The Health Determinants Partnership
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Are Widening Income Inequalities Making Canada Less Healthy?

Executive Summary

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Executive Summary

For most of the 20th century, Canadians have enjoyed continuously improving standards of health – including dramatic reductions in infant mortality, and large increases in life expectancy. But these health gains have not been shared equally: there still exists a large gap in health standards between the rich and the poor. Literally hundreds of scientific studies have established that an individual's socio-economic status (income, education, occupational status, etc.) is a powerful determinant of their health. But these health differences are not only a matter of concern for the poor. At each level of income or education, greater socio-economic status confers greater health.

Key Message #1: Social and economic factors strongly influence the health of all Canadians and such factors can be modified by social and economic policy.

The 'social gradient in health', as it is known, implicates everybody across the social spectrum, and its effects are large. Studies have shown that the influence of socio-economic factors on health outweighs other conventional factors, including access to curative health care, health behaviour modification (diet, exercise, etc.). In addition, for all but a few, very rare, single-gene diseases, social and economic environmental factors have been shown to interact with gene expression. It follows from the research evidence that policy levers, which would reduce inequality and improve living standards for all Canadians, and especially the poor, could narrow the large gaps that exist in standards of health across Canadian society. This would allow us all to share more equally in overall health gains.

This report gives an overview of the evidence base for the social gradient in health, demonstrates the strong trend towards greater social and economic inequality in Canadian society in the 1990s, and draws policy recommendations from these findings. The report also goes one step beyond the social gradient and extends the analysis by considering the relationship between the overall degree of income inequality in a society and its relationship to average health in that society. This question arises from international evidence, which suggests that when we consider the macro-level determinants of health in the affluent, industrialized societies, countries with a wider distribution of income have poorer health status, even after adjusting for the overall wealth (GDP per capita) of each country.

Key Message #2: Societies with a greater gap between rich and poor may have poorer overall health. Canada appears to have some attributes, which protect it from some of the impacts of provincial- and metropolitan-level income gaps.

More recently, a number of population health researchers have directed their attention to the relationship between indices of overall income inequality and average population health *within* affluent, industrialized countries. One such study compared Canada and the United States in 1990. Both countries demonstrate a strong social gradient in health, meaning that

individuals with higher incomes and better education have better health. But when the relationship between overall state/provincial income inequality and population health was analyzed, a different result was seen in the two countries. In the United States, greater inequality was strongly associated with higher premature mortality (poorer population health) in U.S. states, while in Canada, overall provincial income inequality was only very weakly associated with higher provincial mortality (poorer population health), and in Canada the association was not statistically significant.

At the metropolitan level (cities with greater than 50,000 population), a similar result was seen. In the United States, greater income inequality at the metropolitan level was strongly associated with higher premature mortality (poorer population health) in U.S. states, while in Canada, overall metropolitan income inequality was not associated with higher provincial mortality (poorer population health) at all. These Canada-U.S. differences at the population level exist despite a strong, clear socio-economic gradient in health for individuals in both countries.

Key Message #3: Canadians cannot afford to be complacent about income inequality in our society. The 1990s witnessed a dramatic widening of the gap between rich and poor, a substantial reduction in entitlements to social benefits, and an under-investment in human capital. If the United States can be used as a weather vane, the health effects of population-level inequality may already be on the way.

One possible explanation for the difference in the relationship between income inequality and population health in Canadian and American metropolitan areas and states / provinces is that there is just not enough inequality in Canada to produce such relationship at the metropolitan or provincial level. This hypothesis has been tested and dismissed: when all U.S. metropolitan areas with greater inequality than the worst Canadian city are excluded from the analysis, U.S. metropolitan areas still show a relationship between income inequality and population health.

But this does not mean that income inequality is not a health problem in Canada. At all levels of the social ladder, greater income (and education) is associated with better health. Yet, indices of overall inequality didn't show a relationship with health in Canada, at least not in 1990. But since 1990, income inequality in both Canada and the United States has widened substantially. Section B of this report documents the dramatic increases in inequality seen in both Canada and the United States over the 1990s. Although it won't be possible to determine if widening inequality in the 1990s has had an impact on the health of Canadians until 2003 when the census 2001 data are released, there is strong evidence that inequality widened substantially over this time.

Key Message #4: A commitment to social and economic equity may enhance economic growth and competitiveness. Research evidence does not support the claim that social policies, which produce equality, undermine economic growth.

Even if one accepts that widening income inequality may be compromising the health of Canadians, many argue that we couldn't possibly afford to take measures to reduce inequality because it would necessarily compromise economic growth. It is commonly believed that greater inequality is the price we must pay for economic growth and maintaining competitiveness in attracting investment to Canada. But this belief is founded on very little evidence. There is now very good evidence, as is described in Section B of the report, that *greater inequality often undermines economic growth* in affluent, industrialized economies. One of the reasons for this is that where there is a wide distribution of income, people of lower income have less opportunity (no money) and less incentive (no hope of upward mobility) to invest in their own human capital, for example through education.

A similar belief is that Canada simply cannot afford to pay for a universal health system, high quality, universal elementary and secondary education, affordable university education, and social services and still hope to remain competitive in attracting investment and business. Again, this belief has little foundation in fact. There is good research evidence that the Canadian health care system, for example, *saves* industry a considerable amount of money in benefit costs because the single-payer, public system is able to provide health insurance at a much lower cost. Indeed, it follows that if benefit costs are lower in Canada than the U.S., we will be more competitive.

Key Message #5: Traditionally, Canada's system of progressive taxation and strong 'public goods' (e.g., public infrastructure, health care, education) has been instrumental in ensuring an equitable society, providing us with a high quality of life, and producing high standards of health. The United States, by comparison has a poor record in these areas. The public goods Canadians enjoy are in decline and any further loss may have the potential to undermine our health.

There are several hypotheses that might explain Canada's advantage over the U.S. in the relationship between population-level income inequality and population health. The report reviews these in Section C and finds that the factors which could most likely account for such a finding include: progressive taxation systems, universal health care, more equal access to primary, secondary, and post-secondary education, and race. While each has its merits, the report highlights two key points: the importance of universal access to primary care (family physicians) free of cost and the influence of progressive taxation systems and universal public services in redistributing non-cash benefits.

Health care is an important difference between Canada and the United States, not so much because Canadians have access to life-saving technology, but more so because they have access to primary care. If there is a financial disincentive to seek care when someone is sick, they will wait until their symptoms are intolerable before seeking care (indeed, many Americans are only insured for catastrophic costs), and by this time they are typically much

sicker and may face a poorer prognosis. It also tends to be more costly to treat patients once their symptoms have become quite severe, because they are more likely to require things like lab tests and referrals to specialists, which are expensive.

But moving outside the formal health care system, where it is believed most of the key determinants of health in Canadian society lie, this report argues that the key difference between Canada and the United States is that because of the high level and quality of 'public goods' (goods and services everyone receives free of cost, like health care, education, safe streets, municipal infrastructure, public recreation, etc.) that all Canadians receive to support them in achieving a high quality of everyday life. In U.S. metropolitan areas there are wide disparities in public goods and quality of life between the best neighbourhoods and the worst neighbourhoods – much wider than in Canada. This report argues that such disparities are caused by the way cities are governed and the way tax revenues for municipalities are raised in the U.S.

In the U.S. municipal governments are responsible for more services than in Canada and municipalities must use regressive tax instruments (the poor pay a greater proportion of income to such taxes: e.g., sales tax, user fees, property taxes, etc.) to generate the revenue to deliver those services. Coupled with the high degree of municipal fragmentation in U.S. metropolitan areas, this means that municipalities with wealthy people are able to offer good services at low cost, while municipalities with many poor people can only offer poor services at high cost. Such a situation creates wide disparities in the bundle of public goods received by different areas of the city, much wider than in Canada. This report argues that this may partly explain why metropolitan level income inequality is strongly associated with population health in the U.S. but not in Canada.

It is valuable to consider the value of universal public goods to be 'non-cash benefits' and to recognize that in Canada enjoys a more generous bundle of public goods, which tend to be funded by tax instruments, which are progressive (i.e., they better reflect ability to pay), whereas the United States is the opposite. This means that inequality in total *effective* income (cash income plus the value of all public goods received) is much greater in the U.S. than implied by cash income inequality and in Canada, inequality in effective income is much lower than inequality in cash income.

Key Message #6: Poor health, illness and disease have substantial economic costs, both in terms of direct expenditures on services (health care, etc.) and in terms of indirect costs resulting from lost productivity. These costs may be significantly exaggerated by the existence of strong socio-economic inequalities in health.

While there are few studies which directly estimate the social and economic costs of socio-economic inequalities in health (mainly because of a lack of data which would allow such an analysis), there is good evidence that many of the major causes of death (heart disease, cancer) and disability (mental illness) in Canadian society are much more common in people of lower socio-economic status. In Section D, the report reviews the evidence on the

direct and indirect costs of the major causes of mortality and morbidity in Canada, with a special emphasis on the economic burden of mental illness.

It is likely that increasing income inequality and rising poverty have a detrimental effect on mental health, and recent studies suggest that this will translate into substantial direct and indirect costs. The Business and Economic Roundtable on Mental Health estimates that over the next 20 years, depression will disable more people than AIDS, cancer and cardiovascular disease combined in Canada. They also estimate that the economic cost of mental disorders ranges from $8 billion a year in Canada to what former Finance Minister Michael Wilson, Honorary Chairman of the BECRMH, says may be twice that figure, or 13.8 per cent of the net operating income of all business enterprise in Canada. Such figures provide a powerful argument for taking action to take drastic action to address the root causes of the common mental disorders, especially depression and anxiety.

Message #7: There are readily identifiable policy levers, which could make a substantial difference to reducing health inequalities and protecting our health advantage over the United States.

The final section of this report develops five key public policy principles which follow from the analysis of the health inequalities, in terms of the individual-level relationship between socio-economic status and individual health, as well as the relationship between the degree of population-level income inequality and population health. The public policy principles recommended include: 1) invest in human capital; 2) improve working conditions and reduce unemployment; 3) enhance 'public goods' and invest in infrastructure to support a high quality of life for all Canadians; 4) prioritize 'progressive' sources of public finance and reduce dependence on 'regressive' sources of revenue; and 5) strengthen programs and services which redistribute cash and non-cash benefits from wealthier households to poorer ones.

Concluding Comments

Canada enjoys a quality of life and a standard of health that is the envy of the world. We have, by world standards, safe streets free of violence, high standards of health and well-being, good employment standards, very good housing standards, and a rich endowment of recreational, cultural and social facilities and opportunities. These are the products of substantial investments in human, social and physical capital over a long period of time. As of 1991, our stock of public goods may have insulated us from possibly corrosive health effects of widening income inequalities. Those inequalities have widened over the 1990s, eroding investments in public goods, and undermining individuals' ability to invest in their own human capital, especially for individuals of lower socio-economic status. As a matter of prudence, it is important that Canadians support policies that protect and enhance the substantial stock of public goods we enjoy. Our very health and quality of life may depend on it.