and their communities.

Tarasuk^{50,51} at the University of Toronto has carried out a series of studies on food security that highlights a significant outcome of increased economic inequality and poverty: hunger. Shah⁸² has written on the health effects of unemployment and was instrumental in having the Canadian Public Health Association address the issue of unemployment.¹⁰ He also has written extensively about the health status of aboriginals in Canada, a situation that continues to be particularly problematic for Canada.⁸³

While at Dalhousie University, Travers examined the structural issues associated with hunger among low income people⁸⁴ and McIntyre, Travers and Dayle considered some of the unintended consequences of feeding programs in the Atlantic provinces.⁸⁵ At the University of Manitoba, economist Chernomas⁸⁶ has produced a monograph that examines how the different phases of capitalism have determined the health status of Canadians and the forms and distribution of illness across the population. These papers need to be publicized and more needs to be written.

Use the media to educate Canadians about the consequences of increasing economic inequality and poverty upon health

The media has been very slow to report issues related to economic inequality and poverty effects upon health. It is not particularly clear why this has been the case. One reason may be the reluctance of public health departments to highlight these issues. Also of significance is the media's continuing tendency to equate health issues with medical issues, a phenomena that was recently described in Australia.⁸⁷ Clearly, there is a need to educate media medical and health reporters of recent findings concerning the determinants of health and how economic inequality and poverty affect health.

Lobby local health departments to begin taking seriously a determinant of health approach including consideration of the importance of economic inequality and poverty

Members of all of the sectors concerned with economic inequality and poverty effects upon health should petition their local public health departments to address these issues. Most departments and units in Canada are led by citizen boards. The information increasingly becoming available should be presented to them in a manner that will lead to increased understanding of these issues and increased willingness to move on such issues.

These lobbying efforts should be accompanied by appropriate presentation of documents such as the *Ottawa Charter for Health Promotion*⁸⁸ that will help legitimate actions in the policy development and advocacy spheres. The presence of government documents that acknowledge the importance of economic inequality and poverty as determinants of health will also be useful in educating these citizen members of health departments, as well as health department staff.

Lobby governments to maintain the community and service structures that help to maintain health and well being

The work being carried out by the Federation of Canadian Municipalities³⁹ on quality of life indicators should be linked to the increasing evidence concerning the role of social infrastructure in supporting health. Advocacy and lobbying activities can be carried out to highlight the importance of infrastructure and detailing how policies that increase economic inequality both weaken these infrastructures and help to produce poverty and poor health.

Begin to understand the forces that create economic inequality and poverty

Finally, those concerned with economic inequality and poverty effects upon health must begin to educate themselves and others about the causes of economic inequality.^{89, 90} Muntaner and Lynch⁹¹ have pointed out that the research on the economic inequality and health relationship has been primarily carried within social epidemiological frameworks. The emphasis to date has been on examining the health effects of economic inequality rather than considering how economic inequality is created. The question remains of how economic inequality comes about and what are the forces that maintain and increase it?

Muntaner and Lynch argue for moving beyond 'neo-Durkheimian' theories of social cohesion towards analyses that draw upon neo-Marxist, e.g., control over productive assets and neo-Weberian, e.g., labour market position perspectives. This perspective urges health workers to look beyond ameliorative public health measures to one that will identify the processes that lead to the health problems associated with economic inequality.

Within Canada there are many resources available to assist in this analysis. Volumes such as *Richer and Poorer: The Structure of Inequality in Canada*⁹² provides background to the economic inequality issue in Canada. As noted earlier, the *Growing Gap* report¹ provides documentation of increasing economic inequality in Canada. Linda McQuaig's volumes outline the causes of inequality⁵⁻⁸ and the Centre for Policy Alternatives provides Alternative Federal Budgets⁹³ and ongoing analyses of current economic and political trends from a progressive perspective. The Caledon Institute for Policy Analysis has also been carrying out a series of studies that have examined the impact of spending cuts upon Canadians' well being.⁹⁴ Coburn's⁴² analysis of the role of neo-liberalism in creating economic inequality is especially timely and reflects the increasing interest in these issues among university health science academics.

While some initial beginnings have been made in bringing together some of the economic inequality, poverty, and health literature, this information needs to be consolidated, shared with others concerned with the health of Canadians, and linked with effective ongoing action to improve health. Most importantly, Canadian public health workers have to become reacquainted with the basic principles of health promotion and begin to seriously address the determinants of health in their practice.

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