Toward Health Equity:  
A Comparative Analysis and Framework for Action  

*Working Document*  
*March 9, 2009*  

Produced for the Public Health Agency of Canada,  
Strategic Initiatives and Innovations Directorate  

by  

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1. Introduction

1.1 About this Background Paper

In March 2009, the Public Health Agency of Canada (the Agency) will co-host the Action to Reduce Health Inequalities in Canada Working Session with the National Collaborating Centre for Social Determinants of Health (NCCDH), the Canadian Population Health Initiative (CPHI-CIHI), the Canadian Public Health Association (CPHA), the Institute of Population and Public Health (IPPH-CIHR), and the Population Health Promotion Expert Group (PHPEG). The session is designed to advance key recommendations from recent reports. These recommendations all share the common goal of seeking to reduce health inequalities.

This paper identifies and analyzes common approaches and recommended actions; it presents key considerations designed to inform a critical analysis of what is feasible in the Canadian context and the steps required for action, both within the health sector and beyond. Based on the reports' recommendations, it suggests a broad framework for action that includes common guiding principles evident throughout the literature, priority areas for action, and cross-cutting strategies required for progress on any of the determinants of health.

To develop this background paper, the Agency and its consultants agreed on a total of 12 reports for review, representing international, national, provincial and local perspectives. Eight of these (listed in Section 2) were selected as central reports.

1.2 Limitations

The recent focus on the social determinants of health, together with the sheer volume of thoughtful, evidence-based literature, makes the task of reviewing this issue a daunting one. Analysing the information is complicated by the fact that there are many determinants of health, each defined in a variety of ways. Clear definitions of the determinants will be important in future communication, particularly with the media and public. The reports reviewed have several limitations, particularly regarding a lack of analysis based on gender (and to a lesser extent cultural analysis) and incomplete data on Aboriginal health. These limitations are, unfortunately, also reflected in this background paper.

This report attempts to provide a focused, practical snap-shot of possible action in Canada. Such a brief paper cannot possibly do justice to the impressive existing body of work aimed at reducing health inequities. Instead, the main report aims to summarize key points, while the appendices provide more detailed information. The reader is encouraged to go to the original papers for a more complete description of the issues.

1.3 Some Key Terms

In the papers analyzed for this report, the terms “determinants of health” and “social determinants of health” are both used. However, discussions on the social determinants of health usually exclude genetics and biology and address personal health practices (or lifestyle choices) as a secondary factor (i.e., because behavioural choices are influenced by broader social determinants, they are not a root cause of poor or good health). In keeping with the need to address the modifiable root factors that affect health, this paper focuses on the social determinants of health.
Similarly, health “inequity” and “inequality” are often used interchangeably in the literature. Except when making a direct reference to a reviewed report, this paper defines “inequities” as avoidable health inequalities that arise because of A) the circumstances in which people grow, live, work and age and B) the nature of the systems currently in place to deal with illness. These conditions are, in turn, shaped by political, social and economic forces. These terms are more fully defined in the attached glossary (Appendix 1).

2. Key Reports on Health Equity

Brief summaries of the eight selected key reports are provided below. Appendix 2 provides a reference table noting their common principles, strategies and key recommendations.

The Chief Public Health Officer’s Report on the State of Public Health in Canada, Public Health Agency of Canada

In his first annual report, Canada’s Chief Public Health Officer (CPHO) chose to focus on population health, determinants of health, and efforts to reduce health inequalities. While noting that poor health is often viewed as a quality-of-life issue, his report focuses on the cost to our health and welfare systems and society as a whole. He addresses the economic fall-out of poor health, such as high rates of absenteeism and lower productivity. In his words, “Healthy people contribute to healthy economies.”

The report lays out the determinants of health and how they contribute to health inequalities, including lower life expectancy and higher rates of infant mortality, injury, disease and addiction. The CPHO argues that “a society is only as healthy as the least healthy among us.” He also notes that health inequalities can be overcome through public policy and individual and collective action, and he invites all sectors of society to contribute to their resolution. The report recommends three priority areas for action: fostering collective will and leadership, reducing child poverty and strengthening communities.

Healthy People, Healthy Performance, Healthy Profits: The Case for Business Action on the Socio-Economic Determinants of Health, Conference Board of Canada

The Conference Board of Canada reviews the key determinants of health; it provides health and economic arguments to build a case for supporting a determinants-based approach. The report does not make recommendations to address particular health determinants. Rather, it lays out opportunities for businesses to benefit from a population health approach by identifying profit-making endeavours and laying out benefits to employee health. The report notes a number of barriers to action, including a lack of public knowledge of the importance of health determinants; difficulties in establishing clear, causal relationships between the determinants and health; and the complex nature of coordinating inter-sectoral action. It offers a 10-pillar framework for action, noting the need for businesses to both have a clear purpose for their actions and develop an integrated, collaborative approach to implement programs that are aligned with corporate objectives, values and philosophy. Finally, the report recommends six areas of government action, including knowledge development and translation, a supportive regulatory and legislative environment (including incentives for action), and support for multi-sectoral action.

Senate Committee on Population Health: Issues and Options

Note: The Senate reports “Population Health Policy: Federal, Provincial and Territorial Perspectives” and “International Perspectives” were also reviewed, and inform Section 3 (Key Considerations in Canadian Context: Historical and Current Trends).
The Senate Committee’s “Issues and Options” report reviews the level of health disparity in Canada and makes a case for the federal government to implement a population health policy. It outlines issues to be addressed and provides a number of options for doing so. The report’s recommendations relate more to the process of addressing determinants of health, than to the specific determinants to be dealt with. As the final policy option indicates, the Senate report suggests that efforts be made to build consensus on priority issues on three levels (community, provincial/territorial, and national) to determine which actions will have the greatest support. The exception is Aboriginal health, which is the focus of one issue area. The remaining three issue areas support (1) research, monitoring and knowledge translation; (2) a reorientation of government policy to support a population health framework; and (3) fostering political will by engaging the public and non-health sectors and building consensus among key stakeholders on priority actions.

Health Inequities in British Columbia, Health Officers Council of BC

The Health Officers Council of BC report presents a series of guiding principles and policy considerations which focus on the need to apply both universal and targeted approaches in order to improve the health of all citizens while ensuring that the most disadvantaged benefit most. It suggests a combination of regulatory and structural interventions and recommends applying them through multiple, interrelated strategies. Successes in other jurisdictions, the report notes, point to the need to make health equity a government and societal priority that addresses clear goals and targets through a multi-sectoral approach. Recommendations focus on five policy areas: income and food security; education and literacy; early childhood development; housing and healthy built environments; and health care. The report notes that there is a great deal of best practices literature that should be consulted regarding criteria for designing and implementing programs and policies most effectively.

Health Disparity in Saskatoon: Analysis to Intervention, Saskatoon Health Region
http://www.saskatoonhealthregion.ca/your_health/ps_public_health_pho_reports_publications_and_presentations.htm

The Saskatoon Health Region (SHR) report analyses health disparity in that city, reviews Canadian and international successes in reducing health inequalities, and proposes 46 evidence-based policy options for consideration. To build support for the implementation of health equity policies, the SHR developed a communications strategy to inform the community and engage them in developing action plans, including one that addressed the social determinants of health. A survey of the community’s awareness of health disparities showed that while people knew that poverty affects health, they underestimated the extent of its impact. However, an overwhelming 91% of the respondents said they believed something could be done to address this disparity. Of the 30 policy options they were asked to consider, the preferred three were

- Strengthened early intervention programs for children and youth (82%)
- Earning supplements to help people move off welfare (82%)
- An increased number of disease prevention programs (81%)

Surveillance of health disparities led to a fundamental shift in attitudes and priorities in Saskatoon. The report notes that solutions are complex, and while they can be led by health authorities, success requires strong partnerships with both other organizations and the affected communities themselves.

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1 The term “Aboriginal” refers to individuals who identify with at least one Aboriginal group, i.e. First Nation (North American Indian), Métis or Inuit (Eskimo), and/or those who report being a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada and/or are members of an Indian Band or First Nation (Statistics Canada, 2008).

Public Health Agency of Canada,
Strategic Initiatives and Innovations Directorate
Health Inequalities and Social Determinants of Aboriginal Peoples’ Health, National Collaborating Centre for Aboriginal Health (URL not available)

This report addresses the social determinants of health from an Aboriginal perspective. It reviews the health status of First Nations, Métis and Inuit people, which is overwhelmingly worse than that of other Canadians, physically, mentally and emotionally. Determinants of health are presented as “proximal” (health behaviours; physical environments; employment and income education; and food insecurity), “intermediate” (health care systems; educational systems; community infrastructure; resources and capacities; environmental stewardship; and cultural continuity) and “distal” (colonialism; racism and social exclusion; and self-determination). While all determinants are experienced differently by Aboriginal peoples, distal factors are noted as having, “…the most profound influence on the health of populations because they represent political, economic and social contexts...within which all other determinants are constructed.” It suggests “historical trauma” as a determinant that may explain the residual gap between the health of Aboriginal peoples and other Canadians when all other factors are accounted for. An Integrated Life Course and Social Determinants Model is introduced that reflects “the complex and dynamic interplay of social, political, historical, cultural, environmental, economic and other forces that shape Aboriginal health.”

While the report does not make specific recommendations for action, it speaks to the need for better health data on Aboriginal peoples, and points to some priorities, including early child development and employment/income as “causes of the causes” of inequity. It notes that self-determination has been cited as the most important determinant of health, as it influences all other determinants. The report’s strongest recommendation is that Aboriginal people participate equally in political decision-making and have control over their lands, economies, education systems, and social and health services.

Closing the Gap in a Generation, World Health Organization Commission on the Social Determinants of Health

The WHO Commission on Social Determinants of Health makes a compelling case for global action by governments, civil society, local communities, business, and global organizations to reduce inequities in health. The report notes that life expectancy for girls varies from less than 45 years in some African nations to over 80 years in wealthier parts of the world and argues that this is largely due to social and economic policies: “…The social gradient in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally.” The consequences of this, the report states, are played out in daily life.

As the report title indicates, the Commission believes that the knowledge exists with which to close the gap in health within a generation. It calls for “urgent and sustained action, globally, nationally and locally,” and offers three overarching recommendations:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money and resources
3. Measure and understand the problem and assess the impact of action.

Focusing the Equity Lens: Arguments and actions on health inequalities, WHO Collaborating Centre for Policy Research on Social Determinants of Health (URL not available)

This report synthesises discussions from an Expert Group Meeting of the WHO Collaborating Centre for Policy Research on Social Determinants of Health (University of Liverpool, October 2007). It cites factors that might facilitate the successful implementation of policies and programs to reduce inequities, including political commitment, time to allow equity initiatives.
to take effect, and multi-sectoral action. Forces that may impede progress include policies and conditions that work against health equity, such as the erosion of universal social welfare systems; fragmentation and privatisation of health services; the increasing influence of regional and global powers; and market forces. Pilot initiatives that are rarely scaled up to become sustainable mainstream policies also impede progress, as does the need to balance national implementation with local and regional action. The roles and requirements of various players are outlined, including the need for professional capacity building, the involvement of civil society, and support from the World Health Organization. The report notes the need for more research and development on equity-oriented policies, the interactions of risk factors and risk conditions, and social influences on risk factors. It suggests that an effort be made to capture the value of community development and stresses the need for a greater understanding of the policy implementation process.

3. Key Considerations in the Canadian Context

3.1 Historical and Current Trends

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Persistent gaps and the importance of the health gradient - While several indicators of health have steadily improved in Canada, certain trends continue to raise concerns. For example, the gap between those with the highest and lowest incomes continues to grow, and poverty rates for some children, Aboriginal Peoples, recent immigrants, and persons with disabilities are significantly higher than for the general population. In the face of the current economic recession, unemployment rates are climbing rapidly (particularly in the manufacturing sector) and remain persistently higher among certain populations, such as recent immigrants and Aboriginal Canadians.

Typically, a stepwise decrease in health is seen with decreasing socioeconomic status (the social gradient). This is true for each level along the gradient. If all neighbourhoods in Canada had the age- and sex-specific mortality rates of the highest-income quintile neighbourhoods, the total potential years of life for all urban neighbourhoods would increase by approximately 20%. This would be equivalent to wiping out all premature deaths from either injuries or cardiovascular diseases.

The aging of the population and the importance of a life course approach - The number of Canadians aged 65 years and older has more than doubled since 1970; by 2031, there will be approximately 9 million seniors who will account for 25% of the total population. Aboriginal peoples are the exception to this trend, with almost 60% of the population under the age of 25. Although Canadian policies have been effective in improving the socioeconomic status of seniors in Canada overall, inequities continue to exist; almost one in five seniors live near the poverty line, especially women who are divorced or separated, women over the age of 80, visible minorities, and immigrants. Premature aging, high rates of chronic diseases and low levels of life expectancy among older Aboriginal people represent a particular challenge.

Investing in healthy aging is not an “either-or proposition” that sets up competition for...
resources between the young and old. Rather, it is part of a life course approach that seeks to improve well-being at various life stages by making strategic investments at different times and transition periods (e.g., childhood, entering school, adolescence, parenthood, older age). Policies that reduce inequities protect and support vulnerable people at these critical times.\(^{15}\)

**Increasing diversity in the Canadian population** - Sustained immigration from non-European countries has increased Canada’s cultural diversity in recent decades. Statistics from the 2001 Census show an increase in the number and proportion of immigrants whose mother tongue is neither English nor French, members of visible minority groups, and people whose religion is non-Christian. By 2017, it is predicted that 20-25% of all Canadians will be members of visible minority groups. The ratio will be much higher in some major cities (e.g., over 50% of the population in Toronto and Vancouver).\(^{16}\)

With rapidly increasing diversity, issues related to health inequities are likely to accelerate unless action is taken. The “healthy immigrant effect”, that sees immigrants in better health than the Canadian-born population when they arrive in this country, diminishes with time.\(^{17}\) Newcomers to Canada are more likely to be unemployed or underemployed, to have difficulty accessing affordable housing, and to experience racism and discrimination.\(^{18}\) An inability to speak English or French can be a major obstacle to accessing education and health and social services. In 2004, low-income rates among immigrant families during their first full year in Canada were 3.2 times higher than those of Canadian-born people.\(^{19}\)

**Urbanization and disparities in rural and isolated areas** - In urban Canada, where over 80% of the population resides,\(^{20}\) people with lower levels of education have lower life expectancies, as do those living in lower-income neighbourhoods.\(^{21}\) This points to the need for social policies that focus on urban design and the built environment (including public transportation) as critical determinants of health. Neighbourhoods are key settings for influencing health, so the importance of local government must be recognized and supported.

Living in remote (mostly Northern) areas is another major factor in health inequities. For example, in British Columbia, there is a gap of 10-14 years of life expectancy between the southern, urban areas and the north and central coastal regions.\(^{22}\) Generally, residents of remote communities across Canada face difficulties accessing healthy foods, adequate housing, higher levels of education, employment and health care.

Adequate, safe and affordable housing is an issue in both urban and rural settings. It is particularly problematic in Northern and isolated communities, where residents are likely to experience overcrowding, poorly constructed and ventilated housing and a lack of access to affordable shelter. Homelessness is an increasing concern in urban centres and is a growing crisis for young Canadians. Approximately one third of the homeless are between the ages of 16 and 24 years.\(^{23}\)

**Globalization** - Many of the social programs developed in the past 50 years were not predicated on the current reality of a globalized century and a globalized economy. Products and services such as food and agriculture, tobacco, and pervasive advertising are now controlled by global corporations and trade procedures. While globalization has brought new opportunities for equitable health, it has also brought threats, risks and increased inequities, especially for inhabitants of the world’s poorest countries. Overall, the number of people living at or under US$1/day dropped by 414 million between 1981 and 2003. However, in sub-Saharan Africa during this same period, the number of people living on US$ 1/day or less doubled, and the number living on US$ 2/day or less almost doubled. Reducing health inequities between and within countries requires policy coherence at the global level, just as internal inequities do at the national level.\(^{3}\)

**Growing understanding and demonstrated success** - The wide range of documents reviewed for this paper provide us with a more common and clear understanding of the causes of health inequities and how to address them. The increasingly robust evidence shows how the unequal
distribution of the social determinants of health undermines the health of millions of Canadians, as well as the health of our economy.

Successful initiatives have been studied and documented in Canada and internationally. For example, the UK and Ireland have successfully reduced health inequities through dedicated, coordinated, and significantly resourced inter-sectoral strategies. Nordic countries have reduced child poverty with policies that encourage progressive taxation, equality of benefits and services, full employment, gender equity, and low levels of social exclusion. Québec and Newfoundland and Labrador have successfully implemented provincial anti-poverty strategies.  

Public support for addressing health inequities is increasing. A recent Angus Reid poll in British Columbia found that 79% of British Columbians support a provincial action plan to improve the health of disadvantaged citizens.  

When informed of the wide health inequities in Saskatoon, 91% of residents said something could be done to address the problem.  

Scattered progress in a federated system - While Canada has been recognized as a leader in health promotion for decades, progress on a “population health” approach has been scattered and incomplete. In 1997, the federal government endorsed a Memorandum to Cabinet on Health Promotion; unfortunately, due to subsequent funding cuts, it did not succeed in mobilizing the 17 departments involved. In Newfoundland and Labrador and Québec, population health policy emanates from the health department, but the two jurisdictions also have separate policies on poverty and social exclusion. In other provinces, current whole-of-government approaches tend to be structured around singular health determinants, such as early childhood development in the case of Healthy Child Manitoba. Each province implemented health goals between 1989 and 1998, but by the end of the 1990s, they were no longer being used. In 2005, Federal, Provincial and Territorial Ministers of Health established health goals for Canada but, to date, they have not evolved into a national strategy or translated into measurable actions. Moreover, national targets have not been set for reducing inequities in health.  

Canada has invested in surveillance systems that provide sound data on population health status by health determinants and on health inequities at both national and provincial levels. Institutions and centres of excellence such as the Canadian Institutes of Health Research, the National Collaborating Centres on Public Health, the Canadian Population Health Initiative, the Institut national de santé publique du Québec, and the Ontario Institute for Work and Health are well established and can provide knowledge development and transfer.

The legacy of social exclusion for Aboriginal people - Although intra- and inter-group differences exist among First Nations, Métis and Inuit peoples, historical research indicates a clear link between the social inequalities created by colonialism and residential schools and the high levels of disease, disability, violence and early death experienced by Aboriginal peoples in Canada.  

In other words, successive traumatic events continue to affect the health of contemporary Aboriginal peoples through what is referred to as ‘historic or cultural trauma’.  

The authors of the NCCAH paper suggest that the “historic legacy associated with Aboriginal identity” in Canada needs to be addressed as a primary determinant of health in its own right, and go on to make recommendations to that effect.  

The economic downturn - Public and political concerns about the current economic downturn will likely provide the greatest challenge to ramping up social policy investments. Yet this is the very time that inequities increase. All over the world, the most vulnerable populations will experience the impact of domestic and global financial, food and climate problems at double or triple the rate of their more wealthy neighbours.

Moral imperative aside, a number of recent reports have focused on the economic benefits of addressing health inequity.  

In 2005, the total annual cost of poverty in the US was estimated to be $1.5 trillion (US) and in Europe, €1 trillion. The BC Healthy Living Alliance has estimated
that the cost of three major risk factors associated with poverty - tobacco use, physical inactivity and overweight/obesity - cost approximately $3.8 billion annually.\textsuperscript{28}

At the same time, the financial crisis has put a spotlight on some of the business sector's worst practices, both on Wall Street and in the area of credit lending. There is a growing understanding that everyone suffers when private wealth is prized over public good, and that a balanced approach is needed.

Canada's Economic Action Plan, outlined in the 2009 federal budget, proposes to improve the country's financial situation by providing $8.3 billion for the Canada Skills and Transition Strategy, which includes extra support for those Canadians most affected by the economic downturn, including enhancements to Employment Insurance and more funding for skills and training. This is in keeping with efforts to address employment as a basic determinant of health. The budget also supports enhanced funding for clean energy and green technology, another area that matches a determinants of health approach to reducing inequities.

3.2 \textit{Anticipating and Addressing Resistance}

Advocates must be prepared to address resistance from different quarters when acting on inequities in health at their root causes.

\begin{itemize}
  \item Economic growth will, on its own, improve everybody's health
  \item The high taxes needed to fund a strong welfare system limit economic competitiveness.
  \item Inequalities are largely the result of poor lifestyle choices amongst poorer people.
  \item The best way to improve health is to invest more in our healthcare system.
\end{itemize}

\textit{Economic growth on its own will improve everybody's health.}
\textit{Response:} There is a long-term positive relationship between economic growth and improved health. The health effects of economic growth, however, also depend on who is benefiting from the economic resources that are generated. Resources can be used in ways that promote the health and well-being of a small portion of society or they can be used to even out social and health benefits across society as a whole. It is possible to balance economic growth with social investment to reduce inequities. Countries such as Sweden, Nicaragua and Costa Rica have better population health than would be expected for their level of national income, because they prioritize policies and programs that address inequities.\textsuperscript{8}

\textit{The high taxes needed to fund a strong welfare system limit economic competitiveness.}
\textit{According to the Fraser Institute, “A plethora of international evidence strongly correlates high levels of taxation with economic decline and unemployment, yet the WHO maintains that this is key to tackling inequality. In reality, the only equality high taxation brings is equality of impoverishment, as individuals and businesses pack up shop and leave for other, more attractive jurisdictions.”}\textsuperscript{29}

\textit{Response:} The empirical evidence refutes this claim. On the Global Competitiveness Index, for example, high tax Nordic countries are ranked near the top in terms of competitiveness (in 2008: Denmark 3rd, Sweden 4th, Finland 6th and Norway 15th).\textsuperscript{30}

\textit{Inequalities are largely the result of poor lifestyle choices amongst poorer people.}
\textit{Response:} Lifestyle practices themselves show a social gradient. For example, Canadians with lower levels of socioeconomic status are more likely to smoke. This suggests that social and structural factors affect the uptake of healthy and unhealthy behaviours. Wider social conditions need to be addressed alongside efforts to promote healthier lifestyles. It is difficult for a single mother to maintain a healthy weight when she has neither enough money to purchase healthy foods nor any childcare to allow her to join an exercise program.
The best way to improve health is to invest more in our healthcare system.

Response: Evidence suggests that simply spending more money in the health care system is not the most effective strategy for increasing the overall health of the population. This observation is well-supported by comparing Cuba and the United States on life expectancy and health care spending. Cuba, with an average life expectancy of 77.1 years, is ranked 28th in the world, just behind the US (78.0 years). However, the annual per capita spending on health care in Cuba is among the lowest in the world: at $186 it is a small fraction of the $4500 per person spent in the US. At the same time, protecting the Canadian system of universal access to healthcare and ensuring equitable access to care is critical to health equity.

Action to reduce health inequities benefits the economy, health outcomes and the overall quality of life of Canadians in the following three ways:

- Given that there is a gradient of health status across the entire range of socio-economic determinants, addressing specific health inequities will improve the health of all.
- Better health enables more people to participate in the economy and reduces the cost of lost productivity. Healthier employees, customers and communities positively affect economic growth.
- Addressing health inequities has the potential to stem the rapidly increasing use of health services. Easing the demand for services would decrease system cost drivers, reduce pressures on the delivery of health services, and, over the long term, contribute to the financial sustainability of our health care system.

4. Common Directions and Recommendations

4.1 Summary of Common Principles, Strategies and Determinants

Of the eight reports reviewed for this paper, five (four of the six Canadian reports, and the WHO Commission on the Social Determinants of Health) look at cross-cutting strategies and provide specific recommendations for action or focus of effort. The others reports (two Canadian and the second WHO report - “Focusing the Lens”), look at cross-cutting strategies and guiding principles while leaving the specific area of action for others to determine. Table 1 (Appendix 2) summarizes the recommendations and approaches of each report. Common approaches and strategies are noted here.

Guiding Principals - Most of the reports either explicitly or implicitly support four guiding principals: social justice; universal and targeted programs; accountability and best practices; and “levelling up, not down”. The Conference Board of Canada report looks at the targeted role businesses may play and does not address social justice. The NCCAH report addresses the specific situation of Aboriginal peoples in Canada, so a universal approach does not apply. With its broad scope, the WHO also supports universal, rather than targeted programs.

Cross-cutting strategies - Six cross-cutting strategies are identified in the reports, with support as follows:

1. invest in social policies, programs and incentives for action (8 of 8 reports)
2. develop and transfer knowledge (8 of 8 reports)
3. provide leadership (7 of 8 reports)
4. foster inter-sectoral action (7 of 8 reports)
5. build public and political support (6 of 8 reports)
6. develop community capacity (3 of 8 reports)

Determinants of health - Of the 12 determinants listed (Appendix 2), five are highlighted in all reports that make recommendations:

1. income and social status
2. education and literacy
3. physical environments (housing)
4. healthy child development
5. Indigenous status (the only specific recommendation is in the Senate report).
While the other determinants are mentioned, fewer specific recommendations are made with regard to health services (4), employment/working conditions (3), social environments (3), personal health practices and coping skills (1), and gender (1). No recommendations are made specific to social support networks, although the issues of community development and social inclusion are mentioned in several reports.

4.2 Analysis of Recommendations

Common recommendations for both cross-cutting strategies and priority areas for action are analysed below.

Cross-cutting Strategies

1. **Invest In Social Policies, Programs, and Incentives for Action (8 of 8 Reports)**

Policies may take the form of legislation, regulations, guidelines, and commitments. Government at all levels as well as employers, school boards, unions, insurance companies and community services all enact policies that affect population groups in different ways. Incentives encourage policy-makers to enact social policies in all of these sectors. Canada has strong social policy foundations that have helped to make it both healthier and more egalitarian. Programs like the Canada and Quebec Pension Plans, Old Age Security, Employment Insurance, Social Assistance programs, tax redistribution policies, publicly funded health care and universal primary and secondary education have all helped to establish a minimum standard of living. These must be protected in times of economic restraint. However, in order to reduce growing inequalities, some of these policies may need adjusting and other new policies are needed. For example, if social assistance recipients lose money or benefits as the result of increasing their income or gaining employment, they are essentially discouraged from becoming independent and leaving social assistance. In these cases, government benefits programs work contrary to their purpose. Complementary and coherent action is therefore needed over broader social policy and investments.

The Conference Board report makes a compelling case for creating “healthy strings attached” incentives for the private sector, such as tax relief, subsidies or eligibility for public funds. These incentives would support initiatives that promote health and reduce health inequities. The report also suggests that governments create enabling conditions through legislation and regulation that allow employers to take action to improve employee health without risking losing out to competitors who do not take these actions. Examples of effective policies and programs are provided in all of the reports. The key ones are discussed in the next section.

2. **Develop and Transfer Knowledge (8 of 8 Reports)**

This strategic direction includes investments in research, surveillance, evaluation and knowledge transfer, as well as in building and sustaining knowledge infrastructures. Some specific recommendations include:

- Measure and understand the problem. Measure health inequity, within countries and globally.
- Track health outcomes by enriching the population health database.
- Assess the impact of action: evaluate policy and action on health inequity, including the long-term impacts and legacies of key pilot programmes.
- Invest in public health research on the social determinants of health and on interventions that enhance the health of the population.
- Enhance the translation of knowledge and disseminate evidence on what works.
- Invest in the training of policy makers and health practitioners in health determinants.
- Increase public understanding of the social determinants of health.
- Support research that explores new and emerging issues such as actions to tackle the full social gradient in health (equity-oriented policies); the interactions and clustering of risk
health-damaging behaviours.

- Establish a greater understanding of policy implementation processes.

3. **Provide Leadership (7 of 8 Reports)**

Bringing about action requires more than good ideas or honourable ideals. High-level leadership in all sectors - health and otherwise - is crucial to reducing health inequities. Canada also has an obligation to provide leadership on the global front, to fully support health equity efforts spearheaded by the WHO.

Some specific recommendations include:

- Make addressing health inequities a government and societal priority, and allocate resources accordingly. Consider putting legislation in place that makes reducing health inequities a legislative commitment (as was done in Québec regarding poverty).
- Establish clear plans to address specific issues (e.g. a plan to address child poverty).
- Require a health impact assessment of policies related to the social determinants of health in both the public and private sectors.
- Set clear and measurable goals and targets, with processes in place to track progress. For example, the Saskatoon report suggests one target is to reduce the number of children living below the low-income cut-off from 20% to 2% in five years.
- Implement a federal population health strategy and framework across all appropriate departments.
- Engage leaders and champions across all sectors of society to take up the cause of reducing health inequities and inequalities.

4. **Foster Inter-sectoral Action (7 of 8 Reports)**

All the reports studied make it clear that addressing inequities through a social determinants of health approach is a complex undertaking; it requires cooperation across all levels and areas of government and across the private sector, non-governmental organizations and communities.

Some specific recommendations for multi-sectoral action include:

- Recognise the role of the public health sector in tackling the problem. While this sector may serve as an important catalyst, mediator and advocate, it has neither the expertise nor the capacity to lead work in other sectors.
- Create a dialogue with other sectors and identify entry-points with different sectors.
- Establish mechanisms such as high level, cross-sector steering committees, indicators for key outcomes and regular public health reports for parliament.
- Develop tools that facilitate cross-sectoral work, such as the health equity impact assessment.

5. **Build Public and Political Support (6 of 8 Reports)**

Political commitment at all levels is an essential ingredient in tackling health inequities. This leadership must be rooted in public support to achieve broad-based political commitment, from all parties and at various levels of government.  

Both the Health Officers Council of BC and the Saskatoon Health Region conducted extensive public consultation to gauge public opinion and involved multiple sectors in seeking solutions to health disparities. A survey of community awareness in Saskatoon showed that while people were aware that poverty affects health, they underestimated the extent of its impact. The overwhelming support given for action in both regions demonstrates the value of engaging the public and providing them with clear, detailed information on health inequities and opportunities to address them.
Engaging the media is an important strategy to use when seeking to educate and gain support from the public. Several nongovernmental organizations and training groups have developed sophisticated media advocacy tools and resources for this purpose. While promoting a determinants of health approach may seem more difficult in trying economic times, the following editorial gives a different perspective:

“Spending on poverty is the best form of stimulus because the poor spend every cent they receive on food, clothing and services in the local economy. And report after report has convincingly catalogued just how much keeping people poor costs us all in billions of dollars of increased health, justice and social service costs and lost productivity and tax revenues.”

(Don’t Forget Poor in Ontario Budget, editorial, Toronto Star, February 13, 2009)

6. Develop Community Capacity (3 of 8 Reports)

Working to strengthen communities is a critical component of any comprehensive plan to address health inequities and is an area of strength in Canada. Programs and initiatives that rely on input and participation at the community level - like the Community Action Program for Children and Aboriginal Head Start - enable communities to be directly involved in identifying their own needs and tailoring appropriate solutions. In addition to building capacity within communities, investments in these sorts of initiatives are often managed by coalitions of local stakeholders, ensuring more comprehensive, cross-sectoral approaches. Local governments, businesses, non-governmental organizations, professionals in health, education and social services, schools, and faith communities all play key roles in building community capacity. Population groups such as youth, parents, older people, people with disabilities, people with Indigenous roots, and new immigrants are also “communities”. These groups need to gain empowerment and confidence through an active involvement in defining needs and building capacity.

Finally, it is essential to measure longer-term progress being made in communities so that programs can be supported consistently based on their impact and effectiveness.

Priority Issue Areas

All five reports that make recommendations identify the five priority issues for action that follow. Common recommendations are noted, and specific policy options that support them are provided, where available. With a total of 46 policy recommendations, the Saskatoon report provides by far the most detailed plan; some applicable policy options from that report are noted here as examples to help guide further deliberation.

1. Income and social status (focus: child poverty)

Income and socio-economic status are “upstream” factors; they are noted in a number of the reports as the prime cause of health disparities in Canada. According to the Health Officers’ Council of BC, “Among all the policy areas for addressing the social determinants of health and reducing health inequity, none is more significant than that of income security and measures for reducing poverty in the province.”

As for economic payback, research shows that “...people in the lowest quartile of income groups use approximately twice as much in the way of health care services as those in the highest quartile.” Canada’s Chief Public Health Officer speculates on the long-term savings to taxpayers possible by addressing child poverty. “It is estimated that $1 invested in the early years saves between $3 and $9 in future spending on the health and criminal justice systems, as well as on social assistance.”

The private sector, as reflected by the Conference Board of Canada and the media, recognize the value of investing in “upstream” determinants of health as a way of reducing “downstream” costs in the health-care delivery system. The arguments noted in Section 3.2
(Anticipating and Addressing Resistance) point to several reasons why the private sector can support reducing poverty, including the prospect of improved performance and profits. The public is also supportive, as noted in the following polling result:

“An overwhelming majority (92%) of Canadians say that if nations like the UK and Sweden can make significant progress on reducing poverty, then Canada can too. 86% say governments should take concrete action, reducing poverty by 25% in five years.” (Environics, October 2008)

A common recommendation across reports is to create a plan to reduce poverty (or specifically child poverty) rates against set, measurable targets.

Prime mechanisms for doing so are income redistribution programs (cited by CPHO, BC, Sask, WHO) and include:

- Increase and index minimum wage and social assistance payments.
- Remove earning clawbacks, and ensure that benefits and earnings from work augment the incomes of working poor and those on social assistance.
- Engage in tax reform and adjusting lower limit tax exemptions.
- Add the federal child benefit to existing benefits (combine the Canada Child Tax Benefit and National Child Benefit Supplement).

The CPHO’s Annual Report and the Saskatoon Health Region report suggest a specific focus on child poverty. Specific recommendations to reduce child poverty include:

- Support children in low income families through targeted interventions. For example: increase support for parents on leave.
- Provide support for food security and nutrition.
- Provide opportunities for healthy early learning and childhood development.

2. Inequities among Aboriginal peoples

All the Canadian reports reviewed, including that of the Conference Board of Canada, single out Aboriginal peoples as particularly vulnerable to poor health, due to low socioeconomic status and the unique effects of the historical legacy with which they have been burdened. The Senate report focuses on the specific need to implement an Aboriginal population health strategy.

Colonial policies to assimilate and acculturate Indigenous peoples into the dominant culture, as exemplified by residential schools, systematically destroyed culture, language, family ties and community networks for generations of First Nations, Métis and Inuit children. The resulting physical, emotional, mental, and spiritual trauma affected the health of those involved, as well as their children. Unless the dire health circumstances of the fast-growing younger generation are addressed, the consequences will be “considerable, compounding and potentially devastating”, according to the NCCAH report.

The report, Health Inequalities and Social Determinants of Aboriginal Peoples’ Health, makes a compelling case for action. While it makes few specific recommendations, the report cites self-determination as the most important influence on health among Aboriginal peoples. The Saskatoon Health Region also cites the need to promote Aboriginal self-determination. It calls for measurable goals to reduce education and employment disparity:

- Set a measurable goal to reduce the number of children not attending school
- Increase high school graduation rates for Aboriginal children from the current rate of 48%
- Set measurable goals to increase employment of Aboriginal people
- Increase Aboriginal control over employment and academic programs
- Support Aboriginal-owned businesses.
The NCCAH report presents evidence of a multi-generational cycle of poor Aboriginal education based on inequities in the distribution of educational resources and opportunities. Lacking a good education themselves, parents often lack the capacity to promote education to their own children. The report calls for adequate funding for preschool programs, which show the most favourable return on investment.

3. Housing

The lack of adequate housing is a determinant that has far-reaching repercussions on income; education; employment; personal health practices and coping skills; and healthy child development. According to the BC report, “Mortality rates for homeless people can be up to 10 times higher than for people who are adequately housed.” The homeless also suffer from more chronic diseases and require more emergency medical services than the rest of the population.

A BC report recently showed that providing adequate housing to people dealing with mental illness and addictions would reduce spending on health and prison costs for this population by one-third, saving the province $211 million annually. Economic reasons alone offer compelling arguments for addressing the housing issue. However, the WHO points out that access to quality housing, clean water and sanitation are “human rights and basic needs for healthy living”.

All of the reports that suggest specific recommendations (CPHO, BC, Sask, NCCAH, WHO) point to the need to provide adequate, affordable housing. Some propose this as a strategy to lift children out of poverty. The Saskatoon report provides recommendations to:

- expand affordable housing projects
- reserve 10% of new development for affordable housing
- expand not-for-profit housing authorities, and
- support home ownership.

Some recommendations address the built environment more broadly, noting the need to create healthy urban neighbourhoods. The “hard to house” and vulnerable populations are addressed in several reports that propose special strategies for youth, the mentally ill and addicted, and Aboriginal people.

Broader strategies to promote increased affordable housing include (Saskatoon):

- Develop a long-term, consolidated, comprehensive, interagency social housing system for hard-to-house individuals
- Build community acceptance for affordable housing
- Increase monthly shelter allowances
- Renew federal responsibility for social housing.

4. Education and literacy

As with income, health follows a gradient according to education, with better-educated people enjoying improved health and increased life expectancy. Education influences socio-economic status by determining, to a large extent, a person’s opportunities for employment, income and access to other resources. As such, it is often described as the route out of poverty.

Changing economic and global policies are putting even greater emphasis on the importance of education. People without high school or higher levels of education have fewer employment opportunities and less stability, particularly in a knowledge-based economy.

Education is a focus in all five reports that provide specific recommendations to reduce health inequities. The CPHO and Saskatchewan reports focus on children, with the CPHO suggesting educational opportunities as a strategy to reduce child poverty. As noted above, the NCCAH
report raises the issue of systemic inequities in educational resources and opportunities for Aboriginal children.

Literacy is addressed in both the WHO and BC reports, with the latter identifying Canadians who are seniors, recent immigrants, less educated or receiving social assistance as having low literacy and health literacy skills. Health literacy is important to chronic disease education and management. Broader outcomes of low literacy and health literacy skills include lower income and less community engagement.\(^\text{32}\)

Specific recommendations from Saskatoon begin with measurable goals for children, particularly Aboriginal students, attending and graduating from school. Support for community schools and low income students is also suggested, along with affordable tuition for university students.

5. Early child development

Among the policy options, early child development (ECD) has, arguably, the strongest evidence base for success. According to the WHO, “Experiences in early childhood…and in early and later education, lay critical foundations for the entire life course. The science of ECD shows that brain development is highly sensitive to external influences in early childhood, with lifelong effects.”\(^\text{3}\)

As for economic support, the WHO contends that, “Investment in the early years provides one of the greatest potentials to reduce health inequities within a generation.”\(^\text{38}\) The potential for quick success provides both economic and political impetus for action.

Support for EDC may also have the most solid backing of the public. Of the 30 policy options presented to the citizens of Saskatoon, the highest support - close to 84% - was given to strengthened early intervention programs for children and youth. The abysmal failure of Parliament’s commitment to end child poverty by 2000 is a source of shame for many Canadians. National rates of child poverty have remained stagnant, at slightly over 11%, since the declaration was made in 1989. Finland has the lowest rates of child poverty in the world, at about 3%.

All of the reports echo the recommendation to provide “a healthy start for all Canadian children,” particularly for children most in need, including low-income and Aboriginal children. There is support for comprehensive approaches for optimal child development,\(^\text{t}\) including interventions that address social/emotional and language/cognitive development.\(^\text{38}\)

Among specific recommendations, there is a call for affordable high quality child care (BC), and universal child care for low income parents (Saskatoon). Support for families and parents through adequately resourced and well-coordinated public programs (BC) is also strong.
5. A Proposed Framework for Action

The following framework suggests the parameters of a broad plan to reduce inequities in health through action on the social determinants of health. Four guiding principles underlie the use of the five key strategies described in Section 4. Five priority issues are suggested, in keeping with the document review and Canadian contextual factors. It suggests a multi-sectoral strategy involving all the key players, carried out in all the everyday settings where Canadians live.
Appendix 1- Glossary of Terms

**Determinants of health** - the range of personal, social, economic and environmental factors that determine the health status of individuals or populations.\(^{39}\) The Public Health Agency of Canada lists the following as examples of determinants of health: income and social status; social support networks; education; employment and working conditions; genetics and biology; social environments; physical environments, personal health practices, healthy child development; health services; gender; and culture.\(^{40}\) These determinants intersect and interact with one another, so that the health of any individual is a complex summation of factors.

**Social determinants of health** - social determinants of health can be understood as the social conditions in which people live and work.\(^{41}\)

See the Public Health Agency of Canada definitions at [http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#key_determinants].

**Health equality/inequality** - the generic terms used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups...that need not imply moral judgment.\(^{42}\) Some inequalities reflect random variations (i.e., unexplained causes), while others result from individual biological endowment, the consequences of personal choices, social organization, economic opportunity, or access to health care. Public policy is concerned with health inequalities attributable to modifiable factors, especially those that are perceived as inequitable.

**Health equity/inequities** - those inequalities in health that are deemed to be unfair or stemming from some form of injustice. The crux of the distinction between equality and equity is that the identification of health inequities entails normative judgment premised upon (a) one's theories of justice, (b) one's theories of society, and (c) one's reasoning underlying the genesis of health inequalities. Because identifying health inequities involves normative judgment, science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair.\(^{43}\)

**Health disparities** - differences in health status that occur among population groups defined by specific characteristics. For policy purposes, the most useful characteristics are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socioeconomic status, Aboriginal identity, gender, and geographic location.\(^{44}\)

**Inter-sectoral action** - A term espoused by health-related and other international agencies meaning action that involves several sectors of society, for instance action by the health, education, housing and local government sectors to enhance community health.\(^{45}\) Variations include **inter-department/inter-Ministry/ inter-agency action** (within an organization), **cross-sectoral action** (across multiple sectors, including public private, non-profit, faith, academic, professional, etc), and **vertical integration** (action across multiple levels, such as federal, provincial/territorial, municipal or international).
Appendix 2 – Summary of Key Recommendations from Health Equity Reports

While most of the determinants of health are discussed in each of the reports reviewed, the table notes only specific recommendations in each area.

<table>
<thead>
<tr>
<th>Cross-cutting Strategy</th>
<th>CPHO</th>
<th>Conference Board</th>
<th>Senate</th>
<th>BC Health Officers</th>
<th>Saskatoon Health</th>
<th>NCCAB</th>
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<td>Provide leadership</td>
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<td>Invest in social policies, programs and incentives for action in the SDoH</td>
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* - As defined by the Public Health Agency of Canada [http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#key_determinants], with the addition of “Indigenous Status”
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