In 2008, the Population Health Promotion Expert Group (PHPEG) of the Pan-Canadian Public Health Network (PHN) commissioned a synthesis of the following population health reports that were released in 2008:

1. Closing the Gap in a Generation: Health equity through action on the social determinants of health, World Health Organization, Commission on Social Determinants of Health, released August 2008
2. The Canadian Census Mortality Follow-Up Study, Statistics Canada, August 2008
3. Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada, Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information (CIHI), released November 2008
4. Report on the State of Public Health in Canada: First Annual Report, Chief Public Health Officer of Canada, Public Health Agency of Canada, released June 2008
5. Poverty and Chronic Disease, Chronic Disease Prevention Alliance of Canada, released April 2008
6. Healthy People, Healthy Performance, Healthy Profits, Conference Board of Canada, released December 2008

The purpose of this synthesis is to summarize the key themes and findings of the original authors. The material summarized in this report and any opinions that may be expressed by the author do not necessarily reflect the official views of the PHN, the PHPEG, the Provincial/Territorial jurisdictions, or the Public Health Agency of Canada.

Closing the Health Gap: Synthesis of the Significant Population Health Reports of 2008

Executive Summary

The next revolution in health improvement in Canada is within the reach. The number of people afflicted with chronic diseases and injuries can be greatly reduced. Life expectancy can be extended and premature deaths delayed. Hospitalizations rates can go down, as can the number of people with drug addictions and mental illness. The general health and wellness of the least healthy Canadians can improve. Moreover, the health and wellness of future generations can be enhanced, reducing or preventing the likelihood that the children of today, and the unborn children of tomorrow, will experience chronic diseases, injuries, addictions and other health afflictions.

But this dramatic health improvement will not come from spending more money on our existing health care systems of hospitals, doctors, nurses and other acute care health services, which already takes up the largest single portion of provincial and territorial government spending, rising from 32.7 % of program expenditures in 1993 to 39.2 % by 2007.[1] Rather it will come from addressing the determinants of health – the social, economic and environmental factors that greatly influence why some people and some populations are healthy and others are not. The determinants of health include income, employment, education, literacy, housing and the built environment, the natural environment, early childhood experiences, food security, social supports, access to preventive health services and general empowerment over the choices in our lives.

It is now abundantly clear that populations with the most resources – the highest incomes, most education, good housing, good neighbourhoods, good jobs, high personal empowerment etc – consistently have the best health and live the longest lives. Those with the fewest resources – the lowest incomes, poor education, bad housing and unsafe neighbourhoods, little or no employment, poor early childhood experiences, little empowerment etc. have the worst health and the shortest lives. The 'health gap' between the most and least healthy is large in Canada, as it is elsewhere. Where it is not only avoidable and preventable, but is also considered unjust or unfair, it is considered to be a health inequity. Such inequity is a significant public health issue and a societal concern.

The population that falls in between these extremes line up in a distinctive step-wise gradient of increasingly better levels of health based on each step up the socio-economic staircase. These observable differences from top to bottom translate into an additional burden of disease that is carried by those lower down the scale. That greater burden of disease and injury not only causes excess harm to those who suffer from it and their families, it also both places additional demands on the health care system – thus increasing costs – and reduces productivity in the workplace. This distinct gradient is also relevant because research is now clear that every action taken that creates an increment of improvement up the ladder of SES can translate into improved health status.

In 2008, six key reports, one international and five Canadian, added tremendous weight and momentum to the 35 years of international and national research and reports examining and attempting to address the pervasive influence of the determinants of health. These reports were:

[1] Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2008. pg. 46*

1. ***Closing the Gap in a Generation: Health equity through action on the social determinants of health -*** World Health Organization, Commission on Social Determinants of Health, released August 2008;
2. ***The Canadian Census Mortality Follow-Up Study*** Statistics Canada, August 2008
3. ***Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada,*** Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information (CIHI), released November 2008
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6. ***Healthy People, Healthy Performance, Healthy Profits,*** Conference Board of Canada, released December 2008

These reports, while each presenting a unique facet of the health inequity picture, share a number of key themes and findings. A more detailed discussion of the individual findings and some of the key recommendations of each of these reports occurs in the pages of this synthesis document. Each of the reports also give some compelling examples and fascinating evidence of the determinants of health at work. Taken together, however, they create an encompassing picture of the current understanding and wide range of evidence around the determinants of health and a consensus for action we need to take now to improve health in the future. The documents all share:

- A common understanding of what constitutes the major determinants of health: income, education, employment, literacy, housing, and the built environment, sanitation, air and water quality and the state of our global life support systems, early childhood experiences, food security, social supports, access to preventive health services and general empowerment over the choices in their lives.
- A common and increasingly robust set of evidence that the unequal distribution of the determinants of health is undermining the health of millions of Canadians and costing our economy, in particular causing significantly higher mortality rates, and higher rates of chronic disease among those with lower socio-economic status, with resultant increases in the utilization and costs of health care and lost economic production.
- A common understanding that the population groups most affected in Canada are those at the lowest 20 % of annual income, children in poverty, lone-parent families, new immigrants, and the Aboriginal population.
- A common understanding that while the gap between the most and least healthy is a matter of great concern, the unequal distribution of health across the gradient also has a significant cost in lost lives, worse health and higher costs, and that reducing the gradient is also of importance.
- A common concern that some trends are worsening, particularly unemployment, food insecurity and the size of the gap between the richest 20% of Canadians and the poorest.
- A common understanding that Canada can do better, particularly when we compare our progress on these issues with the Nordic countries. Evidence even from poorer countries like Cuba, China and Costa Rica show that health gaps can be reduced by better support for early childhood development, education of children and youth, and equal access to preventive health services.
- A common call for the need for greater leadership and understanding by the Canadian public, media, health advocates, politicians and corporate leaders about the power of the determinants of health and the need to start better addressing them now.
- A common call for coordinated research and dissemination of findings, drawing on 30 years of increasingly sophisticated research, the need to continue to support research and pilot projects, to evaluate interventions, and to spread the word about successful programs.

- A common understanding that while some research is still needed, enough convincing evidence has accumulated over the last 30 years for action to be taken now. Some of the interventions could include increasing minimum wage rates and social insurance rates, greater support to early childhood development initiatives particularly aimed at children in poverty, support and encouragement for business to address the health determinants, and to focus initiatives such as creating affordable housing, providing better access to higher education, increasing literacy, fostering supportive social networks at the community level, and reducing the impact of child poverty.
- A key message coming out of all the reports is that inequalities in the distribution of the determinants of health across society and in communities are pervasive and damaging, but that this can be addressed through policy, program and community-level interventions.

The next revolution in health improvement is indeed within the grasp of Canadian society. But we must start now to focus investments and actions "upstream" from the health care system, in the basic systems, environments and structure of our society - and in the settings where we live, learn, work and play - to promote more equality of opportunity and less societal disadvantage. Investment in the determinants of health is an investment in the future good health of our society.

Health Determinants Fact Sheet

- The determinants of health include: income, education, employment, literacy, housing, and the built environment, sanitation, air and water quality and the state of our global life support systems, early childhood experiences, food security, social supports, access to preventive health services and general empowerment over the choices in their lives.

- The unequal distribution of health determinants creates differences in levels of health that can be seen playing out time and again, across all nations and across all settings – homes, schools, workplaces and neighbourhoods.

- Those with the most resources – high incomes, the most education, good housing, good neighbourhoods, good jobs, high personal empowerment, etc. – consistently have the best health and live the longest lives. Those with the fewest resources – with low income, poor education, bad housing and unsafe neighbourhoods, little or no employment, part-time or unhealthy jobs, poor early childhood experiences, little empowerment, etc. – have the worst health and the shortest lives. This constitutes a 'health gap'.

  - A conspicuous health gradient exists so that at every level of improved socio-economic status (SES), health status likewise improves, so there is a difference even between the highest and the next highest level. This gradient is of concern, because every step down represents an additional burden of disease, and in total represents a very significant burden of disease. To the extent that these differences are preventable and avoidable, they are also a significant public health issue and a societal concern. This distinct gradient is also relevant because research is now clear that every action taken that creates an increment of improvement up the ladder of SES can translate into improved health status.

Evidence for the health determinants impact

- Canadian aboriginal men live 7 years less than other Canadian men and Aboriginal women 5 years less than other Canadian women.[2]

- While the Canadian infant mortality rate has steadily dropped over the last 4 decades from 27 per 1000 births in 1960 to just 5 per 1000 in 2004, Japan and Norway have the lowest rates at 3 per 1000.

- In Canada, 11.7 % of children under 18 were living in poverty down from a peak of 18.6 % 1996, yet this is almost triple the average rate of the Nordic countries (4%).

- The recent Statistics Canada Census Mortality Follow-Up Study (1991-2001) found the highest mortality rates in Canada were among people with less than secondary graduation, those who were unemployed or not in the labour force, those in unskilled jobs, and those in the lowest income brackets. The lowest mortality rates occurred among the university-educated, the employed, those in professional and managerial occupations, and those in the top income brackets.

- The same study found only 51% of men in the poorest one-fifth of the income distribution were expected to survive to the age of 75, compared with 72% of those in the richest one-fifth of the income distribution. Among women, 72% in the poorest one-fifth were expected to survive to 75, compared with 84% in the richest one-fifth.

[2] See Health Canada: The Government's Role in Aboriginal Health Care
http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_02-eng.php

- The CIHI report, *Reducing Gaps in Health* found the lower your socio-economic status (SES), the more likely you are to be hospitalized for a number of health problems, including childhood asthma, mental illness, substance abuse, diabetes and more. The CIHI study found:

    - Hospitalization rates for mental illness were 2.3 times higher in the low-SES group compared to the high SES group (596 per 100,000 compared to 256 per 100,000.)
    - Hospitalization for substance abuse was 3.4 times higher in low SES groups than high SES groups.
    - Low SES groups were more than twice as likely to be hospitalized for conditions that could be treated with good care in the community such as diabetes and COPD.
    - Children from low SES groups had 56% higher hospitalization rates for asthma than children from high SES groups

- The Wellesley Institute Study, *Poverty is Making Us Sick* found that compared to the richest 20 % of Canadians the poorest 20 % of Canadians have:
    - more than double the rate of diabetes and heart disease
    - nearly double the rate of arthritis or rheumatism
    - more than three times the rate of bronchitis
    - a 60 % greater rate of having two or more chronic health conditions
    - are four times more likely to have a disability
    - and were almost three times more likely to be without an insurance plan for dental care, prescription medications or other private health coverage.

- The 2008 OECD Report *Growing Up Unequal* notes that Canada spends less on cash benefits such as unemployment benefits and family benefits than most OECD countries. As a result, it states, "taxes and transfers do not reduce inequality by as much as other countries. Furthermore, their effect on inequality has been declining over time.

- Support for taking action on health inequity is increasing. For the first time, the Conference Board of Canada, the voice of corporate Canada, urged employers and business leaders to care about the health determinants and to do their part to address health inequity. The rationale was not only because it will improve the health of Canadians, but it will improve firms' performance, productivity and profits and reduce costs to the health care system and society.

- Public support for addressing health inequality is also increasing. A recent Angus Reid poll in British Columbia, as quoted in the BC Health Living Alliance report, *Healthy Futures for BC Families,* found that 79 % of British Columbians support a provincial action plan with targets and timelines to improve the health of disadvantaged citizens.

- Increasing evidence exists for the effectiveness of interventions, particularly from Nordic countries; These interventions include programs to reduce childhood poverty by largely addressing unequal distribution of wealth with policies that encourage progressive taxation, equality of benefits and services, full employment, gender equity and low levels of social exclusion.

Introduction

The next revolution in health improvement in Canada is within the reach of the country's federal, provincial and regional governments, and corporate and societal leaders. Working together, they have the ability to reduce the number of people afflicted with chronic disease and injuries, to extend life expectancy and reduce premature deaths. They can cut hospitalizations rates, reduce rates of drug addiction and mental illness and improve the general health and wellness of all Canadians. Moreover, they can greatly improve the health and wellness of future generations, reducing or preventing chronic diseases, injuries, addictions and other health afflictions that will impact those who are young children today or those who are not yet born.

This revolution is possible because over the last 30 years it has become increasingly clear why some people are healthy and others not and why there are large gaps in health status within and between communities and nations. And there is increasingly convincing evidence from around the world showing what we can do about it.

This revolution, however, will not come from putting even more attention and resources into hospitals, doctors, nurses and the other dominant features of the Canadian health care system as we know it. Rather, it requires a shift in thinking and emphasis. It means putting our focus and more resources on the interrelated social, economic and environmental factors that influence whether an individual or a population is healthy or not.

Called the "determinants of health" these factors include income, education, employment, housing and the built environment, the natural environment, early childhood experiences, literacy, social support, health choices, access to preventive health services, and the general empowerment people have to control decisions in their own lives.

Over the last 30 years, an increasingly large volume of national and international research has consistently revealed just how powerful these determinants are. Taken together, these social, economic and environmental factors create differences in levels of health that can be seen playing out time and again, across nations and across the settings – homes, schools, workplaces and neighbourhoods – where people live, learn, work and play.

It is now abundantly clear: populations with the most resources – those with high incomes, most education, good housing, good neighbourhoods, good jobs, high personal empowerment etc – consistently have the best health and live the longest lives. Those with the fewest resources – with low income, poor education, bad housing and unsafe neighbourhoods, little or no employment, part-time or unhealthy jobs, poor early childhood experiences, little empowerment etc. – have the worst health and the shortest lives. The 'health gap' between the most and least healthy is large in Canada, as it is elsewhere, and may be increasing. Where it is not only avoidable and preventable, but is also considered unjust or unfair, it is considered to be a health inequity. Such inequity is a significant public health issue and a societal concern.[3]. As one commentator noted, "while inequalities can be observed, inequity demands action." [4]

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[3] An important distinction exists between health inequality and health inequity. Health inequality is the generic term used to designate differences, variations, and disparities in the health status and risk factors of individuals which can include genetics, age and lifestyle choices. Health inequity, however, refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice. From: Kawachi I , Subramanian SV, Almeida- Filho N. A glossary for health inequalities. Journal of Epidemiology and Community Health 2002;56:647-52,

[4] D'Arcy, Carl (1988) Reducing Inequalities in Health. Unpublished paper, Health Promotion Directorate, Health and Welfare Canada

Moreover, a conspicuous health gradient exists. Like distinct steps of a staircase, at every level of improved socio-economic status (SES), health status likewise improves. These observable differences from top to bottom constitute a health gap, which translates into an additional burden of disease that is carried by those lower down the scale. That greater burden of disease and injury not only causes excess harm to those who suffer from it and their families, it also both places additional demands on the health care system – thus increasing costs – and reduces the productivity of both the private and public sectors as a result of days lost to short and long-term disability and premature death. This distinct gradient is also relevant because research is now clear that every action taken that creates an increment of improvement up the ladder of SES can translate into improved health status.

A key message in all the reports is that the determinants of health can be addressed through policy and program interventions.

In 2008, six key reports – one international and five Canadian – were released that add to the ever- growing body of literature about the importance of acknowledging and addressing health determinants[5],. These six were by no means the only reports on health determinants that were released in 2008 – in fact dozens of reports featuring aspects of the topic were released by individual provinces, by national and provincial non-governmental organizations, and by international agencies and countries. These six, however, are important because of their authorship and quality, and, when taken together, provide compelling statistics, examples, evidence and understanding of the complex interplay of factors that create such health gaps.

These significant reports and the dates they were released are as follows:

1. ***Closing the Gap in a Generation: Health equity through action on the social determinants of health -*** World Health Organization, Commission on Social Determinants of Health, released August 2008;
2. ***The Canadian Census Mortality Follow-Up Study*** Statistics Canada, August 2008
3. ***Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada,*** Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information (CIHI), released November 2008
4. ***Report on the State of Public Health in Canada: First Annual Report, Chief Public Health Officer of Canada,*** Public Health Agency of Canada, released June 2008
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6. ***Healthy People, Healthy Performance, Healthy Profits,*** Conference Board of Canada, released December 2008

These reports, while each presenting a unique facet of the healthy inequity picture, share a number of key themes and findings. In particular the cluster of three reports linking health status and income/social status create a fuller picture of the current situation in Canada by providing three different perspectives on health inequity: income and mortality (Statistics Canada); socio-economic status and hospitalization (CIHI), and income and self-reported health (The Wellesley Institute) Together, these reports create an overwhelming case that the next leap in health improvement for the Canadian population will come as a result of effective policies and programs that address the social, economic and environmental determinants of health and reduce health inequality. A key message of all of the reports is that it is high time that the determinants of health

[5] All six reports used slightly different language to describe the social, economic and environmental factors that strongly influence health. The WHO called them "social determinants of health." The Public Health Agency called it "social and economic influences." The Canadian Institute of Health Information and Statistics Canada call it "socio-economic status." The Conference Board of Canada calls it the "socio-economic determinants of health." To simplify the language and keep it consistent, this document has specifically chosen to use the general term "determinants of health" to encompass the multitude of factors that influence health including income, education, level of employment, housing, physical environment, early childhood experiences, literacy etc.

be addressed through various policy and interventions. We have the evidence, now we need the actions.

1. Closing the Gap in a Generation: Health equity through action on the social determinants of health

Final Report of the World Health Organization, Commission on Social Determinants of Health released August 28, 2008.

Since its inception in 1946, the World Health Organization has helped focus global eyes and global efforts on improving the health of the world's people, largely by concentrating activities on the essentials of basic health: clean water, safe food, good nutrition, immunizations, prevention and control of endemic diseases, and basic health services and health education. Now to make further progress in health improvement in both rich and poor countries, the WHO has turned its attention to the determinants of health, going beyond the immediate causes of disease to the social, political and economic structures that allow disease to take root and afflict certain peoples.

This report was the culmination of a three-year investigation by the WHO Commission on Social Determinants of Health, whose 18 members include international former heads of state and ministers of health and leading academics and researchers. The commission is chaired by Britain's Sir Michael Marmot, one of the world's foremost researchers in the determinants of health and the lead researcher of the famous "Whitehall Studies" which since 1967 have tracked the health of large cohorts of British civil servants.[6] One of the WHO report commissioners is Canadian Monique Begin, who was Federal Minister of Health and Welfare for two elected terms in the late 70s and early 1980s, when the Canada Health Act was created.

Using examples from most countries of the world, the WHO report lays out the theories and evidence for the impact of the determinants, providing a complex conceptual framework for how the various determinants interact with each other. In essence, it notes, it boils down to the ability for individuals and populations to take control over specific choices and to be masters of their own destiny, with the power to access what they need at critical junctures in the life path.

"Bad policies, economics and politics are responsible for the fact the majority of the people of the world do not enjoy the good health that is biologically possible…. Social injustice is killing people on a grand scale"

The report notes that huge differences in health exist between the rich countries and poor countries of the world, so that life expectancy in places like Japan, Sweden and Canada is more than 80 years, while people in Africa live less than 50. But health inequality is also a huge issue within each individual country, whether rich or poor. For example, in a rich country like Australia, indigenous men have a life expectancy that is 17 years shorter than all other males in the country; (in Canada, aboriginal men live 7 years less than other Canadian men and Aboriginal women 5 years less than other Canadian women.[7])

The commission notes that, to a large extent, health inequalities relate to an unequal distribution of power, income, access to goods and services, and opportunities. However, some very low income countries such as Cuba, Costa Rica, China and Sri Lanka have achieved good health status for their populations by focusing on equal access to education for young girls and

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[6] One of the overarching findings of the series of Whitehall studies is that the lower the person's status in the civil service hierarchy, the worse the health and the greater the mortality from all causes. See www.macses.ucsf.edu/Network/michael.htm

[7] See Health Canada: The Government's Role in Aboriginal Health Care http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_02-eng.php

boys, support of early childhood development and equal access to preventive health programs. The rich Nordic countries have addressed health inequity by largely addressing unequal distribution of wealth with policies that encourage progressive taxation, equality of benefits and services, full employment, gender equity and low levels of social exclusion.

WHO Recommendations

The WHO report makes three overarching recommendations for action:

1. **Improve daily living conditions** – All countries should enact policies and programs that provide access to clean water, safe shelter, early childhood support, equal opportunities for education for girls and boys, education for women, decent jobs for all and universal access to health care with a focus on primary health care. In particular:
    a. Investing in early childhood development is one of the best ways to reduce health inequities. All countries should provide coordinated, collaborative early childhood services that include not just physical support but social/emotional and language/cognitive development.
    b. Education for women is an investment that pays for itself many times over.
    c. Make full and fair employment and decent, less hazardous work a central goal of all national and international social and economic policy making.
    d. Place health and health equity at the heart of urban governance and planning, in particular addressing the needs of 1 billion people who now live in urban slums, ensuring affordable housing, clean water, sanitation systems, and electricity.
2. **Address the inequitable distribution of power, money and resources –** All countries should create and support political and societal structures that address issues of gender and ethno-racial inequality, and create good governance, support for civil society and an accountable public and private sector. Governance systems that create fairer and more equitable systems through such measures as progressive taxation, income redistribution, pension and benefit plans, and gender equality will do much to reduce the health gaps. In particular it recommends the following:
    a. Make health improvement and health equity a central part of coherent policy across all of government and a marker of government performance.
    b. Assess the impact of all policies and programs, and market conditions, on health and health equity.
    c. Make the impact on health equity a central consideration of all economic agreements
    d. Provide fair public financing to fund action across all the determinants of health.
    e. Address gender bias in the structures of society, whether it be laws, cultural traditions, organizational behaviour, or access to finances and appropriate health services, ensuring women and girls have rights and opportunities equal to men and boys.
3. **Measure and understand the problem and assess the impact of action** – While enough evidence exists right now to act on the determinants of health, improved national and global health equity surveillance and monitoring systems, research programs and training infrastructures need to be set up to so actions can be evaluated and investments made in what is shown to work.
    a. Set up routine monitoring systems locally, nationally and internationally that include the registration of all children at birth and that collect data regularly on all the determinants and health.

"All countries must work to create a fairer world where people's life chances and their health will no longer be blighted by the accident of where they happen to be born, their sex or colour of their skin or the lack of opportunities afforded them or their parents."

b. Create systems for the sharing of evidence and the effectiveness of measures to reduce health inequity.
c. Provide more training of policy makers, health care workers and others in positions to affect change so that they understand the impact of the socio-economic determinants.

While the full, exhaustive nature of the report is impossible to capture in a short summary, the report in essence boils down to a single concept: that health inequity is killing people on a grand scale around the world but that government and organizations can enact policy and create interventions that will greatly reduce the health gaps and remove the injustice that creates poor health.

2. The Canadian Census Mortality Follow-Up Study, 1991 through 2001

Statistics Canada, released August 2008

What the WHO expressed about health inequality in global themes and data, the reports by Statistics Canada and the Canadian Institute for Health Information (CIHI) prove in compelling new data from the Canadian census about the impact on the Canadian population. These two reports will be considered together as they both use Canadian census data to show convincing evidence how the determinants of health are currently at work among Canadian citizens and are directly linked to mortality rates and hospitalization rates in Canada. A complementary third report, *Poverty is Making Us Sick,* by the Toronto-based Wellesley Institute also used data from Statistics Canada to show the rates of chronic disease and disability is highest among those at the lowest level of socio-economic status.

Mortality rates were elevated among those of lower socio-economic status, regardless of whether status was determined by education, occupation, or income

The *Canadian Census Mortality Follow-up Study* is the first in Canada to examine mortality by socioeconomic status in the total population through a linkage of census and mortality records, thus providing direct (as opposed to indirect or estimated) data on the relationship between income and this important aspect of health status. It tracked mortality from June 4, 1991, to December 31, 2001, among a 15% sample of the adult population (about 2.7 million people), who completed the long-form census questionnaire. During this period, there were more than 260,000 deaths in the sample.

It found that compared with people of higher socio-economic status, mortality rates were elevated among those of lower socio-economic status, regardless of whether status was determined by education, occupation, or income. The findings reveal, yet again, a stair-stepped gradient, with bigger steps near the bottom of the socio-economic hierarchy.

The highest mortality rates were among people with less than secondary graduation, those who were unemployed or not in the labour force, those in unskilled jobs, and those in the lowest income brackets. The lowest mortality rates occurred among the university-educated, the employed, those in professional and managerial occupations, and those in the top income brackets.

Only 51% of men in the poorest one-fifth of the income distribution were expected to survive to the age of 75, compared with 72% of those in the richest one-fifth of the income distribution. Among women, 72% in the poorest one-fifth were expected to survive to 75, compared with 84% in the richest one-fifth.

For both sexes, and for all except those over age 85, mortality rates were highest among those with the least education, and fell with each increment of education.

While the Census mortality study simply presents the data and does not make policy recommendations, it does note that a goal of Canadian health policy, as set out by the 2003 First Ministers Accord on Health Care Renewal, is to reduce or eliminate socio-economic inequalities in health. This data provides clear evidence that health inequity is occurring in Canada and needs attention. It notes that the study gives detailed baseline data on the nature and extent of inequalities in mortality and can provide an evidence base for informed policy decisions and a yardstick with which to measure future progress.

3. Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada

Report of Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information (CIHI), released November 2008

The CIHI study, *Reducing the Gaps in Health: A Focus on Socio-Economic Status in Urban Canada*, is an excellent companion piece to the Census study. CIHI is a non-profit, independent organization created by the federal, provincial and territorial governments to collect and analyze Canada's wealth of health information. The study uses hospital admission data mapped against census information by neighborhood in major urban areas across the country. Its findings also reveal compelling evidence showing that socio-economic status (SES) is directly linked to specific rates of hospitalization in Canada. SES is a measure of material and social position based on income, education, employment and family structure.

Socio-economic status (SES) is directly related to specific rates of hospitalization. The lower the SES, the higher the rate of hospitalization for all causes.

The study shows that in 15 major urban areas across the country, the lower your socio-economic status, the more likely you are to be hospitalized for a number of health problems, including childhood asthma, mental illness, substance abuse, diabetes and more. The report is the largest of its kind to examine differences in self-reported health and health system use among high-, average- and low- socioeconomic status groups and then plot that information on a maps of those urban areas.

The report examines Canada's age-standardized hospitalization rates for 12 acute and chronic conditions using CIHI's hospital Discharge Abstract Data Base and the National Trauma Registry[8]. Also collected was a subset of eight age-standardized self-reported health indicators collected by Statistics Canada's through its Canadian Community Health Survey (CCHS)[9].

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[8] The 12 indicators were: Ambulatory care sensitive conditions(under 75); Diabetes (all ages); Chronic obstructive pulmonary disease (COPD)(20 years of age or older); Asthma in children (under 20 years of age); Injuries (adults and children); Land transport accidents (all ages); Unintentional falls (all ages); Mental health (all ages); Anxiety disorders (all ages); Affective disorders (all ages); Substance-related disorders (all ages).

[9] The eight self-reported health indicators were: Self-rated health (ages 12 and over); Physical inactivity (ages 12 and over); Smoking (ages 12 and over); Alcohol intake (heavy drinking or "bingeing")(ages 12 and over);Overweight or obese (ages 18 and over); Risk factors (self-reported physical inactivity, body mass index, smoking and/or alcohol intake) (ages 18 and over); Influenza immunization (ages 65 and over); Participation and activity limitation (ages 65 and over).

All this data was mapped against national census data in 15 major Canadian urban areas. Using a deprivation index developed by the Institut national de santé publique du Québec (INSPQ), individual neighborhoods in the 15 urban areas were assigned rankings of low-, average- and high-SES labels. The urban areas examined were: Victoria, Vancouver, Calgary, Edmonton, Saskatoon, Regina, Winnipeg, London, Hamilton, Toronto, Ottawa-Gatineau, Montreal, Quebec City, Halifax, St. John's. The report notes that examining these 15 urban areas provides complex SES/hospital information on 66 % of Canada's urban population.

The results show startling differences in hospitalization rates from high to low SES groups. The findings included the following:

- Hospitalization rates for mental illness were 2.3 times higher in the low-SES group compared to the high SES group (596 per 100,000 compared to 256 per 100,000).
- Hospitalization for substance abuse was 3.4 times higher in low SES groups than high SES groups.
- Low SES groups were more than twice as likely to be hospitalized for conditions that could be treated with good care in the community, such as diabetes and COPD.
- Children from low SES groups had 56% higher hospitalization rates for asthma than children from high SES groups
- The higher the SES group, the higher the self-reported health, although only small gaps existed in influenza immunization rates, alcohol binging and obesity.

Individual urban areas differed in the extent of the disparities. The starkest hospitalization rate differences between SES groups occurred in Regina and Winnipeg while the least amount of difference occurred in Ottawa-Gatineau and Toronto. For self-reported health, the least difference between SES groups occurred in Halifax and St. John's, while the greatest difference in self-reported health between SES groups was found in Victoria and London. The latter section of the report is devoted to detailed looks at individual urban areas, providing a wealth of information for local organizations.

Like the Statistics Canada study, the CIHI report in conclusion notes that identifying the specific gaps and where they occur may then suggest national or provincial targeted interventions tailored to meet the needs of the lower SES groups. Where gaps between the groups were narrower, more universal approaches encompassing the whole population might be needed. At the city and neighborhood level, the specific characteristics of each region may provide useful information for the development of targeted policies and programs at the neighborhood level in each city. Program results could then be evaluated against the baseline information, greatly adding to our knowledge about what works to reduce health gaps.

A third related report, *Poverty is Making us Sick,* was released in December 2008 by the Wellesley Institute, a Toronto-based health policy think tank largely devoted to issues around health determinants and urban health. It also used the 2005 Statistics Canada Community Health Survey, looking at a sample of 92,000 people across Canada focusing on the relationship of income and self-reported health outcomes, as well as a sample in Ontario of 28,0000 to examine private extended health insurance coverage. Comparing the richest 20 % of Canadians to the poorest 20 % it found the poor have:

- More than double the rate of diabetes and heart disease
- Nearly double the rate of arthritis or rheumatism
- More than three times the rate of bronchitis
- A 60 % greater rate of having two or more chronic health conditions
- Almost four times more likely to have a disability
- Were much more likely to be without an insurance plan for dental care, prescription medications or other private health coverage (based on the Ontario sample)

The findings in these three reports, when taken together, starkly show that health inequity is widespread in Canada and is increasing mortality rates, morbidity rates and hospitalization rates

among the poorest members of our society. The reports provide a valuable base line and the compelling motivation to act to address these startling health gaps.

4. Report on the State of Public Health in Canada

First Annual Report, Chief Public Health Officer of Canada, Public Health Agency of Canada, released June 18, 2008

Health inequality in Canada was the major focus of this first annual report to the Canadian public since the 2006 formation of the Public Health Agency of Canada. Dr. David Butler-Jones, Chief Public Health Officer of Canada, notes in the report's opening pages that while the majority of Canada's 31. 6 million residents enjoy good to excellent health, there are Canadians in every corner of the country who experience higher rates of injury, chronic disease, addictions and premature death.

"Actions targeting individual health choices and behaviours must also consider the social and environmental conditions that shape those choices."

The report notes that, in general, Canada is doing fairly well by standard health status indicators. Life expectancy at birth is currently 80 years, one of the world's highest. But while this has increased over the last 25 years, it is not increasing at the same rate as other top-ranked countries such as Japan (82 years) and Australia (80.5 years). Our infant mortality rate has steadily dropped over the last 4 decades from 27 per 1000 births in 1960 to just 5 per 1000 in 2004, significantly ahead of the USA's 7 per 1000. However, Japan and Norway have the lowest rates at 3 per 1000. Six out of 10 Canadians currently die of either circulatory diseases or cancer, much of which is preventable. While premature death rates have declined steadily over the last 50 years, in 2005, 42 per cent of all Canadians over the age of 11 were reported to be living with some type of chronic disease such as asthma or other respiratory problems, high blood pressure, arthritis, diabetes, heart disease, mental health disorders, and even cancer. Obesity currently presents a significant health challenge, with 24 % of all adults obese and a further 35 per cent over weight in 2005. The obesity rates for Canadian men are among the highest in the world and among both men and women those who have not completed high school are more likely to be obese, as are Aboriginal people.

The report notes a number of current trends in health inequalities in Canada:

- The size of the gap between people with the highest and lowest incomes continues to grow, creating greater extremes of economic disparity between the haves and the have-nots. In 2005 the highest 20% of Canadians were earning more than $160,000 a year while the lowest 20% were earning $20,000.
- While the overall poverty rate is at 11%, poverty rates are higher than the general population for specific sectors of society: lone parent families (26 %), recent immigrants (19 %) and Aboriginal people (17%).
- In some 2005, 11.7 % of children under 18 were living in poverty down from a peak of 18.6 % 1996. Yet, while the number of Canadian children living in low income families is less than the US rate of 22% (after tax transfers) it is almost triple the average rate of the Nordic countries (4%).
- While in 2006 Canada had its lowest rate of unemployment in 30 years, at 6.9 %, it was not shared equally by all citizens. Recent immigrants had rates of 11.5% despite being more likely than native born Canadians to hold a university degree.
- Poverty levels for seniors have been reduced by the introduction of a number of national public pension plans over the last 50 years, taking Canada from one of the highest rates of low income seniors in the developed world to one of the lowest. This shows that national programs can shift income imbalance and protect the vulnerable.

- Food security is a concern, with 9% of all Canadian households in 2004 reporting they are food insecure. At the lowest quintile of income levels, the number of food insecure rose to 48.3%.
- Housing is also an issue with 13.7 % of Canadians reporting they are unable to access acceptable housing. The most recent figure has some 150,000 people in Canada being homeless, which is seen to be an underestimate.
- Canada ranks well in educational indicators, putting it in the top 5 of industrialized countries for high school completion rates. University degrees continue to climb, but women's rates are climbing faster than men's and now six out of 10 undergraduates at university are women, raising the concern that a health gap relating to education may emerge among men in future years.
- Literacy is a concern, with 42 % of those aged 16 to 65 performing below the literacy level considered the minimum to succeed in today's economy and society.
- Some health behaviours are improving – fewer Canadians than ever are smoking, more women are breastfeeding, deaths from alcohol dependence are declining. However, only 41.2 % of Canadians age 12 and over eat enough fruit and vegetables and while 62% of high income Canadians report being physically active, only 44 % of the lowest income Canadians are physically active.

National public pension programs for seniors over the last 50 years have given Canada one of the lowest rates of low-income seniors, showing that policies and programs can shift income imbalance and protect the vulnerable.

The report sets out priority areas for action such as social investment, engaging communities and building their capacity to act, building the knowledge infrastructure of better research, surveillance and evaluation of health inequality issues, and more commitment to address health gaps from all levels of government leaders.

PHAC Recommendations

It concludes that three actions are the most urgent:

- **Foster collective will and leadership**: addressing health gaps must become a priority for all Canadian society, building awareness and recognition of the issues, collecting appropriate data to measure and monitor progress, and engaging leaders and champions across all sectors of society to take up the cause of reducing health inequality.
- **Reduce child poverty:** More investment needs to be made to ensure a healthy start for all Canadian children, learning from other jurisdictions that have had success in reducing child poverty rates; we need to investigate income redistribution programs, targeted interventions aimed at supporting children in low income families; housing and food supports, educational opportunities and other initiatives.
- **Strengthen communities:** The report notes that people living closest to the problem are often closest to the solution. Therefore communities must be honored and supported to develop their own responses, to build on existing knowledge, experience and energy at the ground level.

The report is replete with a host of examples of innovative programs and policies many at the provincial or regional level that have addressed or are addressing certain aspects of the socio-economic determinants of health. Examples include BC's Act Now Program which encourages healthy living, the Cape Breton Eskasoni Primary Health Care Program, which was a broad-based community program that built a new health centre that housed health and communities services under one roof, leading to improved outcomes and reduced costs. Other projects are a mobile health unit in Toronto that brought health services to immigrant women and Canada's Prenatal Nutrition Program that provides nutrition counseling, food supplementation, prenatal

vitamins and health programs such as smoking cessation to about 50,000 pregnant women annually in more than 2,000 communities.

As Dr. David Butler-Jones noted during the report's release, a chief goal of the report will be to foster discussion among all Canadians about health inequalities, raise more awareness and understanding about how addressing factors outside our health care system may do more to improve the health of all Canadians, and to explore how we build on Canada's existing successes to do more to reduce health inequalities.

5. Poverty and Chronic Disease: Recommendations for Action

Report of the Chronic Disease Prevention Alliance of Canada, released April 2008

The Chronic Disease Prevention Alliance of Canada (CDPAC) is a national coalition of health care organizations that share a common vision for health promotion and chronic disease prevention in the country. Individual organizations that are founding members include the Heart and Stroke Foundation, the Canadian Cancer Society, the Canadian Diabetes Association, the Canadian Public Health Association and the Dietitians of Canada, among others.

The importance of their latest report on Poverty and Chronic Disease is that the focus is entirely, as the subtitle notes, on recommendations for action. The document notes that one of the key reasons for taking action now on health gaps is to address social justice, correcting unfair inequalities that are not consistent with Canadian values. Another compelling reason is that chronic diseases each year cost Canada billions of dollars and a great deal of money could be saved in the health system, and the productivity of our economy increased, if the health inequalities were addressed.

The alliance makes three key recommendations for either federal or provincial public policy initiatives, with subsets of recommendations under each theme. Many of these recommendations the Alliance has made in earlier documents and restates in this report:

1. **Income:** Increase and index income transfers to at-risk groups and increase income generally by the following:
    a. **Increase the Child Tax Benefit (federal):** This recommendation has been made by many Canadian organizations in recent years, with the average recommendation being an increase to $5,100 a year. The benefit must not be clawed back by provinces or social assistance rates lowered as a result.
    b. **Improve Employment Insurance (federal):** Reassess and reform EI so that the program has realistic and reasonable eligibility requirements and that the payments reflect an acceptable living wage that keeps pace with cost of living.
    c. **Increase and index minimum wage (provincial):** All provinces should increase the rate to $10 per hour.
    d. **Increase social assistance rates (provincial):** Index all social assistance rates in all provinces and annually increase the rate to keep ahead of inflation and cost of living increases.
2. **Housing:** Ensure access to adequate housing across Canada by the following:
    a. **Reinstate the federal Social Housing Program and increase funding to the Affordable Housing Initiative:** Low income wage earners and those on social assistance must have access to safe and affordable housing.
3. **Priority Populations:** Ensure the people who are in the most need benefit first. Children in poverty, lone parent families, recent immigrants and Aboriginal peoples should all be the focus of new poverty reduction policies.

The CDPAC report at the national level nicely dovetails with the findings and recommendations of a 2008 report[10] of the BC Healthy Living Alliance, a provincial-level coalition of similar organizations to the CDPAC. The BCHLA report *Health Futures for BC Families,* carries much the same message, that policy action is necessary to address the facts that can impede or enhance the health of a society, including access to affordable housing, early childhood development and care, income and food security, and supportive environments. The BCLA document however has important data from province-wide opinion surveys they commissioned that indicate strong public support for taking action on these key determinants. It notes in the report, for example, that 79 % of British Columbians support a provincial action plan with targets and timelines to improve the health of disadvantaged citizens[11].

6. Healthy People, Healthy Performance, Healthy Profits

Report of the Conference Board of Canada, released December 8, 2008

The business-focused Conference Board of Canada puts a new and refreshing spin on the issues of the determinants of health by challenging Canada's business and corporate community to do its part to reduce health gaps. While the previous four documents made the case for government investment and action because it was the right thing to do for social justice, good governance, and improved health, this report makes the convincing case that employers and business should care about this issue and take action not only because it will improve the health of Canadians, but it will improve firms' performance, productivity and profits and reduce costs to the health care system and society. This report is an important landmark as it marks the first time that the Canadian business community has embraced the evidence and urged action on the determinants of health.[12]

"Employers who take action on the socio-economic determinants of their employees' health can expect better performance and profits than those employers who take no action."

The Conference Board makes the case that investment in reducing health gaps yields both individual and corporate benefits. This new line of argument to address health gaps may be the most important to make in the current Canadian market economy. In essence, the Conference Board stresses that reducing health inequality is good for the economic bottom line for Canadian businesses and the corporate community as well as Canadian society as a whole. This marks the first time that the business community has begun to recognize the impact of health determinants and to recommend that businesses be part of the solution to address them.

The report stresses that employers and businesses have much to gain by taking the lead in reducing health gaps in their workplace, such as healthier, happier employees who are less stressed, more productive, less likely to quit or have high numbers of absent days, and more committed to the company culture. In short: less stress and illness in the workplace, more profits and productivity. As one of the many examples in the report, it describes how when CIBC introduced an onsite backup emergency childcare centre it not only reduced stress among its employees, but it saved 2500 days of employee absences in the first year and saved $1.5 million in lost productivity costs.

The report draws on research and statistics from the 2008 PHAC Annual report, described earlier in this document, as well as other as other seminal reports over the last decade,

[10] See *Healthy Futures for BC Families: A BCHLA Policy Discussion Paper,* released September 2008 and available at www.bchealthyliving.ca

[11] Angus Reid Strategies: Attitudes and Barriers to Healthy Living, 2008 (BCHLA Public Opinion Research) as cited in the Health Futures for BC Families.

[12] Although not overtly stated in the Conference Board document, over the last 30 years, especially among corporate Canada, calls to address the determinants of health often raised fears of increased taxation and an anti-business approach that corporate leaders were afraid would discourage or even penalizes free-enterprise.

to establish the evidence base for the impact of the determinants of health. The latter half of the document describes various actions companies can take to address employee health and how to go about determining what action will have the greatest impact in a work place.

The report notes that in general there are two basic business approaches to reducing health gaps:

1. **Creation of workplace policies and programs that address a key health determinant affecting employees** – the document gives many examples, such as on-site emergency child care or daily childcare programs; housing assistance and support; fitness and wellness programs including on-site gyms, counseling or fitness subsidies and healthy food in cafeterias ; fair wage policies, good maternity and paternity benefits and other income incentives; flexible work arrangements; transportation subsidies and support; education programs and skill advancement; benefit plans such as dental programs or smoking cessation programs; These sorts of programs, while having a cost to implement will increase profits, employee retention and morale and health while reducing absenteeism.
2. **Creation of a business product or service that addresses a key determinant:** The report notes that many businesses are already addressing social determinants without knowing it – housing developers, transportation companies, educators. Other businesses could develop new product lines or services that would improve the health outcomes of their customers. Businesses creating a product or service must first reject two assumptions
    - *The poor do not have enough buying power to make a service profitable* In fact, high volume, need and aggregate buying power can create profitability. A good example is how cell phones in African villages have created economic prosperity; or how some companies have repositioned expensive products (computers, cell phones) by making them affordable services on a pay-per-use basis.
    - *That the person who benefits most from the service must pay for the service.* In fact, many third parties will pay if the service improves their operations. In the UK a telephone translation service linked translators in their own homes to non-English speaking clients who needed to use a wide variety of government, non-profit and community services. The service provider paid the bill for translation because it enabled them to better serve their clients.

The document sets out 10 pillars of successful business action that will help companies take the right steps to address the determinants of health the most important steps of which were to engage the employees in each individual workplace, continually consulting and communicating with them to ensure their needs are best being met, to not take on to much, to evaluate programs and to have the whole corporate culture of the workplace embrace the initiative.

"Government must understand that altruism cannot and should not be the driving force behind private sector investments….The essential BUSINESS CASE is about improving performance and profits by addressing socio-economic determinants of health."

Conference Board Recommendations

The Conference Board notes that various levels of government play a role as motivators, facilitators and enablers to business actions to reduce health gaps. Government could provide the following supports:

- Disseminate evidence on what works
- Provide start up funding and promote promising models or fund research
- Provide a supportive regulatory and legislative environment
- Provide additional incentives for action such as tax relief, subsidies, or eligibility for public funds
- Create enabling conditions, such as "even the playing field" so that an

employer who takes action does not lose out to competitors

The Conference Board report concludes with four main points:
- As employers, businesses that focus on the socio-economic determinants of health may improve productivity, organizational performance and increase profits
- As producers of goods and services, companies can improve health outcomes while building a business and getting a positive return on investment
- As stakeholders in the economy, business can encourage governments to address health gaps for the long-term benefit of the general economy, productivity of the workforce and creation of a healthy future workforce.
- As respected members of society, businesses can help spread the message across Canadian that action on the socio-economic determinants of health is good for all Canadians and can collaborate with others business and sectors of society to make progress on reducing health gaps.

Conclusion

For 35 years now, evidence has been steadily increasing that the determinants of health are key factors in the health status of Canadians. In fact it was in 1974 that the federal Government's famed Lalonde report was the first in the world to make the following observation:

> ". . . the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate. . . there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology." [13]

The Lalonde Report's impact was international, helping spawn the field of population health promotion and spurring a great deal of research about the impact and importance of health determinants all around the world.

Now in 2008, a new round of important reports have added even more momentum to the issue of health determinants and have provide a common consensus on the issues and greater platform for awareness. Taken together the reports make it clear that the issue is coalescing around a number of commonalities, which include:
- **A common understanding of what constitutes the major determinants of health**: income, education, employment, literacy, housing, and the built environment, sanitation, air and water quality and the state of our global life support systems, early childhood experiences, food security, social supports, access to preventive health services and general empowerment over the choices in their lives.
- **A common and increasingly robust set of evidence of how the determinants of health are impacting Canadian lives and our economy:** Health inequity in Canada is in Canada causing significantly higher mortality rates, higher hospitalization rates and higher rates of chronic disease among those with lower socio-economic status. Health inequity also occurs in the lack of access to dental care insurance, prescription drug insurance and extended benefits. This health disparity is costing money to the health care system and reducing the productivity of our economy, and most importantly, impacting the lives of millions of Canadians.
- **A common understanding of the main population groups affected:** In Canada those at greatest impact from the health determinants are those at the lowest 20 % of annual income, children in poverty, lone-parent families, new immigrants, and the Aboriginal population.

[13] The Lalonde Report, *A New Perspective on the Health of Canadians* 1974, page 18

- **A common concern that some trends are worsening:** unemployment is increasing and is projected to increase even more in the current economic climate; the gap between the richest 20 % and the poorest 20 % of the Canadian population has steadily widened over the last decade; food insecurity and reliance on food banks has increased over the last decades, with 48. 3% of those in the poorest 20% reporting being food insecure in 2004.
- **A common understanding that Canada can do better:** Evidence from the Nordic countries show that child poverty rates of 4% are possible, compared to Canada's 11 %, that health gaps can be reduced through targeted programs such as early childhood education, affordable housing, equal access to higher education, and targeted income transfers. Evidence from other countries like Japan and Australia we can lengthen life expectancy, particularly among the disadvantages population. Evidence from even poor countries like Cuba, China and Costa Rica show that focusing on support for early childhood development, education for boys and girls and preventive health services can reduce health gaps.
- **A common call for the need for a greater understanding by the Canadian public, media, health advocates, politicians and corporate leaders about the power of the determinants of health:** Public discussions about improving health must shift from a focus on pouring more money into the existing health care system. With current government spending on the existing health care system at about 39.2 % of provincial government budgets, there must be recognition that further will not improve health and in fact is a threat to healthier populations. As Canadian Senator Dr. Wilbert Keon, who for most of his career was a leading heart surgeon and founder of the Ottawa Heart Institute noted in a recent editorial: "Increased expenditures on healthcare are likely impacting negatively on the general health of our population by virtue of diminished investments in other areas like education (especially early childhood education), public housing, income security, and other public services." [14]. All the documents called on increased leadership to spread the word and become champions of addressing the health determinants
- **A common call for coordinated research and dissemination of findings:** As the WHO, Conference Board, Public Health Agency of Canada, and the CIHI and Stats Canada report all noted, we must fostering a research culture around the health determinants, building good surveillance systems, charting progress and evaluating efforts. The CIHI and Stats Canada documents in Canada give excellent baseline data against which we can compare our progress in future years. Sharing what works between nations and region is essential. Some research needs include what interventions, or combination of interventions are the most likely to reduce the health gaps in the Canadian context; what are the financial costs of interventions compared to the cost of not taking action?
- **A common understanding that enough evidence has accumulated and the time to act is now:** Thirty years of research and discussion is long enough – the time to act is now. While there are still some outstanding research questions about the most effective actions, enough evidence exists to design pilot programs that can be evaluated, create targeted interventions for at risk populations and make policy changes, such as minimum wage increases and social insurance rate increases, and give greater support to early childhood development initiatives. Governments in particular can fund promising business models or supported targeted research in the communities identified by the CIHI study that show the highest hospitalization rates and the greatest need. Other common recommendations include creating affordable housing, ensuring equal access to education and increasing literacy, and a focus on early childhood development.

The next revolution in health improvement is indeed within the grasp of Canadian society. But we must start now to focus investments and actions "upstream" from the health care system, in the

[14] Senator Wilbert Keon, "*Health for all: questions from the past, lessons for the future.*" The Hill Times, Monday January 21, 2008

basic systems, environments and structure of our society - and in the settings where we live, learn, work and play - to promote more equality of opportunity and less societal disadvantage. Investment in the determinants of health is an investment in the future good health of our society.