The State of Health Equity in Ontario

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Introduction

Working towards health equity is about creating the circumstances where avoidable differences or inequalities in health – that is health inequities -- among groups are reduced and eventually eliminated (Braveman & Gruskin, 2003). There is increasing consensus that the key path towards health equity is creating public policy that strengthens and makes more equitable the distribution of the social determinants of health, that is the living and working conditions that are the primary factors that shape health outcomes (World Health Organization, 2008).

Social determinants of health refer to the economic and social conditions that shape health and create health inequities (Raphael, 2009). They include amount of income, quality of employment, working conditions, and features of housing. When these factors are inadequate, they contribute to material deprivation, stress, a higher likelihood of adopting health threatening coping behaviours, and lower levels of access to quality health care, among other things (see Table 1). Canada's distribution of the social determinants of health is among the most unequal of wealthy developed nations (Bryant, Raphael, Schrecker, & Labonte, 2011). In this chapter, I detail the current state of health equity in Ontario and recommend ways to address health inequity through public policy action.

Table 1. The Social Determinants of Health

Aboriginal Status	Health Services
Disability Status	Housing
Early Life	Income and Income Distribution
Education	Race
Employment and Working Conditions	Social Exclusion
Food Security	Social Safety Net
Gender	Unemployment and Employment Security

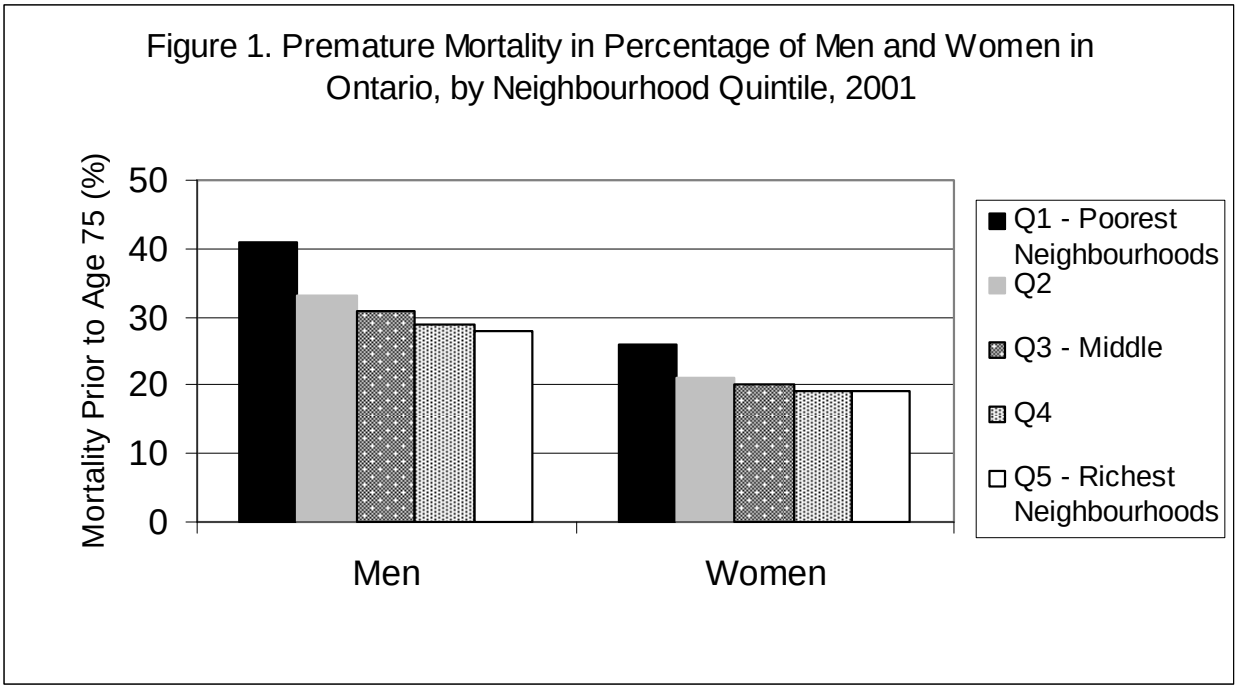
Source: Mikkonen, J. and Raphael, D. (2010). Social Determinants of Health: The Canadian Facts. Toronto: York University School of Health Policy and Management. Available at http://thecanadianfacts.org.

The Health Gap in Ontario

There is an extensive literature on health inequities in Ontario (Gardner, 2010; Project for an Ontario Women's Health Evidence-Based Report, 2012). Health inequities exist for life expectancy, infant mortality, and mortality rates from a number of diseases among those differing in incomes and living in urban versus rural settings. There are also income-related inequities in incidence and prevalence of various diseases and injuries. Two illustrative examples of such inequities are provided here: a) premature mortality prior to age 75 as a function of income, and b) differences in incidence of injuries among Ontarians of differing ages and income.

Differences in Mortality Prior to Age 75

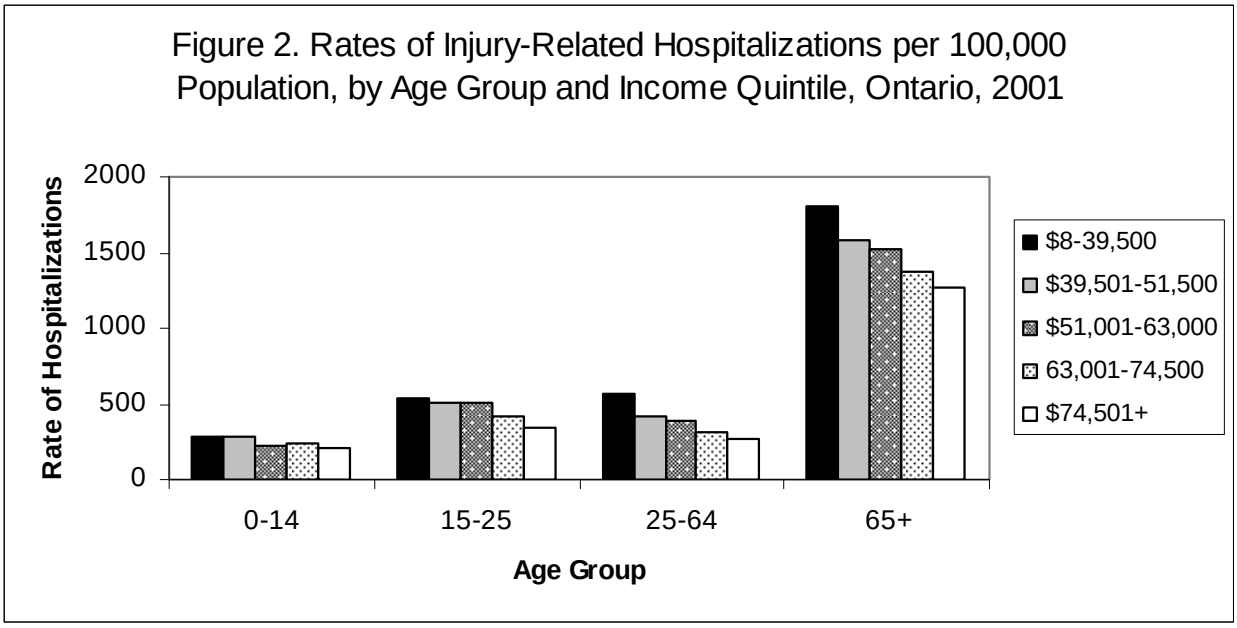
One study provides data on premature mortality (percentage of the population who died before age 75) by gender and neighbourhood income quintile in Ontario for the year 2001 (Project for an Ontario Women's Health Evidence-Based Report, 2012)(see Figure 1). Premature mortality is distinctively higher among residents of the poorest 20% of Ontario neighbourhoods. The lowest-income men have a 41% chance of dying before age 75 while the best-off men have a 28% chance. This 13% absolute difference translates into a relative greater risk of dying prior to age 75 for the lowest income men of 45% using the best-off group as a base-line. For women, the absolute difference of 7% between the lowest income women (26%) and best-off women (19%) converts into a 35% greater risk of dying prior to age 75 for the lowest income women.



Source: Power Study (2012).

Differences in Injuries as a Function of Age and Income

Profound differences in injuries are seen in Ontario between those of differing incomes. Figure 2 provides rates of injury-related hospitalizations per 100,000 population, by age group and income quintile in Ontario for the period 2002/03 (Macpherson et al., 2005). Amongst the youngest age group, the rate for hospitalizations for the lowest income group (287/100,000) is 35% higher than for the most well-off group (213/100,000). Among the oldest group, the hospitalization rate for the lowest income group (566/100,000) is 42% higher than for the most well-off group (1269/100,000). These inequities in health status as a function of income are seen for just about every disease or affliction. Further examples of health inequities in Ontario including inequities in access to health care are available (Raphael, 2012).

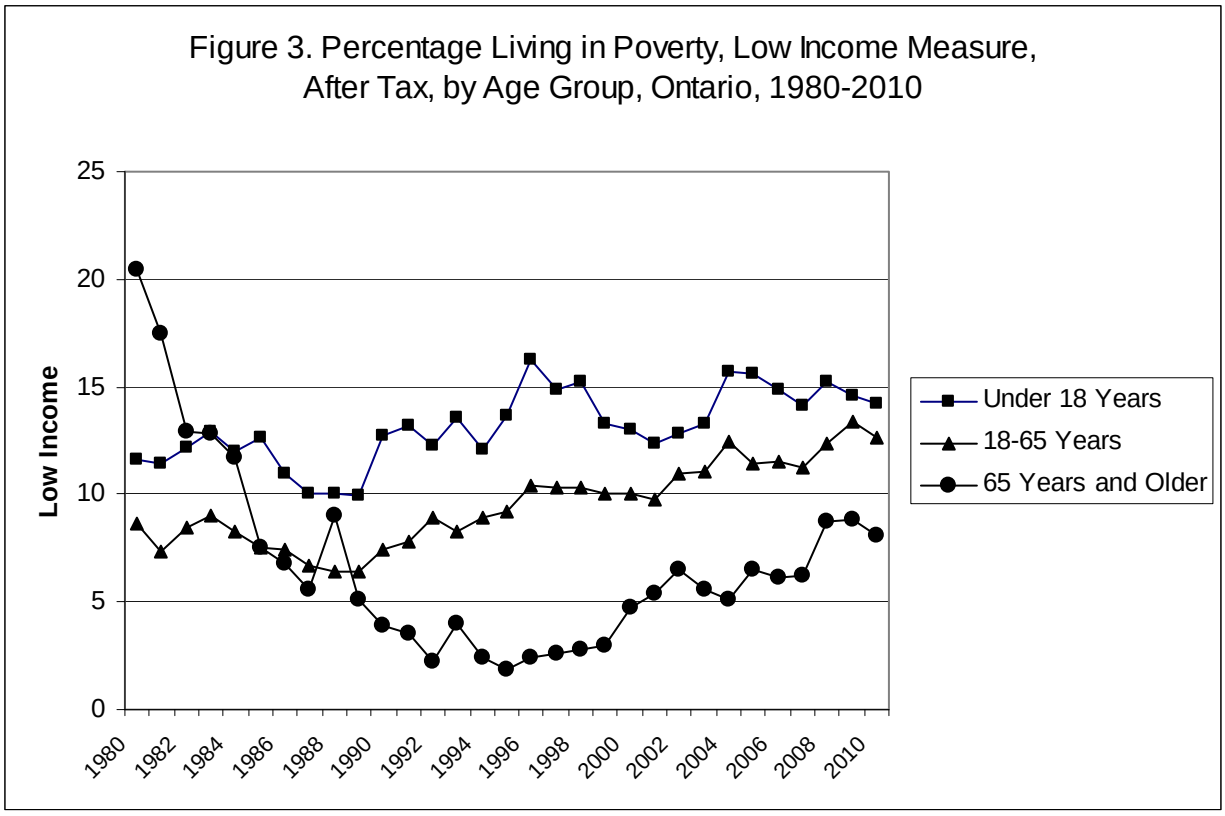


Source: Macpherson, A. K., Schull, M., Manuel, D., Cernat, G., Redelmeier, D. A., & Laupacis, A. (2005). *Injuries in Ontario. ICES Atlas.* Toronto: Institute for Clinical Evaluative Sciences.

Factors Driving these Health Inequities in Ontario

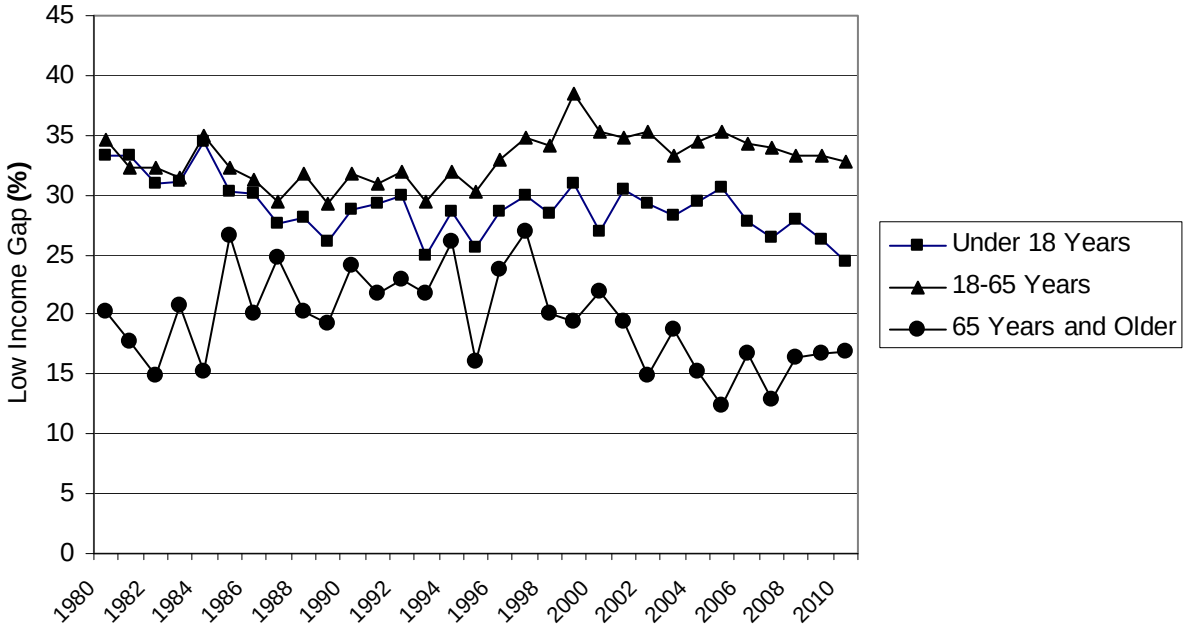
Consistent with the social and health inequalities literature the World Health Organization argues that health inequities result from the inequitable distribution of power, money, and resources. A good indicator of these inequities is the poverty rate, a situation that reflects the inequitable distribution of monetary resources. Figure 3 provides evidence of the extent of poverty among Ontarians across the life span using the after-tax LIM, a measure that signifies people having less than half the average income of others as being in a situation that denies access to the resources necessary for health.

Poverty rates for Ontario children are above 14% and rates across all age groups have been increased since the mid-1990s. The trend for those over 65 years is particularly striking with their rates growing to close to 10% after the lows of 4% seen during the mid 1990s. Canada – including Ontario -- is one of the very few wealthy developed nations whose poverty rates for children are higher than for the general population, a finding noted by UNICEF in its most recent report on child poverty (Innocenti Research Centre, 2012).



An important question concerns how much on average those identified as living in poverty are below the poverty line. Are poor people in Ontario just below the poverty line or are they very much below? Figure 4 provides a measure of how far below the poverty line people in Ontario living in poverty are as a percentage of the poverty line. The gap is rather large. For poor children the gap is currently is 24%, for adults aged 18-65 it is 33%, and for those older than 65 years, it is less, at 17%. For adults aged 18-65, these figures show little change since 1980 but for children there has been a lessening of the poverty gap. For seniors there is a slight decline during this period but note that the poverty rate for seniors has been increasing. Poverty rates are closely related to extent of income inequality within a jurisdiction and evidence shows that income inequality is on the rise in Ontario (Raphael, 2012).

Figure 4. Low Income Gap, using the Low Income Measure, After Tax, by Age Group, Ontario, 1980-2010



Promoting Health Equity in Ontario

The World Health Organization suggests that health equity can be promoted by improving living conditions by considering health equity in all policies, systems, and programmes. This includes promoting fair financing and market responsibility such that no one is denied the economic and social resources necessary for health. Raphael (2012) suggests that these immediate steps would help create living conditions that would reduce health inequities in Ontario.

- Raising minimum wage, social assistance and child benefit levels to a level that would assure health;
- Improving working conditions and employment standards and making it easier for workplaces to unionize;
- Creating a fairer tax system;
- Providing an affordable regulated childcare system;
- Ensuring affordable healthy foods and adequate housing;
- Including a consideration of health impacts when developing economic and other policies;
- Ensuring public support through raising awareness for a health equity agenda.

Building Long-Term Commitments

Currently, the political context in Ontario is not one that easily aligns with the promotion of health equity through public policy action. The Health Council of Canada provides an analysis of what is needed to have governments address health inequities through a Whole of Government approach (Health Council of Canada, 2010). The checklist specifies what values, information, and government infrastructure would be needed to tackle health inequities in Ontario (see Table 3). Without such commitments, we can expect little government action to address health inequities through public policy action.

Table 3. The Health Council of Canada's Checklist for Whole-of-Government or Intersectoral Approach to promoting Health Equity

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The checklist on this page synthesizes key pieces of information from Canadian and international reports and documents about implementing intersectoral and whole-of-government approaches; our consultants' experience working with Canadian governments, agencies, and organizations; and the information gathered from interviews with officials from across Canada.

Values and Commitment

- An overriding philosophy that health initiatives will be viewed through a population health lens.
- Leadership at the top from the prime minister, premiers, ministers, cabinet secretaries, and others.
- Recognition and awareness among elected representatives of the importance of the determinants of health for promoting population health and reducing health inequities.
- Recognition that it may take years, even decades, for benefits to materialize.
- Willingness to name the difficult problems and barriers that exist, and to provide the resources necessary to transcend them.
- Commitment of civil servants to undertake a broader approach to addressing population health and reducing health inequities.
- Willingness and commitment to ensure a structural approach to placing health projects on the public policy agenda.
- Allocation of significant funding that allows for governmental commissioning of research, analysis, and policy implementation.

Information and Data

- Decisions should be made and actions taken based on available evidence without necessarily waiting for conclusive evidence.
- Information and evidence on the state of population health and the presence of health inequities is presented in a government-instigated integrative report or statement.
- Development of clear, identifiable, and measurable goals and targets.

- Focusing on explicit concrete objectives and visible results. Ensuring transparency in governmental efforts and activities.
- Messaging to the public, including media support, about the importance of dealing with population health and reducing health inequities through action on the determinants of health.
- Development of practical models, tools, and mechanisms, such as health impact assessment, to support the implementation.
- Setting of realistic timelines.
- Support for academic and agency researchers who provide data and evaluation.
- Provision of ongoing public reports that document successes and challenges.

Governmental Infrastructure

- Governments must establish the means for society's participation in the initiatives.
- Establishment of an independent authority within government that will be responsible for coordinating activity across ministries and departments.
- Cross-ministry structures and processes that provide a basis for these kinds of whole-of-government or intersectoral approaches.
- Contacting and drawing support from various external organizations that would be responsive to governmental action on the determinants of health.
- Government civil servants' capacity to carry out the task.
- Ensuring that leadership, accountability, and rewards are shared among partners.
- Provision of adequate resources to sustain activities beyond the tenure of the present governing authority.
- Establishment of a balance between central direction and discretion of local authorities to implement goals and objectives.
- Establishment of accountability and evaluation frameworks.
- Building of stable teams of people who work well together, with appropriate support systems.

Source: Health Council of Canada (2010). *Stepping it Up: Moving the Focus from Health Care in Canada to a Healthier Canada*, p.25. Toronto: Health Council of Canada.

Unfortunately, there is little evidence that governing authorities – or opposition parties for that matter – are concerned with addressing health inequities and the conditions that create them. There is however grass-roots activities on the part of the public health community to draw public attention to these issues. Local public health units across Canada are engaging in public education activities (Raphael, Brassolotto, & Baldeo, 2014) One public health unit in Ontario created a video animation *Let's Start a Conversation about Health and Not Talk about Health Care at All* (Sudbury and District Health Unit, 2011) that has been adapted for use by no less than 14 other public health units in Ontario (out of the total of 36).

Mikkonen and Raphael created the public primer *Social Determinants of Health: The Canadian Facts* that has been downloaded over 200,000 times since April 2010. Eight five percent of these downloads by Canadians (Mikkonen & Raphael, 2010). And a new Canadian organization *Upstream Action* aims to create a movement to create a healthy society through dissemination to the public – as well as policymakers -- of evidence-based, people-centred ideas

(Upstream Action, 2013). Hopefully, these activities will create a groundswell of public interest and concern that will force Ontario to take seriously the issue of addressing health inequities.

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