Reducing Health Disparities – Roles of the Health Sector: Discussion Paper

Prepared by the
Health Disparities Task Group
of the Federal/Provincial/Territorial
Advisory Committee on
Population Health and Health Security

The opinions expressed in this publication are those of the authors and do not necessarily reflect the view of the Public Health Agency of Canada.

Également disponible en français sous le titre : *Réduire les disparités sur le plan de la santé – Rôles du secteur de la santé : Document de travail*

Cat. N° HP5-4/2005
ISBN 0-662-69313-2

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December 2004

ACKNOWLEDGEMENTS

We would like to thank the members from across Canada of the Health Disparities Task Group of the Advisory Committee on Population Health and Health Security, who shared in the responsibility of developing and completing this report.

In addition, we would like to recognize the work of the following people, who were contracted to contribute to the development of the report through research and writing: Steven Lewis, Katherine Frohlich, Nancy Ross, Susan Swanson and Diane Kinnon.

We would also like to thank the many people who provided input to the development of the report, including people from all parts of Canada who attended the CIHR (Canadian Institutes of Health Research) Health Disparities and Promoting Equity for Vulnerable Populations initiative Think Tank in Ottawa, September 2003, and the Health Disparities Policy Forum consultation in Ottawa, March 2004, hosted jointly by CIHR, the Canadian Population Health Initiative, Health Canada and the Health Disparities Task Group.

Thanks are also due to staff at the Public Health Agency of Canada (previously Health Canada), Heather Fraser, Brenda Steinmetz, Diane Alfred and Mana Herel, as well as to Laura Donatelli of Manitoba Health, all of whom provided advice and policy expertise in developing the report.

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PAPER HIGHLIGHTS

- Canadians are among the healthiest people in the world, but some groups of Canadians are not as healthy as others. Major health disparities exist throughout the country. These health disparities are not randomly distributed; they are differentially distributed among specific populations (e.g. Aboriginal peoples) by gender, educational attainment and income, and other markers of disadvantage or inequality of opportunity.

- Socio-economic status (SES), Aboriginal identity, gender and geographic location are the most important factors associated with health disparities in Canada. The consequences of health disparities are most pronounced in the lowest 20% of the SES scale and for Aboriginal peoples.

- These health disparities persist among lower SES groups despite higher overall use of health services. Because they are more often and more severely sick or injured, people in the lowest quintile of income groups use approximately twice as much in the way of health care services as those in the highest quintile. On the basis of an estimation of health care resources used by Canadian households, approximately 20% of total health care spending may be attributable to income disparities.

- Health disparities are not simply a have-have not issue; there is a gradient, and all Canadians are affected. At every step in the SES gradient there are differences in risk factors and risk conditions, health status, incidence of disease and mortality across a wide range of physical and mental disorders.

- The most important consequences of health disparities are *avoidable* death, disease, disability, distress and discomfort; but it is clear that disparities are also costly for the health system and Canadian society as a whole. Health disparities are inconsistent with Canadian values, threaten the cohesiveness of community and society, challenge the sustainability of the health system, and have an impact on the economy. These consequences are avoidable and can be successfully addressed, but they nevertheless persist and, in some cases, are growing across the country.

- Given the magnitude of the issue and the great potential for health gains, greater focus and investment should and can be given to health disparities. Recent First Ministers' Health Accords have made national commitments to reducing health disparities. The 2003 Accord was a natural culmination of 30 years of policy development that has progressively positioned the health sector to play a strong role in the reduction of health disparities.

- Several European countries have developed comprehensive, integrated strategies for health disparities reduction and have formulated goals and targets to achieve them. Canada can learn from the approaches adopted by the health sector in other countries.

- Canada has launched a number of promising initiatives to reduce disparities. Over time, Canada can be more effective by building on this foundation to develop a comprehensive, integrated strategy for addressing health disparities. Canada's Healthy Living Strategy has the potential to be one key component of a framework for accelerating progress in disparities reduction. Research has consistently shown that a limited number of non-medical determinants underlie the greatest health disparities. The most appropriate and effective way to improve overall population health status is by improving the health of those in lower SES groups and other disadvantaged populations.

- Making health disparities reduction a health sector priority with coordinated effort on several fronts, including promotion of a health disparities perspective among all public policy-makers to address the determinants of health, will have the greatest impact. Leadership on disparities reduction within the health sector is needed to facilitate the roles of the health sector and to support growing awareness and policy action in other sectors to achieve health gains.

- The health system is a key determinant of population health. If health care and public health programs and services do not include a focus on the needs of disadvantaged individuals, populations and communities, there is a risk of increasing rather than reducing health disparities. The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities.

- Taking action on a wide spectrum of factors - and their interactions - known to influence health is essential to reducing health disparities. This requires participation from those sectors whose work is aligned with key health determinants. As noted in its Global Strategy on Diet, Physical Activity and Health, the World Health Organization (WHO) sees engaging with other sectors as an essential responsibility of the health sector. Such partnerships and promotion of a health disparities perspective are most effective when they extend to the public, voluntary and private sectors.

- Comprehensive approaches to disparities reduction in other countries originated in a commitment to documenting the extent of disparities, developing evidence-based policies and evaluating interventions. Further development and ongoing expansion of the knowledge base in Canada is key to advancing policy development, priority-setting and evaluation efforts.

INTRODUCTION: WHY DISPARITIES MATTER

Canadians are among the healthiest people in the world, but some groups of Canadians are not as healthy as others. Major health disparities exist throughout the country. These health disparities are not randomly distributed; they are differentially distributed among specific populations (e.g. Aboriginal peoples) by gender, educational attainment and income, and other markers of disadvantage or inequality of opportunity.

Large health disparities are not inevitable: some gaps in Canada are wider than elsewhere, and some are narrower. As in other countries around the world, there is an increasing emphasis in Canada on the need to adopt policies and take action to reduce disparities. The main purpose of this paper is to explore the role of the health sector in addressing health disparities in Canada.

The reasons are many for increased health sector action on reducing health disparities. First, the health sector has a clear mandate in this area:

- The 2002 and 2003 First Ministers' Health Accords have made national commitments to reducing health disparities. As part of the 2004 First Ministers' Meeting a special meeting with Aboriginal leaders resulted in specific measures to address disparities in the health status of Aboriginal peoples.
- Ministers of Health have approved the strategic framework of the Healthy Living Strategy, establishing the reduction of health disparities as one of its two goals*.

Second, health disparities are a major burden for individuals and groups. For individuals, poor health creates an uphill battle to participate fully in the social, cultural and economic life of their communities. When ill-health clusters in identifiable groups, the adverse effects can be compounded to include exclusion, stigma and hopelessness.

Third, health disparities are health system cost drivers. Because they are more often and more severely sick or injured, people in the lowest quintile of income groups use approximately twice as much in the way of health care services as those in the highest quintile. On the basis of an estimation of health care resources used by Canadian households, approximately 20% of total health care spending may be attributable to income disparities.[1] Despite this higher overall use of health services, health disparities persist among lower SES groups.

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* It should be noted that although Quebec shares the general analysis of this document, it was not involved in developing it because it intends to remain solely responsible for developing and implementing programs for reducing health disparities within its territory. However, Quebec does intend to continue exchanging information and expertise with other governments in Canada.

Finally, health disparities are inconsistent with Canadian values, challenge overall quality of life, including the cohesiveness of community and society, and place a burden on the economy.

Evidence and experience have shown that health sector action on reducing health disparities has many potential benefits - for the health system, health outcomes and the overall quality of life of Canadians.

- The overall health of the community can be improved by reducing disparities.
- Because there is a gradient of health status across the entire range of socio-economic status, addressing health disparities will improve the health of all of society.
- Reducing the health care needs of low SES populations and other disadvantaged groups can decrease cost drivers and result in reduced pressures on the delivery of health services.
- Better health enables more people to participate in the economy, reducing the costs of lost productivity.

Now is the time for health sector leadership and action to realize these benefits. At this juncture, there are several opportunities for addressing health disparities.

- Thirty years of policy development culminating in the 2003 Health Accord have positioned Canada's health sector to play a strong role in developing and implementing strategies for reducing health disparities, and promoting this agenda within all governments.
- Some promising initiatives, ranging from research, to targeted community programming, to issue-based intersectoral collaboration, are already in place.
- The framework for the development of the Integrated Pan-Canadian Healthy Living Strategy provides one key opportunity to advance the health disparities reduction agenda.
- Research and non-government partners are engaging in this issue in a variety of ways, including highlighting the extent of disparities, analyzing and developing policy options, and delivering innovative, on-the-ground programs.
- The current environment of change in the health sector has also created opportunities for new structures and mechanisms to promote the reduction of health disparities. The transition to new organizations, including the Health Council, the Public Health Agency of Canada, the Pan-Canadian Public Health Network and the National Collaborating Centre for Determinants of Health, provides opportunities to incorporate a health disparities focus into these new entities as an essential element of their work.

Health disparities are avoidable and can be successfully addressed. This paper will explore the role of the health sector in addressing health disparities in Canada by:

- Presenting some facts of health disparities - how and why they occur and persist, the nature, extent and costs of health disparities in Canada and, where possible, comparisons between Canada and other countries;
- Reviewing how Canadian and international thinking on health disparities has evolved and current Canadian and international strategies for reducing health disparities;
- Suggesting policy directions and actions for the health sector to take to reduce health disparities, both within its sphere of direct control and through partnerships and promotion, and knowledge development and exchange.

A note about terms used in this paper

Health disparities is a term central to the discussion in this paper. Health disparities refer to differences in health status that occur among population groups defined by specific characteristics. For policy purposes, the most useful categorizations are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socio-economic status (SES), Aboriginal identity, gender and geographic location.

Other terms used internationally to refer to differences in health status include *health inequalities* and *health inequities*. Definitions and distinctions between these terms can be found in the "Key Terms and Definitions" section at the end of the paper.

Another key term used in this paper is *health sector*. It refers to the policies, laws, resources, programs and services that fall under the jurisdiction of Health Ministries. The sector spans health promotion and preventive health, public health, primary health care, including primary care, community health services such as home care, drugs and devices, mental health, long-term residential care, hospitals, and the services generally provided by health care professionals (doctors, nurses, therapists, pharmacists, etc.).

PART I

What We Know About Health Disparities

A. Health disparities in Canada: where we stand[2]

Major health disparities exist in Canada, and the most important relate to socio-economic status, Aboriginal identity, gender and geographic location. For example:

1. Women live 6 years longer than men but are more likely to experience long-term activity limitations and chronic conditions.[3]

2. All men in Canada (as a whole) live 7 years longer than First Nations men; for females the gap is 5 years.[4]

3. The death rate from injury among Aboriginal infants is 4 times the rate for Canada as a whole, among preschoolers 5 times and among teenagers 3 times.

4. Men in the highest income quintile live 5 years longer than men in the lowest; the gap for females is 2 years. The gaps have declined by about a year in the past quarter-century.

5. Of Canadians in the bottom income quintile 47% report their health as excellent or very good compared with 73% in the top quintile. People in the lowest quintile are five times more likely to rate their health as fair or poor than people in the highest. Aboriginal peoples are twice as likely to report fair or poor health status than non-Aboriginal peoples with the same income levels.

6. Infant mortality rates have been declining overall, but the rates in the poorest neighbourhoods remain two-thirds higher than in the richest, and the gaps have not closed since 1996. Rates in the richest neighbourhoods are about the same as those achieved nation-wide in Sweden, while those in the poorest parallel overall rates in the United States. Aboriginal rates are 1.3 to 3.1 times the national rate; they are highest in the north.

7. Men will spend, on average, 10 years of their lives with a disability, women 12 years. Education has a stronger impact on disability-free life expectancy (DFLE) than income. DFLE is highest in large urban centres and lowest in rural and remote areas.

8. Women experience more chronic, non-fatal conditions than men, and middle- and low-income Aboriginal peoples have more chronic conditions than non-Aboriginal peoples with the same income levels. Higher education protects against chronic conditions.

9. People living in Canada's northern remote communities have the lowest DFLE and lowest life expectancy in the country. Their rates of smoking, obesity and heavy drinking are above Canadian averages.

10. Some 10% of Canadian households, representing 3 million people, experience food insecurity each year. Prevalence is greatest among those who rely on social assistance, lone mothers with children, Aboriginal people and Canadians who live in remote communities. Food insecurity is associated with increased odds of poor or fair self-rated health, multiple chronic conditions, distress and depression.[5]

These realities raise two important issues. First, Canadian health status at the top of the SES gradient rivals the world's best. During at least the past three decades health status has been improving, and it appears that the gains have been greatest among those already healthy. For example, a Manitoba study found that between 1985 and 1999, mortality rates among people of above-average health declined by 13%, as compared with 7% among people with average health, and no change among those with below-average health.[6]

Second, lower down the SES gradient, health disparities persist despite higher overall use of health services. The availability of fully insured Medicare services (and no-cost additional services for status Indians and others eligible for full subsidy) has not eliminated major health disparities. Large increases in health care spending - up 55% between 1997 and 2003 - have not been able to eliminate health disparities. This reaffirms how important it is to evaluate not only the accessibility but also the effectiveness of health care for those in poorest health.

B. The causes and costs of health disparities

Health disparities result, in part, from the concentration of risk factors in certain segments of the population. These risk factors can come into play in a short period of time or over a lifetime. Early childhood development affects health and achievement throughout the life course. However, lives and disparities are not predestined: risk factors rise and fall with circumstance. For instance, people in temporary jobs appear to have higher mortality rates than those in permanent positions.[7] Job insecurity lowers self-reported health status,[8] but the prospect of impending unemployment appears to have a more negative effect on well-educated people.[9] Researchers have made great progress in understanding these phenomena, but the map of causal relationships remains incomplete. However, research confirms that a limited number of determinants underlie the greatest health disparities. Thus we have good reason to be confident that addressing a few but important conditions should reduce disparities.

The strongest predictors of disparities are socio-economic status (SES), gender, Aboriginal status and geographic location. They are not independent of each other: both Aboriginal peoples and some other groups, such as female single parents and older men and women, are more likely to fall into lower SES categories. In addition, it is important to note that the distribution, accessibility and quality of health care services also contribute to health disparities, as do community characteristics. For example, suicide rates in Aboriginal communities are lower where important governance and cultural continuity factors are present. Youth suicide rates are lower where the following six attributes are present: land claims, self-government, educational services, health services, police and fire services, and cultural facilities. They are very high where only one or two of these attributes are present.[10]

Socio-economic status (SES)

There is a widely documented SES gradient effect, most vividly shown in the landmark Whitehall studies[11] in the UK and reproduced in most Western societies. At every step in the SES gradient there are differences in risk factors and risk conditions, health status, incidence of disease and mortality across a wide range of physical and mental disorders. It is not just that the poor are less healthy than the rich; the near-poor are healthier than the very poor, and the rich are healthier than the nearly rich. Hence health inequalities affect everyone, not just the most obviously disadvantaged. What causes inequalities in health status higher up the SES gradient may not be as evident as in groups that are more clearly deprived.

Socio-economic status includes income, employment and education. The origins of poor health are not just money, although money and the decision latitude it affords is a factor. Low SES often translates into low self-esteem, the absence of life skills essential to making healthy choices, an unhealthy physical environment, indifference to risky behaviours, the stress of working in low wage, precarious employment and a lack of opportunity to participate in community life, etc. The overall effect is negative and may persist through several generations. How all of these factors translate into poor health is not fully understood; the pathways are complex and vary among individuals. Low SES is both a cause and an outcome of poor health. Integrating marginalized people into society and rebuilding lives requires more than material resources.[12]

In summary, health disparities are not simply a have-have not issue; there is a gradient, and everyone is affected. However health disparities and their consequences are most pronounced at the bottom end (roughly 20%) of the SES scale. Given the large impact of SES on health disparities, the focus in this paper with regard to the "non-medical" determinants of health will be on this key determinant. For the "medical" and other health system determinants of health, discussion will focus on the impact of health care and public health on health disparities (see discussion in Section D).

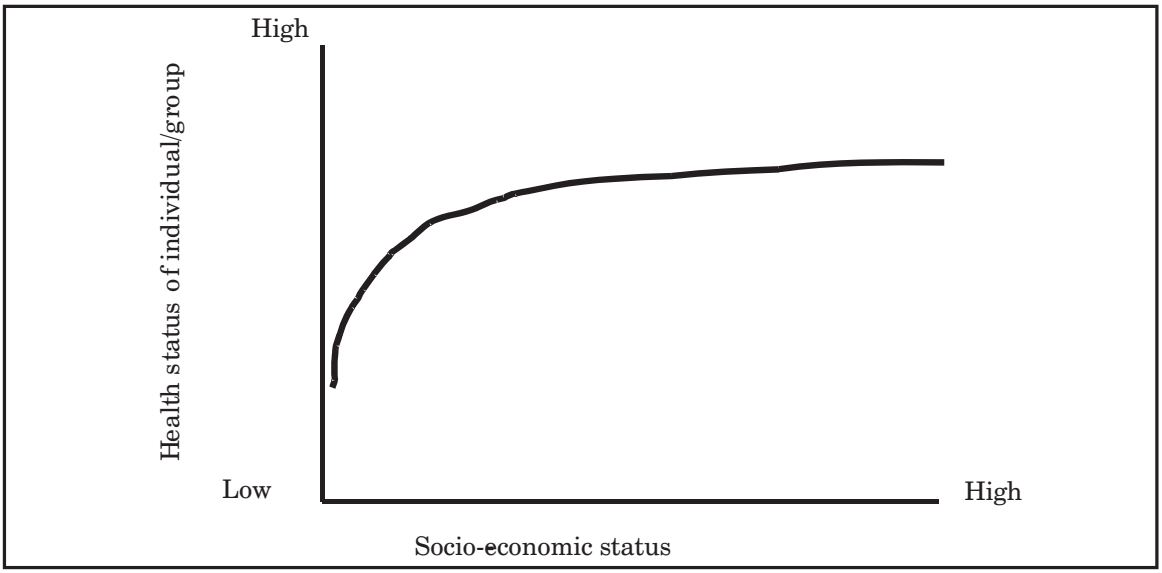
The costs of health disparities

The gradient is not a straight line. It looks more like a field hockey stick. Those on the "blade" of the stick suffer the greatest burden in terms of health status and other deprivations. However, groups higher up the shaft are not immune to the adverse impact of the disparities. Poor health and the conditions that cause it also create huge direct costs for the health care system and indirect costs to the economy in general. By one estimate, the total cost of illness and injury in Canada in 1998 was $150 billion, about equally split between direct (health care) and indirect (lost productivity and other factors) costs.

Neither ill health nor lost productivity is entirely avoidable, but simply raising the health status of people with lower SES status to the median level would have a major impact on overall health and should improve productivity. SES disparities drive public health care spending upward. Because they are more often and more severely sick or injured, people in the bottom quintile of income groups use, on average, 31% of all health care services in Canada, approximately double that of the top quintile.

The most important consequence of health disparities is avoidable death, disease, disability, distress and discomfort; but it is clear that disparities are also costly for the health system and Canadian society as a whole. Without a concerted effort to reduce disparities, it is likely that the health and cost burden of disparities will accumulate and grow.

Figure 1: Relationship of health status to SES



C. The potential economic benefit of reducing health disparities

Reducing health disparities has the potential for major benefits:

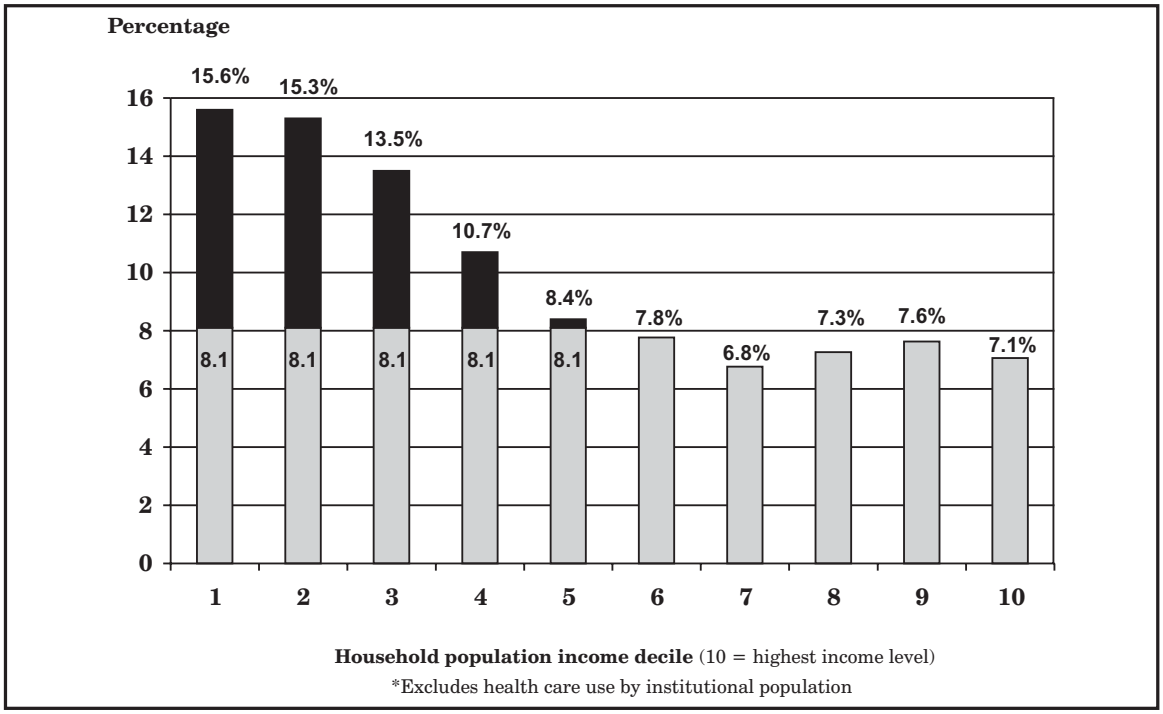
1. There should be a reduction in health care needs. If it is assumed that the utilization profile by income in Manitoba applies across Canada and were translated into 2004 dollars, the economic possibilities become clear (see Figure 2).

    a. Total current health care spending in Canada is about $120 billion per year, with the institutionalized population accounting for $26 billion of the total and the household population accounting for $94 billion. The lowest income quintile of the household population accounts for approximately $29 billion, or 31%, of the $94 billion, double the utilization of the highest income quintile, which uses about $14 billion, or 15%.

    b. As shown in Figure 2, it can be estimated that over 20% of health care spending may be attributable to income disparities. Households at the middle income point utilize 8.1% of health care spending, whereas utilization at the lower five income quintiles exceeds this spending by a range of 0.3% to 7.5 %. Thus, 23% of this spending is associated with income disparities. If the health status and utilization patterns of those in the lower income groups equalled those with middle income, significant savings could be possible. Examples of how this new situation could be achieved include effective public policy to improve the income and other non-medical determinants of the lowest two quintiles and more effective preventive and primary health care services to reduce the need for more costly hospital and other health care.

2. Better health enables more people to participate in the economy. Reducing the costs of lost productivity by only 10% to 20% could add billions of dollars to the economy.

Figure 2. Percentage use of publicly financed health care by household population* income decile Manitoba, 1994



Adapted from: Mustard CA et al. Paying taxes and using health care services: The distributional consequences of taxed financed universal health insurance in a Canadian province. Conference on the state of living standards and quality of life in Canada, Ottawa, October 30-31, 1998.

D. Does health care reduce or increase disparities?

There is a large literature on the association of health care and health disparities.[13,14,15,16,17,18] If all things are equal, better access is associated with reduced disparities. Policies and organizational approaches to health care that eliminate financial and other barriers can improve the health status of lower SES groups to some extent, but all things are not equal. Examples of how health care can affect health disparities follow:

1. Lower SES groups use some health care services less even where programs are universal at no direct cost to users - for example, coronary angiography[19] and stroke care.[20] Lower SES (and sicker) people use more primary care and hospital services than others, but despite better health, higher SES groups tend to use more specialist medical services.[21,22]

2. Lower SES groups have more complex needs and are less likely to have a continuous source of care and providers familiar with their needs.[23] Comprehensive care is important to identify multifaceted needs, ensure that there is access to care teams able to address complex problems, increase

adherence to recommended therapies, and improve quality of life and functional status.[24] Relatively few Canadians have access to single-centre, interdisciplinary comprehensive care.

3. Some services are partly or entirely uninsured in Canada. Among the most notable are prescription drugs. While most provinces provide first-dollar coverage for the indigent (defined as those eligible for social assistance), many people do not fill prescriptions because they cannot afford them. The consequences can include major health breakdown and in some cases, avoidable death.[25,26]

4. Higher SES groups are more likely to make use of some preventive services, e.g. Pap test and mammography screening. In general, lower SES groups are less likely to adopt preventive measures,[27,28] even when recommended by primary care providers.[29]

5. In general, higher SES groups are more likely to receive optimal care, thereby widening disparities.

6. Health care financing in Canada, and Medicare in particular, is organized to ensure that all SES groups have access to services and hence reduce health disparities. However, an episode-oriented medical and hospital system that focuses on discrete events and crises is often unable to address the more complex and continuous needs of at-risk populations. Primary health care innovations and reforms to increase comprehensiveness and accessibility have great potential to benefit lower SES groups, although these groups are usually less able to mobilize to influence changes; often they are not even participants in the policy and planning process. By and large, Canada has removed many (but not all) financial barriers to care. The next challenge is to find ways to make services more effective across the SES gradient.

7. An emerging literature shows that significant percentages of people across the SES spectrum do not understand the information they receive from health care providers.[30] Also, the news media tend to focus on issues related to health care (e.g. waiting times) rather than the broad determinants of health in Canada, despite more than 30 years of policy development.[31]

Thus, there is a need and an opportunity for the health sector to play an important role in any health disparities reduction strategy. Primary health care efforts and removing non-financial barriers to high-quality care can make a real difference. A sharper focus on disparities within the health sector should also lead to greater awareness elsewhere of the potential to make huge gains.

E. Public health, prevention and other challenges

The health sector has traditionally pursued two principal roles: treatment and prevention. Historically, at least some of the prevention measures also reduced health disparities. The 19th century public health advances - increased understanding of communicable disease mechanisms and the importance of clean water and other hygiene measures - undoubtedly improved the health of all. Similarly, the immunization revolution that began in the late 18th century led to universal programs that have largely eliminated some serious diseases, such as smallpox and polio.

Lower SES groups were usually more vulnerable to these diseases. Where preventive strategies were universally effective, the health gains were likely greater in these populations than in higher SES groups, and disparities were reduced. Such achievements were more likely when the impact of the programs did not depend on individual lifestyles or behaviours.

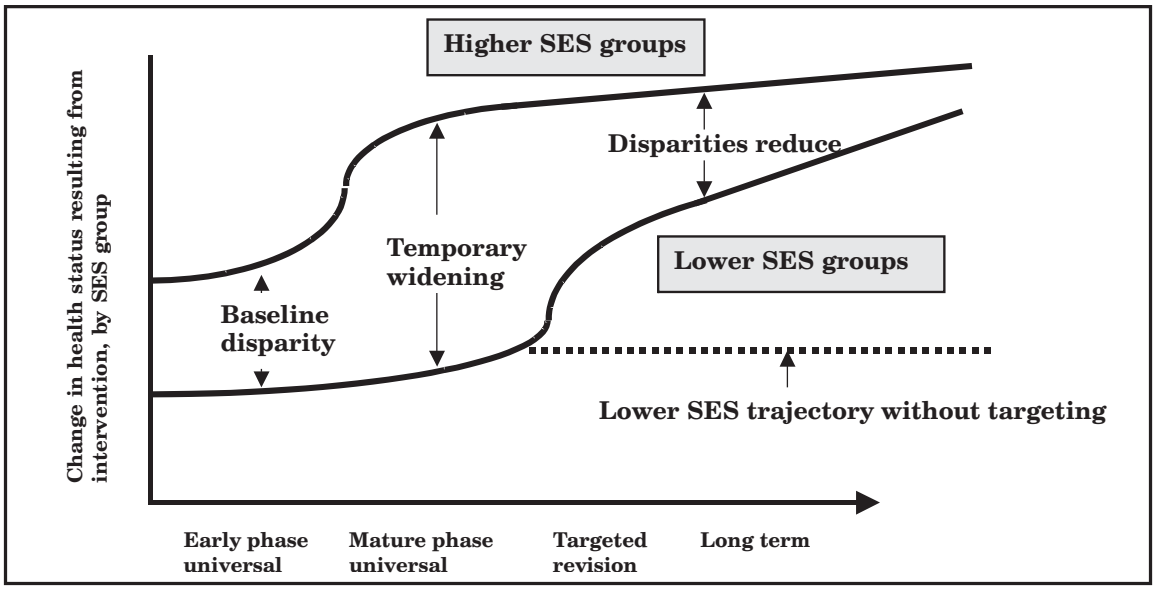
An integrated approach to population-based prevention programs can increase uptake and reduce disparities at the same time. For example, disparities in mammography screening rates in Manitoba fell after a government program was introduced. By contrast, significant SES disparities persist in cervical cancer screening, for which no organized program exists.[32]

Many contemporary health promotion strategies aim to improve health by encouraging people to change lifestyle or behaviour. In many cases, there is a transitional period during which improvement comes with an unintended negative consequence: health disparities actually widen. Smoking cessation and the promotion of an active lifestyle are examples. Higher SES groups are more likely to respond effectively to antismoking and active lifestyle messages: they have the motivation, resources, social support and environment to succeed. Often intervention strategies are undifferentiated - everyone gets the same media campaigns, educational materials and programs. Universal health promotion strategies, such as general lifestyle education, tend to be more effective in higher SES groups. The higher SES groups become "early adopters" of the desirable behaviours, and unless and until those in lower SES groups follow suit, health disparities will increase. The same story unfolds, more or less, in efforts to reduce the obesity rate.

Figure 3 illustrates this general effect over time. Usually, the unhealthy behaviour in question will be more common among lower SES groups, resulting in some degree of disparity. Early on, the disparities will actually widen because the higher SES groups will adopt healthy behaviours in greater numbers. Unless interventions can be and are tailored to the needs and circumstances of lower SES groups the disparities may continue to widen for some time. Strategies that can be effectively aimed specifically at the disadvantaged groups are more likely to mitigate this effect, but it is important to evaluate experiments and pilot projects, because success is by no means assured.[33] If lower SES groups were to achieve the same non-smoking rates as others, disparities would narrow (because the lower SES groups started with higher smoking rates). These potential effects illustrate the importance of supporting programs with partnerships that address the economic, community and environmental characteristics that affect uptake across a diverse range of life circumstances. Where

the determinants are addressed, health sector-specific initiatives are likely to be more effective. How these partnerships are configured should be of major interest to health sector decision-makers.

Figure 3. Conceptual model of impact of health promotion over time on health status and health disparities



F. Where to focus efforts

Given the current state of knowledge and plausible policy levers for making gains, where should efforts be focused? Three characteristics of the current landscape suggest an answer:

1. The health of middle and upper SES Canadians as a group is relatively good and might be improved even further through a combination of individual behaviours and public policies to improve the broader determinants of health.

2. It is clear that lower SES populations have the potential to be much healthier if their determinants of health improve. Improving the non-medical determinants of health of the most disadvantaged populations is the key to improving their health. While differences in health status occur at all points in the SES gradient, there is a sharper drop-off at the lower end.

3. While healthy people continue to get healthier, success is reversible. The obesity pandemic is more pronounced in women in lower SES groups but affects the entire gradient. If it continues unabated, a large cohort of younger adults will experience serious health breakdown beginning in middle age. This again confirms that continuous health status improvement at the middle and upper ends of the scale may not continue indefinitely.

Research has consistently shown that a limited number of modifiable non-medical determinants underlie the greatest health disparities. The most appropriate and effective way to improve overall population health status is by improving the health of those in lower SES groups and other disadvantaged populations. Infant mortality in higher SES groups already approaches zero. By contrast, there are significant life expectancy and disability-free life expectancy (DFLE) deficits among lower SES groups in general, and Aboriginal peoples in particular. These gaps are so large that reducing them substantially would result in a significant improvement in overall Canadian health status even if there were a temporary or longer-term halt in the improvements experienced at higher SES levels.

Key messages of Part I

Patterns and Costs of Health Disparities

- Major health disparities exist in Canada. Health disparities are differences in health status that occur among population groups defined by specific characteristics. They result largely from inequalities in the distribution of the underlying determinants of health across populations.
- Socio-economic status (SES), Aboriginal identity, gender and geographic location are the most important factors associated with health disparities in Canada. The consequences of health disparities are most pronounced in the lowest 20% of the SES scale and for Aboriginal peoples. Because they are more often and more severely sick or injured, people in the lowest quintile of income groups use approximately twice as much in the way of health care services as those in the highest quintile. On the basis of an estimation of health care resources used by Canadian house-holds, approximately 20% of total health care spending may be attributable to income disparities. Despite this higher overall use of health services, health disparities persist among lower SES groups.
- Health disparities are not simply a have-have not issue; there is a gradient, and everyone is affected. At every step in the SES gradient there are differences in risk factors and risk conditions, health status, incidence of disease and mortality across a wide range of physical and mental disorders.
- The most important consequences of health disparities are avoidable death, disease, disability, distress and discomfort; but it is clear that disparities are also costly for the health system and Canadian society as a whole. Health disparities are inconsistent with Canadian values, threaten the cohesiveness of community and society, challenge the sustainability of the health system, and have an impact on the economy. These consequences are avoidable and can be successfully addressed, but they nevertheless persist and, in some cases, are growing across the country.

Role of the Health Sector in Reducing or Increasing Disparities

- Both health care and public health policies and activities can either reduce or increase health disparities depending on how they are implemented and taken up by the population. Focused health care and public health efforts to reduce disparities can be very effective.
- The most appropriate and effective way to improve overall population health status is by improving the health of those in lower SES groups and other disadvantaged populations; this approach needs to be comprehensive, i.e. addressing the health care needs of disadvantaged groups while promoting improvements in their underlying conditions.
- Partnerships and intersectoral policy development are essential to reducing health disparities to the maximum possible extent.
- It is important to monitor whether overall health improvement extends to lower SES groups and to sustain efforts over sufficient time.
- Reducing health disparities will achieve an overall improvement in the health of Canadians because the opportunities for gains are greatest at lower levels.

PART II

Reducing Health Disparities: History, Options and Best Practices

A. Canadian approaches to disparities: 30 years of vision and policy

Two recent First Ministers' Health Accords (2002, 2003] have made national commitments to reducing disparities. A subsequent Communiqué from Health Ministers in September 2002 contained a commitment to work with government sectors and others to establish a national Healthy Living Strategy. The goals of the Healthy Living Strategy are to improve the health of Canadians and to reduce health disparities. The February 2003 Health Accord of the First Ministers stated: "First Ministers direct Health Ministers to continue their work on healthy living strategies and other initiatives to reduce disparities in health status." The 2003 Accord was a natural culmination of 30 years of policy development that has progressively positioned health ministries in Canada to play a strong role in the reduction of health disparities. As part of the 2004 First Ministers' Meeting, a special meeting with Aboriginal leaders resulted in specific measures to address disparities in the health status of Aboriginal peoples.

Soon after implementing Medicare, Canada turned its attention to non-medical strategies for improving the health of the population. For example, in 1974, *A New Perspective on the Health of Canadians*[34] outlined a new vision of health that has enhanced the profile of health promotion and preventive health strategies for three decades. Health Ministries have promoted or endorsed both prevention strategies (anti-smoking campaigns, seatbelt legislation, bicycle helmets, responsible alcohol use) and health-enhancing lifestyle modification (ParticipAction, improved nutrition, "Heart Smart" menus, etc.).

Twelve years later, the federal government released *Achieving Health for All*, drafted in conjunction with the First International Conference on Health Promotion, which produced the Ottawa Charter. The Charter addressed population health and equity more explicitly, incorporating some of the language of the WHO Alma Ata declaration of 1978 that focused on health disparities and advocated a global commitment to equity in health status:

> *The first challenge we face is to find ways of reducing the inequities in the health of low- versus high-income groups in Canada. There is disturbing evidence that shows that despite Canada's superior health services system, people's health remains directly related to their economic status.*[35]

Beginning in the late 1980s Canada became a major contributor to population health theory and research in the international arena. The refinement of the connections among health, wealth, place, behaviour and biology has penetrated the thinking of the public policy community both within and beyond the health system.

Both provincial and federal governments devoted considerable attention to population health. In 1994 the FPT Advisory Committee on Population Health presented its strategy for improvement to the Ministers of Health. Among its aims were to:

> *Strengthen public understanding about the broad determinants of health, and public support for and involvement in actions to improve the health of the overall population and reduce health disparities experienced by some groups of Canadians.*[36]

Many of these concepts found full expression in the 1997 report of the National Forum on Health.[37] The Forum established a working group on the determinants of health, and a major portion of the report synthesized this body of knowledge. The recommendations advocated a broad-based population health strategy involving many sectors.

Canada's long intellectual tradition in population health provides a strong foundation for developing and implementing strategies for disparities reduction.

B. International approaches to reducing health disparities[38]

Whereas Canada has been internationally recognized for playing a strong role describing and promoting concepts in population and public health, with the causes and effects of health disparities at their core, some other countries have taken further strides in advancing comprehensive strategies to address health disparities.

History, economic circumstances, the degree of consensus on public values and priorities, the nature of public and private institutions, and other factors influence the "art of the possible" for reducing health disparities in individual countries. For example, Sweden has a decentralized form of federalism and a political culture compatible with a broad, determinants-based strategy. The motivation to address health disparities in Sweden led to a sustained national dialogue on the determinants of health and their consequences. The government pursued a consensus-building process that involved all political parties, an evidence-based approach and extensive public consultation. The result was a strongly supported strategy that focuses almost exclusively on the non-medical determinants of health. The Netherlands has embarked on a similarly comprehensive strategy, as has the UK in recent years.

Mackenbach and colleagues reviewed experiences to date in nine European countries.[39] The main outcome measures were intention to act and the comprehensiveness of the policies in place. The initiatives are too recent to yield evaluations of the actual impact on disparities over time. However, the over-all

national approaches in Europe are notable for their variety: Holland and the UK have favoured quantifiable targets whereas Sweden rejected them; Sweden has the most explicitly values-based, social justice approach; the recommendations from the work of the Black Report in the UK remain, according to Mackenbach et al., the most comprehensive yet produced.

There has been a general widening of health disparities in Europe in recent years despite, in some countries, strong egalitarian political traditions.[40] No doubt these and other findings have stimulated the policy activities, innovations and research efforts in recent years.

The UK example warrants closer examination. Health disparities between the highest and lowest quintile have widened over time, and there are also major geographic variations in health status and life expectancy. The UK policy explicitly links health care and socio-economic initiatives.[41] It aims to improve everyone's health, but the health of the poor faster. In most OECD (Organisation for Economic Co-operation and Development) countries, financial access to "medically necessary" care is not a barrier,[42] but research confirms that informal barriers at times result in less timely and less effective service delivery.

The European Experience: Innovative and Possibly Effective Approaches

Mackenbach[43] and colleagues reviewed experiences in disparities reduction in nine European countries and identified "innovative and possibly effective approaches" and examples of related initiatives in the following five areas:

1. Policy Steering Mechanisms
    - Quantified targets to reduce disparities in 11 areas such as extent of poverty and smoking rates in the Netherlands.
    - Health inequalities impact assessment of EC agricultural policy done in Sweden.
2. Labour Market and Working Conditions (universal and targeted approaches)
    - Strong employment protection and labour market policies to ensure that there are good opportunities for people with chronic conditions in Sweden.
3. Health-related Behaviours (universal and targeted approaches)
    - Multi-method intervention to reduce smoking in low-income women in the UK.

4. **Health Care (to improve quality of care and partnering with other sectors)**
    - Community strategies led by local government to integrate care across all local public services, including health.
5. **Territorial Approaches (comprehensive health strategies for deprived areas)**
    - Health Action Zones in the UK.

By contrast, the US dialogue focuses heavily on access to health care, the responsiveness of health care to the needs of racial and ethnic groups, and the consequences of inadequate health insurance. Federal law makes it mandatory for the Agency for Healthcare Research and Quality (AHRQ) to publish an annual National Healthcare Disparities Report.[44] The title is telling: the two preoccupations of the report are access and quality of health care, while the broader determinants are absent from the analysis. The US has a more market-oriented political culture, places a high priority on health care and tolerates a greater degree of inequality and concentration of wealth than most other nations.

While it is recognized that the political, social and economic landscape will influence the approaches chosen for reducing health disparities, Canada can nonetheless learn from international exemplars and promising approaches. Approaches undertaken in other countries demonstrate that it is possible for the health sector to lead the way effectively in addressing health disparities by:

- building on existing efforts, meaningfully engaging other sectors and citizens and gaining support across political lines;
- using the evidence base effectively, integrating its further development into a broad range of other activities, and sharing evidence with practitioners, governments and the public; and
- growing from scattered policy-making to a comprehensive, countrywide approach and moving from the health sector to encompass other key sectors.

C. Current Canadian strategies for reducing health disparities[45]

Health disparities are recognized as a key health issue in Canada by all jurisdictions. Health ministries at all levels, often in collaboration with other sectors, have launched initiatives to improve health and reduce health disparities. Most of the identified initiatives focus explicitly on improving overall population health status; disparities reduction is generally addressed through a focus on specific populations or communities. In most cases goals or targets for improving the health of disadvantaged populations and reducing health disparities have not been set. There are few comprehensive, integrated efforts to address known health disparities and the factors and conditions that lead to them. This has resulted in promising, but often disconnected, initiatives across the country.

While initiatives are in some ways unique, they fall into four main categories:

1. Leadership and policy development, e.g. the development of the Healthy Living initiative, establishing population health units in Health Ministries, wellness and health promotion programs, strategic plans that include disparities reduction priorities, primary health care innovations, etc. In Quebec the Health Ministry is required by law to examine the health impact of policies across the government.

2. Intersectoral collaboration and partnerships, e.g. child health initiatives, nutrition programs, prevention and harm reduction strategies, intragovernmental awareness-raising task groups, targeted programs for high-risk groups, etc.

3. Building community capacity, e.g. community development activities at regional health authority level, primary health care outreach, staff training in a population health approach, core area rehabilitation initiatives in cities, comprehensive school health programs, etc.

4. Knowledge development and exchange, e.g. widely publicized health status reports, detailed community profiles, health atlases, workshops for staff, health status indicators, specific research support programs, etc.

Four recent Canadian initiatives explicitly address health disparities:

In 2002, the Canadian Institutes of Health Research (CIHR) established a strategic, cross-cutting research initiative, *Reducing Health Disparities and Promoting Equity for Vulnerable Populations*, in partnership with Health Canada, the National Secretariat on Homelessness, the Social Sciences and Humanities Research Council of Canada, and the Heart and Stroke Foundation. The initiative is documenting and analyzing disparities across subpopulations in Canada, and examining the causes and implications of health disparities, barriers to mitigating them and interventions to address them. This is an important early contribution and one that should be broadened and accelerated.

Similarly, the Canadian Population Health Initiative (CPHI) has produced important and creative research whose findings should influence the policy agenda. The recent report of CPHI[46] provides a useful overview of strategies to improve the health of Canadians and reduce inequalities. It describes the health status of and health disparities among Canadians, and outlines strategies to address income inequalities, early childhood development, Aboriginal health, obesity, and other problems. It cites the evidence on interventions that yield a high return on investment over time and the relationship between health care and other interventions in reducing disparities. The CPHI report and others deserve careful attention as sources of information and ideas for a health disparities reduction agenda.

In September 2002, the FPT Health Ministers confirmed their agreement to collaborate on an Integrated Pan-Canadian Healthy Living Strategy. The goals of the Strategy are to improve overall health outcomes and reduce health disparities. The initial areas of emphasis are physical activity, healthy eating and their relationship to healthy weights. In September 2004, Health Ministers committed to advancing the Strategy and announced that the details of the Healthy Living Strategy would be presented at their annual meeting in September 2005. Key elements of the Strategy are creation of an Intersectoral Healthy Living Network; action in the areas of research, surveillance and best practices; exploration of options for an Intersectoral Fund; options for a communications/health information strategy; and further dialogue with Aboriginal stakeholders. As mentioned earlier, this strategy has the potential to make a significant contribution to addressing health disparities.

Most recently, the federal government has created the Public Health Agency and a set of collaborating centres to provide leadership and support for a new national public health network. At least two of these centres - namely, the National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health - will have the reduction of health disparities as the main focus of their work. The proposed structure for the national public health network includes a network (expert group) on health promotion, which is an appropriate group to address public health policy and practice with respect to health promotion strategies such as the Integrated Pan-Canadian Healthy Living Strategy.

These recent Canadian initiatives are important first steps; however, improved ability to document the extent of disparities, develop evidence-based policies and evaluate interventions is necessary to advancing work in this area.

One example of the need for further knowledge development is in the area of health indicator frame-works. CIHI and Statistics Canada have developed a health indicators framework that includes health status, non-medical determinants, primary health care performance and community characteristics; however, there is a need for more indicators of disparities. For example, under the heading of community and health system characteristics are several indicators of low SES and health status, but it is not clear how these connect to the health system. There is even less emphasis on disparities in the 14 areas and 67 indicators of the Performance Indicators Reporting Committee (PIRC) mandated by the Health Accords.

To be effective, health indicator sets should include measures of the extent of disparities as well as the causes and costs of disparities, and the extent to which health sector programs widen or reduce them. Disparities cluster in lower SES groups; indicators should therefore be broken down by SES group. This may require the capacity to link health sector indicators to social and economic indicators. A performance framework and supporting information system oriented to reducing health disparities would look very different from one focusing on technical quality or short-term outcomes alone. Health promotion and prevention indicators would be more meaningful with an SES breakdown.

Summing up, avoidable, major disparities will be more quickly addressed when governments, ministries, health sector programs and non-government organizations further priorize their commitment to disparities reduction and establish methods of accountability of all stakeholders for improvement. An essential element of any such strategy includes the measurement of disparities and regular reports on progress. Good data not only advance understanding of what works and what does not; good and clear reports also galvanize support for disparities reduction. With the right indicator sets, the health sector can achieve a better balance between accountability for providing high-quality health care services and accountability for addressing disparities.

Key Messages of Part II

- Canada has a strong and internationally respected intellectual tradition in population health that is well suited to developing and implementing strategies for disparities reduction.
- Health Ministries are ideally placed to promote this agenda and encourage government as a whole to reduce health disparities.
- Several European countries have developed comprehensive health disparities reduction strategies and developed goals and targets to achieve them.
- Canada has launched a promising range of initiatives to reduce disparities, and this tradition of innovation should continue.
- A sound and comprehensive research strategy, to build on the initial steps begun by the CIHR and CPHI, is essential to a successful strategy of policy development, priority setting and evaluation.
- The Healthy Living Strategy has the potential to be one key component of a disparities reduction agenda
- Building a disparities perspective and focus into performance indicator frameworks and reporting requirements will strengthen accountability and help mobilize public support for achieving goals.

PART III

Key Opportunities for Reducing Health Disparities

This paper has highlighted the fact that health disparities are detrimental for those who experience them directly and for the rest of society because of lost productivity, increased health care costs and over-all quality of life. The health sector controls activities and agendas that can reduce health disparities and has the authority and voice to influence partnerships that can do even more. Further priorizing of the commitment to this goal could over time profoundly alter public perception and open up new possibilities for a broader and even more effective coalition.

When the health sector champions disparities reduction as a priority and highlights the goal in its public messages, the entire community becomes more engaged with the issues. Drawing upon the experience with successful policies and strategies in Canadian communities and other countries, the following describes key roles for the health sector in reducing disparities, including potential directions for action. An overarching theme of this health sector framework for addressing health disparities is an integrated approach to disadvantaged populations.

HEALTH SECTOR FRAMEWORK FOR ADDRESSING HEALTH DISPARITIES

A. Take an integrated approach to disadvantaged populations

The major health disparities in Canada relate to SES, Aboriginal heritage, gender and geographic location. Discussions of health disparities frequently use terms such as "disadvantaged" or "vulnerable populations" to describe these groups as well as more precise identification for developing the evidence base, e.g. families headed by single female parents, Aboriginal peoples and immigrants from certain countries. The question arises as to whether public policy should frame the issue in terms of specific populations at greater risk of health disparities or focus on the underlying determinants and conditions that are the causes of health disparities.

Health disparities are a widespread problem deeply embedded in societal values and in how communities organize themselves to make and consume goods and services, educate their children and distribute opportunities. It is rarely, if ever, possible to address these problems in a specific, identifiable population without altering factors that affect the entire community. Furthermore, health disparities are not isolated phenomena that can be excised with surgical precision. They are, rather, a function of the whole operation of society, and the "treatment" must be more fundamental and all-encompassing. Finally, health disparities are experienced throughout the population, not just among the obviously deprived.

For these reasons it is recommended to take a more integrated approach to disparities reduction. It may still be necessary and useful to prioritize specific disadvantaged populations, such as Aboriginal peoples and those living in poverty, whose circumstances have galvanized awareness of health disparities and among whom the greatest gains are to be pursued. However, public policy should benefit not some, but all people whose lives are diminished by health disparities and their contextual causes. This inclusive vantage point reinforces the complexity of dealing with disparities and the importance of ensuring that all policies and programs are designed to deal with disadvantage regardless of where and how it presents.

B. Focus on four key policy directions for the health sector

1. Make Health Disparities Reduction a Health Sector Priority

Making health disparities reduction a health sector priority, with coordinated effort on several fronts, will have the greatest impact.

Leadership on disparities reduction within the health sector is needed to facilitate the roles of the health sector and to support growing awareness and policy action in other sectors to achieve health gains.

Recent First Ministers' Health Accords have made national commitments to reducing disparities. Thus, there is a need and an opportunity for the health sector to play an important role in any health disparities reduction strategy and to make health disparities reduction a high-priority policy objective. The 2003 Health Accord was a natural culmination of 30 years of policy development that has positioned the health sector in Canada to play a strong role in the reduction of health disparities.

As described in this paper and demonstrated by international experience, there are many ways to approach health disparities reduction. Canada already has in place a foundation on which to build a comprehensive strategy. Coordinated effort on several fronts is likely to make the greatest impact. Any successful strategy will understandably unfold over the long term.

Proposed activities:

- Ensure that there is national leadership capacity to address health disparities. Key leadership roles should include:
  - Setting health disparities reduction targets, monitoring trends and producing periodic reports on progress.
  - Developing an integrated strategy to reduce health disparities.
  - Assessing the impact of current and potential health sector policies on health disparities to guide policy and program decisions.
- Facilitate and support all governments to make the reduction of health disparities (i) a public policy priority and (ii) a key measure of overall government performance.
- Collaborate among jurisdictions (provinces/territories and federal government) to consider a health disparities reduction fund to support program innovations and evaluation.
- Develop priority areas on which to focus policies and interventions within the health sector and with other sectors. Initial priorities should include key disadvantaged groups and related determinants of health (e.g. socio-economic status, Aboriginal identity, gender and geographic location).

2. Integrate Disparities Reduction into Health Programs and Services

The health system is a key determinant of population health. If health care and public health programs and services do not include a focus on the needs of disadvantaged individuals, populations and communities, there is a risk of increasing rather than reducing health disparities.

The health sector also has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities.

The health sector can reduce health disparities by ensuring that the programs and services that it controls directly - health care and public health - focus on this goal as part of its shared responsibility for achieving it. Given the current state of knowledge and plausible policy levers for making gains, the most predictably effective way to improve overall population health status is by focusing on improving the health of those in lower SES groups.

Engaging citizens in order to foster public awareness and support is also key to reducing health disparities to the maximum possible extent. Research by the Canadian Population Health Initiative reveals that while Canadians recognize behaviour, lifestyle and the environment as important determinants of health, only one in three identifies income, housing and supportive community networks.[47]

Proposed activities:

- Ensure that health disparities reduction is considered in the design, implementation and evaluation of all health programs and services so that disadvantaged populations benefit to the maximum extent possible.
  - Reduce financial and non-financial barriers to health care and public health, and develop strategies to improve access, comprehensiveness, appropriateness, coordination and follow-up for disadvantaged populations.
  - Develop performance indicator frameworks and reporting requirements, which include a range of measures on health disparities, for improved accountability.
  - Develop communications and educational strategies to foster public awareness and understanding of the importance of reducing health disparities.

3. Engage with Other Sectors in Health Disparities Reduction

Taking action on a wide spectrum of factors - and their interactions - known to influence health is essential to reducing health disparities. This requires participation from those sectors whose work aligns with key health determinants.

As noted in its Global Strategy on Diet, Physical Activity and Health, the World Health Organization (WHO) sees engaging with other sectors as an essential responsibility of the health sector.

Such partnerships and promotion of a health disparities perspective are most effective when they extend to the public, private and voluntary sectors.

Partnerships and promotion of a health disparities perspective among all public policy-makers are essential to making the greatest impact. While Canada has few comprehensive, integrated efforts to address known health disparities and the factors and conditions that lead to them, it has launched some promising intersectoral initiatives to reduce disparities, and this tradition of innovation should continue. For example, the Healthy Living Strategy has the potential to be one key component of a disparities reduction agenda.

The World Health Organization (WHO) sees engaging with other sectors as an essential responsibility of Health Ministries. The WHO *Global Strategy on Diet, Physical Activity and Health* includes activities that have a positive impact in the poorest populations as a priority. It states:

> *Health ministries have an essential responsibility for coordinating and facilitating the contributions of many other ministries and government agencies. These include especially: ministries and governmental institutions with responsibility for policies on food, agriculture, youth, recreation, sports, education, commerce and industry, finance, transportation media and communication social affairs and*

environmental / sustainability, planning, as well as local authorities and those responsible for urban development.[48]

Public policy is made in the public sector, but health disparities reduction will occur faster and more effectively if it is a goal also shared by the private and voluntary sectors. NGOs have been leaders in highlighting the extent of disparities, developing policy options and delivering innovative programs. Effective action will use a combination of economic levers, information, regulation and services, all of which rely on public assent and support.

Proposed activities:

- Support and facilitate the contributions of the public, private and voluntary sectors in disparities reduction initiatives.
- Collaborate with other sectors in the development of structures and mechanisms for (i) setting policy, (ii) developing, implementing and assessing programs and (iii) sharing information and resources in ways that are most likely to create the conditions for reducing health disparities, to include
  - Supporting the development of necessary leadership and intersectoral mechanisms at the national, provincial, regional and community levels in order to enhance capacity to address health disparities.
  - Continuing to support current investments in key initiatives that align with priority disadvantaged groups and determinants of health, and where there is evidence of effectiveness in reducing health disparities or the demonstration and evaluation of promising approaches.

4. Strengthen Knowledge Development and Exchange Activities

Comprehensive disparities reduction approaches in other countries originated with a commitment to documenting the extent of disparities, developing evidence-based policies, and evaluating interventions. Further development and ongoing expansion of the knowledge base in Canada is key to the advancement of policy development, priority-setting and evaluation efforts.

While Canada has begun some initial research initiatives, such as those by the Canadian Institute for Health Research and the Canadian Population Health Initiative, an integrated focus and building of a greater critical mass of knowledge is needed to advance a comprehensive disparities reduction strategy.

Proposed activities:

- Develop indicators to measure the impact of health disparities on the economy, community and individual well-being.
- Continue to support research that (i) advances our understanding of the causal mechanisms that result in health disparities (ii) identifies effective interventions for reducing health disparities and (iii) measures the cost-effectiveness of different types of initiatives over time.

- Enhance and refine information systems for improved surveillance, monitoring and reporting, to include
  - Extending capacity to link health data to socio-demographic data in order to support evaluations of access and effectiveness.
- Systematically share knowledge related to addressing health disparities within the health sector and across other sectors whose policies and services play an important role, to include
  - Compiling and maintaining a compendium of best practices in Canada and from around the world in reducing health disparities.

C. Conclusion

This report has highlighted the current status of health disparities in Canada and their consequences, and has described how the health sector can play a leadership role in reducing health disparities. Recommended policy directions and proposed activities set forth in the report provide the health sector with opportunities for action in areas within its span of direct control and through influencing partnerships with other sectors.

Evidence and experience have shown that reducing health disparities has many potential benefits - improving health outcomes and the overall quality of life of Canadians, as well as the effectiveness and sustainability of the health system.

- The overall health of the community can be improved by reducing disparities.
- Because there is a gradient of health status across the entire range of socio-economic status, addressing health disparities will improve the health of all of society.
- Reducing the health care needs of low-SES populations and other disadvantaged groups can decrease cost drivers and result in reduced pressures on the delivery of health services.
- Better health enables more people to participate in the economy, reducing the costs of lost productivity.

The time is opportune for health sector leadership and action to make further advances in realizing these benefits. The transition to new structures, such as the Health Council, the Public Health Agency of Canada, the Pan-Canadian Public Health Network and related Expert Groups, and the National Collaborating Centre for Determinants of Health, provide opportunities to guide and support this effort. There is a sufficient evidence base, and a readiness to act on the part of stakeholders both within and outside the health sector. The health sector has an opportunity to step forward as a leader with a clear commitment to health disparities-reduction.

Key Terms and Definitions

The following terms, which are central to the discussion in this paper, are defined as follows:

Aboriginal peoples: the Constitution of Canada recognizes three groups of Aboriginal peoples - Indians, Métis people and Inuit. These three separate peoples have unique heritages, languages and cultural practices. **First Nation** is a term that came into common usage in the 1970s to replace the word "Indian," which many people found offensive. Although the term "First Nation" is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian people in Canada, both Status (on-reserve) and Non-status (off-reserve).

Determinants of health: the range of personal, social, economic and environmental factors that determine the health status of individuals or populations (WHO, Health Promotion Glossary, 1998). The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services.

Health care: the programs, services, procedures, therapies and interventions that treat and care for individuals with diseases, injuries and disabilities. Health care is by far the largest subset of the health sector.

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 socio-economic status (SES), Aboriginal identity, gender, and geographic location.

Health inequality: "…is the generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups…that need not imply moral judgment…[and may result from] a personal choice that would not necessarily evoke moral concern".[49] 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 inequity: "…refers to 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."[50]

Health sector: the policies, laws, resources, programs and services that fall under the jurisdiction of Health Ministries. The sector spans health promotion and preventive health, public health, community health services such as home care, drugs and devices, mental health, long-term residential care, hospitals, and the services generally provided by health care professionals (doctors, nurses, therapists, pharmacists, etc.).

Population health: both a description and a concept that underlies the discussion of health disparities. "Population health strategy focuses on factors that enhance the health and well-being of the overall population. It is concerned with the living and working environments that affect people's health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health."[51] It is concerned with aggregate rather than individual health status and risk factors, and policies and strategies that address non-medical determinants affecting health throughout the life course.

Primary health care: The World Health Organization defines primary health care as "the principal vehicle for the delivery of health care at the most local level of a country's health system. It is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Beside an appropriate treatment of common diseases and injuries, provision of essential drugs, maternal and child health, and prevention and control of locally endemic diseases and immunization, it should also include at least education of the community on prevalent health problems and methods of preventing them, promotion of proper nutrition, safe water and sanitation."

Public health: "Public health is the combination of science, practical skills, and values directed to the maintenance and improvement of the health of all the people. It is a set of efforts organised by society to protect, promote, and restore the people's health through collective and social action. …Public health activities change with changing technology and values, but the goal remains the same - to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the populations."[52] This broad definition aligns more closely to "population health" and should be distinguished from the definition of the five core "public health" programs and services that are aimed at primary prevention and are provided by health departments, regional health authorities and local units: population health assessment, surveillance, disease prevention, health protection and health promotion.

Socio-economic status (SES): a term that describes the position of an individual group in a population or society, reflecting the overall hierarchy. The most frequently used indicators of SES are income, education and occupational categories. Its conceptual cousin is class, which originated in social theories that explain rather than simply describe the structure and functioning of society. To be consistent with previous national documents on health status and their determinants, SES is used and is intended to be interpreted in the broader sense of the term.

Disadvantaged populations: populations that share a characteristic associated with high risk of adverse health outcomes (e.g. Aboriginal peoples, single mothers in poverty, women, homeless people, refugees). An approach to disadvantaged populations is the use of specific strategies targeted at that particular population. This is distinct from and over and above that of strategies aimed at reducing the gradient or range of underlying determinants of health that affect health on a gradient (e.g. income, education).

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