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A Review of Canadian Policy on Social Determinants of Health

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Abstract

This paper provides an assessment of the social and fiscal policies related to social determinants of health at the federal level in Canada. An extensive review of grey literature was carried out to obtain information about policies and programs that address socio-economic factors influencing population health. Publications and reports on government websites such as Service Canada and non-government organizations such as UNICEF were examined in order to evaluate current socio-economic policies related to social determinants of health in Canada. The study found that Canada has generated a substantial body of research in the area of social determinants of health. Several policies and some programs directed towards social determinants such as income distribution, childhood care and development, education, employment and housing, have been implemented in Canada on the national level. Canada has made major progress in some areas of social determinants of health related policy-formulation and implementation, but it is deficient in several others. There is a need to galvanize efforts across all levels of governance to address the gaps between research and policy development related to social determinants of health at a system-wide level in Canada.

Keywords: Canada, social determinants, policy

1. Introduction

Complex forces governed by many social and economic factors ultimately lead to chronic diseases in populations. Understanding and dealing with these forces represent major health concerns in developed countries, and are gaining attention in developing countries as well (Baum, 2009). It is now well-established that health inequalities go hand-in-hand with social inequalities (Raphael, 2003). Health inequalities within populations are largely a result of conditions in which people live, grow, work, and age and the systems put in place to deal with illness (WHO, 2010). These conditions are commonly referred to as social determinants of health (SDOH). Social determinants interact with each other in complex ways throughout the life course to directly influence health status and the lifestyle choices and behaviors that produce health and illness (Raphael, 2003). A few ways in which policies can intervene to reduce inequalities in health include decreasing social stratification associated with socio-economic status (wealth, power), lessening exposure to specific health-diminishing factors among underprivileged populations and reducing the vulnerability of underprivileged people to injurious conditions (CSDH, 2005).

Closing the gap in a generation, a report published in 2008 by World Health Organization's (WHO) Center for Social Determinants of Health (CSDH) called on the WHO and governments world-wide to lead global action on the social determinants of health in order to promote social justice and health equity among all populations (CSDH, 2008; Baum, 2009). The report provided compelling evidence for all nations to take an SDOH approach to policy-making, and brought the importance of this issue to the forefront of health and social policy discussions (Johnson et al., 2008; Raphael, 2008). Likewise, a recent report by the Canadian Senate Subcommittee on Population Health highlighted the importance of social determinants of health in improving population health in Canada, maintaining that the majority of factors affecting population health were unrelated to the healthcare system (The Standing Senate Committee on Social Affairs, 2009).

Canada ranks relatively high among OECD countries on some commonly-used health indicators to gauge overall population health such as life expectancy and self-reported health status (HRSDC, 2012; CBC, 2012). But

Canada ranks very low on other indicators like infant mortality rates, where it ranks second worst among 17 peer nations (CBC, 2012) and indicators of health status of its indigenous peoples (Mikkonen & Raphael, 2010). Canada has spearheaded a substantial portion of the total body of research involved in identifying and understanding social determinants that influence health (Raphael, 2009). The work of the Population Health Program of the Canadian Institute for Advanced Research (CIAR) over nearly three decades has led to key insights about the role of social factors in health (Evans, Barer, & Marmor, 1994) and the CSDH has established two think-tanks on social determinants-the Globalization and Health unit and the Early Childhood unit—at Canadian institutions (Raphael, 2009). These units contributed substantially both to the CSDH report and our understanding of why some people are healthy while others become ill (Raphael, 2009). In spite of all this readily available information generated within its own borders, Canadian federal and provincial governments have been very slow to create policies based on social determinants research that might reduce overall health inequalities. In striking contrast, several publications and reports released by the Canadian federal government over the past few decades, from the ground-breaking Lalonde report in 1974 (Johnson et al., 2008), to the Final Report of Senate Subcommittee on Population Health in 2009, have stressed the importance of national health goals based on improving social and environmental conditions.

Canada's leadership role in SDOH research and some traditional health indicators such as average life expectancy and educational attainment may lead analysts to assume that there are fewer socio-economic and health inequalities throughout Canadian society as compared to many other developed countries (Rodney & Copeland, 2009). But these traditional statistical indicators do not provide a complete picture of health relevant to the unique needs and geographies of certain communities or population segments in Canada, notably the aboriginal people (Johnson et al., 2008). The Honorable Monique Bégin, former Federal Minister of Health for Canada and a member of WHO Commission on Social Determinants of Health (CSDH), has suggested that Canada's wealth has managed to conceal "the reality of [its] poverty, social exclusion, discrimination, [and] the erosion of employment quality" (Mikkonen & Raphael, 2010). However, despite rising income inequalities and poverty rates compared to other wealthy developed nations, Canadian governments and policymakers have remained largely indifferent to the mounting evidence that advocates improving the social determinants of health through public policy action (Mikkonen & Raphael, 2010).

In light of the final reports published by WHO's CSDH in 2008 and the Canadian Senate Subcommittee on Population Health in 2009, this paper describes some of the major determinants of health in Canada and examines Canada's national social and fiscal policies that address SDOH inequalities. The key social determinants addressed in the paper are determinants identified by the Public Health Agency of Canada (PHAC), namely income distribution, early childhood development and child education, employment, education and housing (2010). For the sake of brevity, our focus is limited to Canadian policies at the federal level and excludes a direct analysis of regional variations in policies related to the social determinants of health.

2. Method

A search of the peer-reviewed literature provided very limited information on current SDOH policies in Canada, therefore detailed information on existing policies was largely acquired through grey literature. A report sponsored by Toronto's York University School of Health Policy and Management entitled *Social Determinants of Health: The Canadian Facts* provided comprehensive background data on many Canadian social determinants. Additionally, information was obtained by reviewing publications and reports on websites for the Public Health Agency of Canada (PHAC), Human Resources and Skills Development Canada (HRSDC), the Canadian Population Health Initiative of the Canadian Institute for Health Information (CIHI) and Service Canada. Publications by certain non-government organizations like the United Nations Children's Fund (UNICEF) and the Organisation for Economic Co-operation and Development (OECD) were examined to compare Canadian statistics against those of other countries. We retrieved social and economic indicators across countries that either report to the OECD or participate in the Luxembourg Income Study (LIS) in order to create the graphical displays presented in the paper.

A short summary of each federal policy mentioned in the paper has been included in Tables 1 and 2. For this paper, the definition of policy was limited to any federal law intended to reduce SDOH inequalities, or to federal funds allocated for programs that address SDOH inequalities. Given the complex nature of power sharing and inter-governmental responsibility that prevails across jurisdictions in Canada, certain policies and programs related to social determinants that have been implemented at provincial levels were also included in order to provide a more complete picture of all SDOH approaches to policy-making in Canada.

3. Results

3.1 Income and Income Distribution

Income is one of the most essential and well-documented social determinants of health; health increases at almost every higher income level (CIHI, 2004). Material and social deprivation as a consequence of low income affects affordability of basic requirements such as food, clothing, and housing, which are cornerstones of good health (Mikkonen & Raphael, 2010). Widening income gaps also widen the social distance between different population units within communities since material deprivation can create barriers to participation in cultural, educational, and recreational activities (Scott & Lessard, 2002).

Income levels not only affect psychological constructs of health behaviors but also govern the quality of other social determinants like food security, housing and child development (Mikkonen & Raphael, 2010). Food Security, for instance, is closely related to income levels (Agriculture and Agri-food Canada, 2004). According to the Canadian Community Health Survey on nutrition conducted in 2004, of the 1.1 million households that experienced food insecurity in 2004, a higher prevalence was observed among households with incomes in the lower income adequacy categories (Health Canada, 2004).

Several reports show that economic inequality among Canadians has persisted over the last two decades; the rich continue to get richer and the poor continue to get poorer (Osberg, 2008; CIHI, 2004; Mikkonen & Raphael, 2010). According to HRSDC, families in the bottom quintile earned 9 times less than families in the top quintile between 1976 and 2007 (HRSDC, 2010) The ongoing impact of economic inequalities can be observed in the fact that urban Canadians in the lowest income quintile finally reached the same life expectancy in the mid-1990's that was experienced by the highest income quintile group 25 years earlier (CIHI, 2004). Among 25 OECD countries, Canada ranks 8th highest in its Gini coefficient and above the OECD average (Figure 1), indicating higher income inequality among Canadians compared to populations in other countries (OECD, 2010).

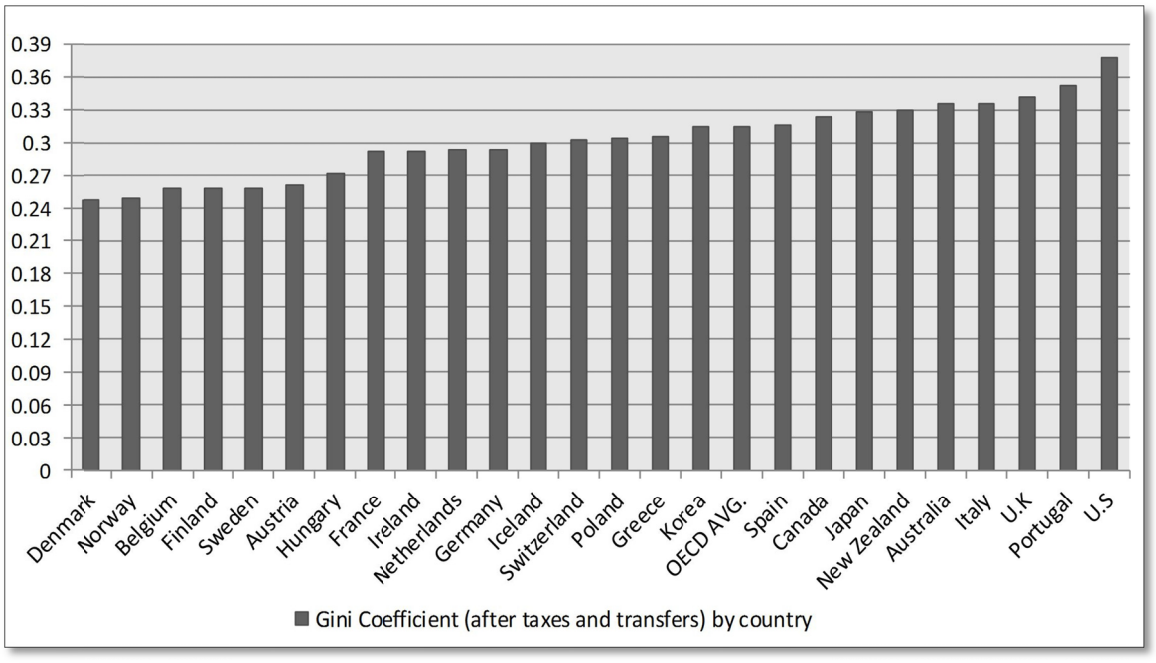

Figure 1. Income inequality (Gini coefficients) in OECD countries

Source: OECD Database, 2010. OECD AVG. represents the OECD Average

Taxation and transfer policies greatly impact low income groups, and Canadian governments play a key role in redistribution of income through the levy of taxes and transfers (CIHI, 2004).The federal government offers income redistribution programs such as Old Age Security and the Guaranteed Income Supplement to seniors aged 65 and over. Other tax credits offered by the federal government include the Goods and Services Sales Tax credit (GGT/HST) for certain low and moderate income families and a Universal Tax Benefit for families with

children under 18 years old. It is noteworthy that income redistribution programs for seniors have led Canada to be ranked highly among countries with the lowest levels of senior poverty (CIHI, 2004).

In Canada, populations at risk for poverty include but are not limited to recent immigrants, single mothers and aboriginal people (Chantall, 2007). It has been suggested that a national anti-poverty strategy, with the cooperation of provincial and territorial governments can overcome jurisdictional challenges, and many social policy advocacy organizations like the National Council of Welfare (NCW) have been campaigning for a unified national effort to reduce poverty in Canada (Chantall, 2007). Currently, six of ten Canadian provinces have established comprehensive poverty reduction programs using different strategies (Klien, 2010). With the exception of programs in Quebec, Newfoundland and Labrador, all other poverty reduction programs were implemented very recently and their success is as yet undetermined (Klien, 2010). The poverty reduction program in Quebec, Newfoundland and Labrador has seen some success. For example, based on the after-tax LICO (Low income Cut-off), the overall proportion of people living on low incomes in Quebec decreased by 7% while the proportion of children living in low-income families decreased by 12% between 1997 and 2005 (Chantall, 2007).

3.2 Early Childhood Development, Education and Care

The ways in which young children are cared for has morphed in several developed countries from a predominantly family affair to an out-of-home activity, in which governments and private enterprise are increasingly involved (Adamson, 2008). The rising generation in OECD countries is spending a large part of their early childhoods in some form of child care (Adamson, 2008). Since early childhood experiences can have immediate or long-lasting biological, psychological and social effects upon health, comprehensive early childhood care and development programs can ensure children's progress through all levels of education, and their successful entry into the workforce (CIHI, 2004). It has been estimated that Canadians will gain $2 for every dollar invested in good quality child care (CIHI, 2004). Additionally, early interventions can counter the lack of opportunities for growth and personal development often experienced by children born into low income households (Mikkonen & Raphael, 2010).

The Canadian federal government provides support to expecting mothers and parents in need through several programs such as the Canada Prenatal Nutrition Program (CPNP), which provides funding to support community programs for high-risk pregnant women and the Nobody's Perfect Program, which provides parenting education and support to parents with young children (Table 1) (PHAC, 2010). Also, Canadian provinces and territories oversee a number of programs for child care and education that meet multiple objectives (CIHI, 2004) but even though the historic 2003 federal/ provincial/ territorial agreement held childcare as a collaborative target, Canada does not yet have a national policy or a pan-Canadian approach to early childhood education and care (Friendly & Browne, 2002). Only 17% of Canadian families have access to regulated child care services with the notable exception of Quebec, where high quality childcare is accessible to 25% of families (Mikkonen & Raphael, 2010).

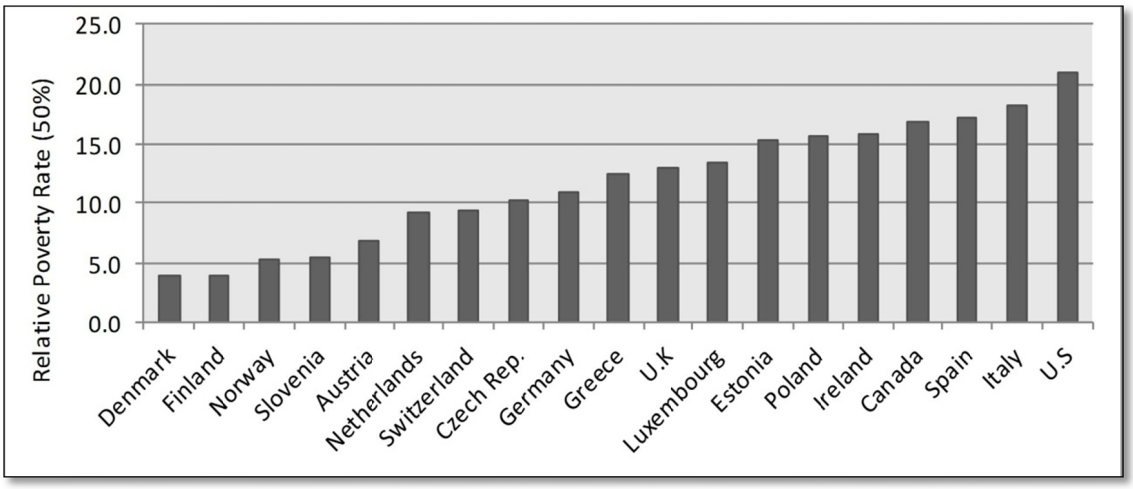

Figure 2. Relative child poverty rates (50%), 2004 Data

Source: LIS Key Figures, 2012

However, compared to other OECD countries, Canada does not perform well on measures of early childhood development and education. According to Key Figures from The Luxembourg Income Study Database (LIS), child poverty in Canada increased from 15% in 1994 to about 17% in 2004 (LIS, 2012). Canada's relative child poverty rate (Note 1) is one of the fourth highest among several western nations (Figure 2) as of 2004 with only Italy, Spain and the U.S performing at worse rates (LIS, 2012). Likewise, a report published by UNICEF that compared early childhood services among 25 OECD countries across 10 benchmarks, including minimal standards for parental leave, child poverty, GDP expenditure on childcare services and staff–to-children ratio in pre-school education, found that Canada met only 1 of the 10 standards for evaluating the adequacy and quality of programs for early childhood development and care (Adamson, 2008).

3.3 Education

Like childhood education, adult education is an important social determinant of health (Mikkonen & Raphael, 2010). The positive association between educational attainment and health is well documented (Low et al., 2005; Furnée , Groot & van den Brink, 2008). People with lower education attainment are likely to be less healthy than those with more advanced levels of education (Mikkonen & Raphael, 2010). For example, Canadian high school non-graduates are 1.5 times more likely to be obese than high-school graduates (PHAC, 2003), while high school graduates report more frequent use of preventative medical services, better knowledge of health behaviors and better general health status (PHAC, 2003).

Higher levels of educational attainment can improve health directly by influencing health behaviors and lifestyle choices or indirectly by influencing determinants like employment, income and housing (Furnée , Groot & van den Brink, 2008; Mikkonen & Raphael, 2010). Higher education attainment can lead to greater employment opportunities, employment security and better access to financial and material resources. More educated citizens are also better equipped to benefit from new training opportunities during economic downturns that result in loss of employment (Mikkonen & Raphael, 2010). Moreover, higher education attainment can be beneficial to a society from a civic standpoint, since better educated citizens participate more effectively in community and political affairs. Then again, approximately three-fourths of Canada's prison population is made up of high school non-graduates (PHAC, 2003).

Social policies can greatly influence the extent to which education affects a population's health (Mikkonen & Raphael, 2010). For instance, adequate income distribution and provision of necessary services such as childcare can alleviate the negative effects of lower education attainment on population health (Mikkonen & Raphael, 2010). In Canada, elementary and secondary public education is provided free to individuals who meet certain age and residency criteria, but post-secondary education is not free (CMEC, 2008). The federal government offers several student grants and loans for post-secondary students who can demonstrate financial need (Service Canada, 2009). Monetary assistance for education through grants is also provided to qualified individuals from low income families (Service Canada, 2009).

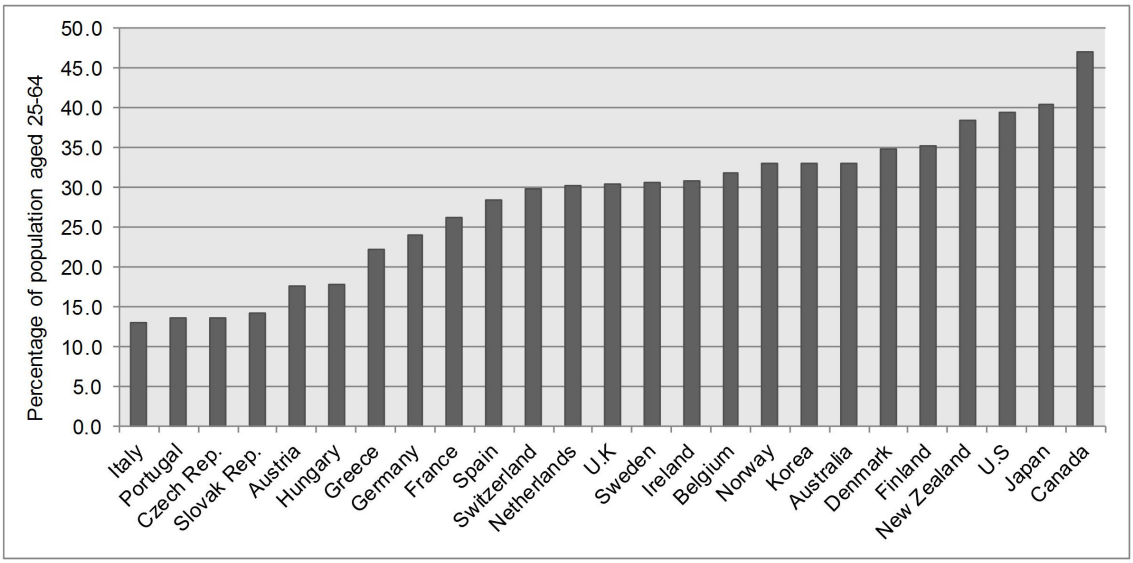

Figure 3. Tertiary level educational attainment in OECD countries for ages 25-64

Source: OECD Database, 2010

Overall, Canada has achieved considerable success in educating its population. Between 1951 and 1991, Canada saw a five-fold increase in the proportion of its population with advanced education (university degrees) (PHAC, 2003). According to HRSDC, between 2005 and 2006, almost 25% of the Canadian population aged 18-24 participated in university education (HRSDC, 2012). At 28%, university participation rate among provinces was highest in Newfoundland and Labrador, Prince Edward Island, and Nova Scotia and the lowest (17%) in Alberta (HRSDC, 2012). In terms of literacy levels (Note2), only a little over half of the Canadian population aged 16 and above had optimal (3 or higher) literacy scores in 2003, scores considered sufficient for persons to function well in society (HRSDC, 2010a).

Among all OECD countries, Canada has one of the highest proportions of people (approximately 50%) with some postsecondary education (PHAC, 2003), (Mikkonen & Raphael, 2010), and over 65% percent of the Canadian population is composed of high school graduates (PHAC, 2003). Moreover, Canada ranks highest in tertiary level educational attainment compared to several OECD countries with over 45% of its population aged 25-64 having attained an advanced degree as of 2006 (Figure 3).

However, some inequalities do exist across children's school performance (PHAC, 2003). Disadvantaged children and youth do not perform as well as advantaged young people (Mikkonen & Raphael, 2010). Moreover, children of parents without post-secondary education perform considerably worse than children of more educated parents (Mikkonen & Raphael, 2010). It has been suggested that this association between children's educational performance and low parental education levels can be alleviated through achievement of greater enrollment rates in good-quality early development and learning programs for children (Mikkonen & Raphael, 2010).

3.4 Employment Status and Job Security

Employment as a social determinant of health provides more than a source of income- it provides an individual with a sense of accomplishment and a distinct identity within social networks (Mikkonen & Raphael, 2010). Lack of employment is often associated with material and social deprivation, emotional stress, and the acquisition of adverse coping behaviors like substance abuse (Mikkonen & Raphael, 2010). Psychological stress due to insecure employment can lead to physical and mental health problems including depression, low self-esteem and suicidal behavior (Mikkonen & Raphael, 2010).

Job security has been defined as a largely subjective perception of risk that depends upon a given person's job situation, the overall economic environment and labor market conditions (PHAC, 2003). Over the last decade market trends have included an increasing number of professionals being involved in multiple jobs over the course of their working careers (Mikkonen & Raphael, 2010). There has also been an increasing diversity in employment status ranging from self-employment to part-time, full-time and reduced-time work. Moreover, work involving voluntary activities, care-giving and parenting has been increasingly recognized as valid work, which further clouds the distinction between employment and lack of employment, and about perceptions of job security and job insecurity, especially amongst women (PHAC, 2003). Thus, it has been argued that traditional objective measures of job security such as the unemployment rate can be problematic in current economic conditions since unemployment rates may no longer provide an accurate reflection of the real labor market and job insecurity (PHAC, 2003).

According to HRSDC, the unemployment rate in Canada was 8.0% in 2010 (HRSDC, 2012). The overall national employment rate, on the other hand, has increased over time and was 50% in 2010 (HRSDC, 2012). Yet even as employment rates have increased, job insecurity in Canada has also increased over the past few decades (PHAC, 2003; Mikkonen & Raphael, 2010; HRSDC, 2012). According to PHAC, only half of all working Canadians have a single, full-time job that has lasted six months or more (PHAC, 2003; Mikkonen & Raphael, 2010). In the same way, although employment has grown more rapidly among women than men over the past few decades, Canadian women are more likely than men to be unemployed, underemployed, and to feel insecure in employment (PHAC, 2003; Mikkonen & Raphael, 2010; HRSDC, 2012). Higher job insecurity among women is in part attributable to the fact that a disproportionately higher percentage of women are represented in unstable employment situations like temporary and part-time jobs (PHAC, 2003; Mikkonen & Raphael, 2010).

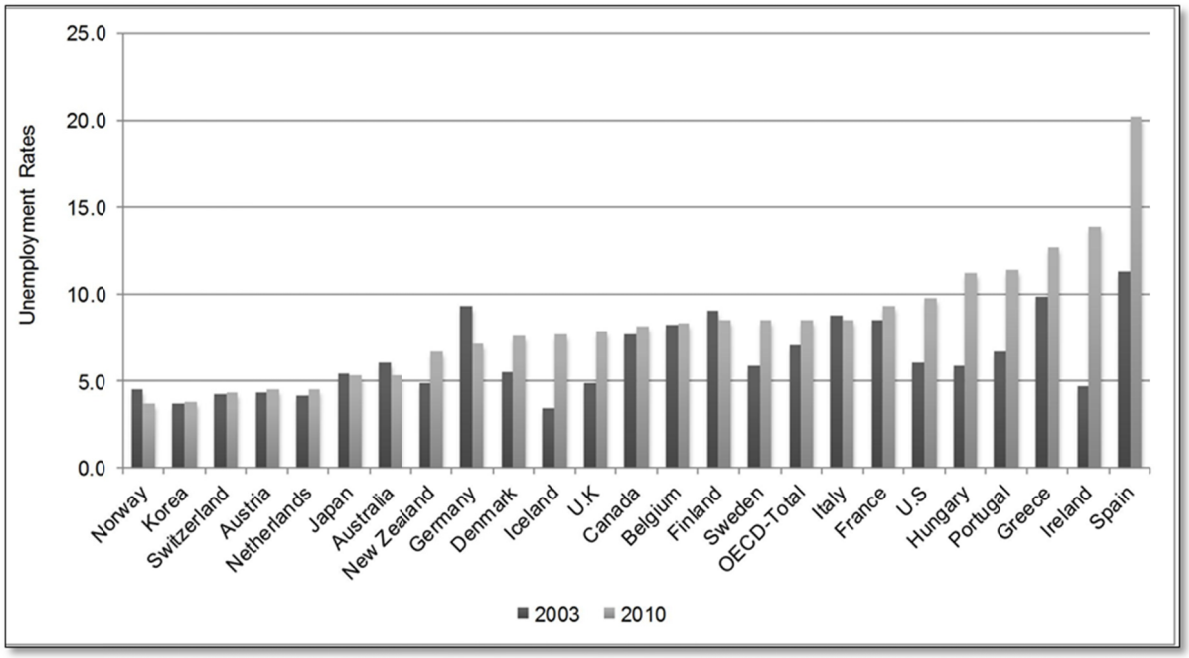

Figure 4. Unemployment rates as percent of labor force in 2003 and 2010 for OECD countries
Source: OECD Database, 2010

The Canadian government has several programs (Table 2) set in place to facilitate employment and to provide financial support for the unemployed. Youth Employment Strategy Programs provide avenues for young people between 15-30 years of age to obtain the skills and work experience they need to be successful in the workplace (Service Canada, 2010). Benefits to certain unemployed individuals are offered through the Employment Insurance (EI) program (Service Canada, 2010). Additionally, as part of its Economic Action Plan, the government of Canada announced temporary Career Transition Assistance initiatives to help long-tenured workers revamp or improve their skills while receiving regular unemployment benefits (Service Canada, 2010).

On the international level, Canada's unemployment rate in 2010 was slightly better than the OECD total, placing Canada at 13th rank among 25 OECD countries (Figure 4). Of note, 2010 unemployment rate in Canada is comparable to the rate in 2003 demonstrating a relatively stable rate (OECD, 2010). Nonetheless, 23% of jobs in Canada are low-paying, which is a very high number compared to other western countries (Mikkonen & Raphael, 2010). Canada also performs poorly among OECD countries on the basis of the employment protection index- an index developed by the OECD which calculates a number based on rules and regulations that protect employment and provide benefits to temporary workers (Mikkonen & Raphael, 2010). Canada was ranked third lowest among 28 OECD nations based on this index, indicating that Canada's population faces greater job insecurity compared to populations in several other OECD nations (Mikkonen & Raphael, 2010).

3.5 Housing

Housing is a multi-faceted concept that includes the physical structure and design of a house, the social and psychological features associated with a home; and additionally, the physical, social and civic characteristics of neighborhoods (Moloughney, 2004). Abundant scientific evidence shows that unsafe, substandard housing increases the risk of many health problems, especially exposure to biological, chemical and physical hazards such as lead, asbestos and many indoor pollutants like radon (Moloughney, 2004). Inadequate housing can lead to overcrowding, which facilitates the transmission of infectious agents that cause disease (Moloughney, 2004; Mikkonen & Raphael, 2010).

High housing costs can put a strain on limited financial resources and affect other social determinants of health such as food security and childhood development (Mikkonen & Raphael, 2010). Because housing has a major influence on people's lives, it also acts as a conduit for how other social and economic determinants influence health (Moloughney, 2004). Numerous studies indicate that people living in poor neighborhoods are more likely to suffer from poor health than those living in wealthier neighborhoods (Moloughney, 2004). For example in 1996, the probability of survival to age 75 among males living in the poorest neighborhoods in Canada was 15% lower than males living in the wealthiest Canadian neighborhoods (Moloughney, 2004). The vital issue at the

center of social policy with regards to housing is whether the prevalence of poor health among the underprivileged is increased by consigning them to hazardous neighborhoods with low social capital, and to what degree can one expect individuals living in low quality housing and less-than-desirable neighborhoods to recover from chronic illnesses and mental health issues if their living environment changes (Moloughney, 2004). The degree to which poor housing per se can lead to poorer health is unclear, however, since residents of poor neighborhoods are often subject to clusters of exposures that make such detailed assessments very challenging (Moloughney, 2004).

The Canadian government provides some housing assistance to low-income individuals through certain residential assistance programs (Table 2). The Residential Rehabilitation Assistance Program provides funding to low-income owners and tenants of substandard housing to ensure that home repairs that meet minimum federal health and safety standards are carried out (Service Canada, 2012). Additionally, the government offers financial assistance for emergency home repairs to low-income rural households through Emergency Repair Program (ERP) and to low income seniors for minor home adaptations in order to ensure the safety of occupants through the Home Adaptations for Seniors Independence (HASI) program (Service Canada, 2012).

Although a majority of Canadians have access to adequate and reasonably priced housing, almost 13% of Canadian households live in inadequate, unsuitable or unaffordable accommodations- either housing that is in need of major repairs, too small given family sizes or unaffordable given income levels as of 2006 (HRSDC, 2012). Similarly, 5.3% of tenants spend more than 50% of their income on rent and are consequently at a very high risk of becoming homeless. Notably, renters are four times more likely to live in core housing need (Note 3) and spending at least 30% of their income on housing than homeowners. Several urban areas in Canada have witnessed a housing crisis due to unaffordable rental accommodations as rents have continued to rise rapidly in major Canadian cities over the past few decades (Mikkonen & Raphael, 2010; PHAC, 2003). For example, in 2006, there was a significant concentration of households in core housing need in two major cities - Toronto at 19% and Vancouver at 17% (HRSDC, 2012).

Since housing plays a key role in determining health, homeless people experience a wide variety of health problems, and the likelihood of early death among homeless people is 8-10 times greater than the general population (Mikkonen & Raphael, 2010). While there were 80 shelter beds per 100,000 people in Canada as of year 2007, HSRDC reports that an estimated 300,000 people in Canada live in homeless shelters or on the streets, which translates to 1% of Canadian population (HRSDC, 2012). For the most part, data on homelessness or housing deprivation between countries is seldom comparable due to differences in definitions of homelessness, methodology of data collection and time/year of collection (Eurostat, 2004). However, Canadian statistics on homelessness are somewhat similar to U.S statistics-the percentage of Americans experiencing homelessness annually is estimated to be 1% of the U.S population or somewhere between 2.5-3.5 million people (NCH, 2009). In order to prevent and reduce homelessness in Canada, the Homelessness Partnering Strategy (HPS) was initiated in April 2009 by the federal government to allow community organizations, provinces and territories to collaborate efforts in establishing community-based programs primarily focused on providing transitional and supportive housing for the homeless (HRSDC, 2011).

4. Discussion

The growing evidence of social gradients in health outcomes in Canada and other countries is increasing the need for formulation and implementation of social policies to reduce SDOH inequalities. Successful, effective public policies must be founded on sound conceptual blueprints and clear knowledge of the mechanisms linking socio-economic factors with health (Moloughney, 2004). Although Canada has made significant contributions to the body of research related to the social determinants of health, the government‘s response to these research findings has been in the form of reports, commissions and even formal plans, but little actual policy implementation (Raphael, 2009).

It can be argued that the financial costs of implementing policies aimed at reducing health inequalities may pose too great an economic challenge in a country that already has many publicly funded economic and social programs, including universal health care. But while medical care in Canada has undoubtedly made positive contributions to individual health status, in the words of the Honorable Roy Romanow (Premier of Saskatchewan from 1991 to 2001 and Head of the Commission on the Future of Health Care in Canada 2001-2002) “a health care system-even the best health care system in the world- will be only one of the ingredients that determines whether [your] life will be long or short, healthy or sick, full of fulfillment, or empty with despair” (Mikkonen & Raphael, 2010). Estimates suggest that roughly half of the gains in life expectancy since the late nineteen-fifties can be attributed to medical care itself (Bunker, 2001). Most of the remaining gains were largely due to public health measures and

improvements in the economic and social conditions in which people lived (Folland, Goodman & Stano, 2009).

In contrast, a SDOH approach to alleviating health inequalities would almost certainly be more cost-effective than the outcomes of the several attempts made so far - primarily at the provincial level- to reform the Canadian health care system (Scott & Lessard, 2002). In 2004, the Health Disparities Task Group reported that the poorest quintile of the population utilized twice as many healthcare resources as the richest quintile, and that income inequalities account for approximately 20% of total national healthcare spending (Health Disparities Task Group, 2004). Since population groups with lower socio-economic status are subject to higher health risks and are more likely to suffer from inadequate health, SDOH inequalities are very important drivers of healthcare costs, and reduction of these (SDOH) inequalities can lead to an improvement in overall health of communities (Raphael, 2003; Health Disparities Task Group, 2004). A case in point is the costing analysis of Canada's Prenatal Nutrition Program (CPNP) by the Public Health Agency of Canada. For the 17,689 CPNP participants included in the analysis, the avoidance of low birth weight outcomes represents an average cost savings of $1.6 million (PHAC, 2010). In European nations such as Sweden and Italy, where policies based on social determinants of health have been in place for years (the benefits of which include generous family support, low child poverty rates, and some of the healthiest people in the world), the involvement of all levels of government and the community were essential factors for successful policy implementation (CSDH, 2008).

Given the constitutional distribution of power between provincial and federal governments, varying jurisdictions of governments play a key role in whether and how policies are implemented in Canada (Health Disparities Task Group, 2004; Privy Council Office, 2012). While taxation, income-distribution and employment policies are mostly under the authority of the federal government, the areas of education and health services are, with a few exceptions, the responsibility of the governments at the provincial and territorial level (Health Disparities Task Group, 2004). Simultaneously, housing and childcare services largely fall under the jurisdiction of local governments and municipalities (Health Disparities Task Group, 2004). Even as some dedicated Canadian researchers and agencies advocate SDOH-related dissemination, translation and exchange of SDOH-related knowledge (Raphael, 2009), the fragmented structure of governance has created formidable barriers even to communication between local, provincial and federal governments (Health Disparities Task Group, 2004). There are other political forces that are continually present in the federal-provincial dialogue, making constructive agreement especially challenging when emerging from fundamentally different ideologies [e.g. free-market versus welfare-state values (Raphael, 2009)].

Notwithstanding such structural and ideological barriers, there is a need for a comprehensive national agenda to integrate efforts across all sectors and at all levels of governance to address social determinants at a system-wide level in Canada (Johnson et al., 2008; Raphael, 2009). The final report of Senate Subcommittee on Population Health (2009) describes intersectoral collaboration as having two dimensions: horizontal and vertical. The horizontal dimension is interdepartmental, linking different departments such as education, finance, employment, etc. The vertical dimension links sectors at different levels; for example, the federal, provincial/territorial, regional, and local or municipal governments are linked to each other and with groups, institutions, organizations and businesses in the community. One excellent source of guidance for creating a comprehensive agenda is the Wellesley report prepared for the Canadian Senate Subcommittee on Population Health (Gardner, 2009). The report points out that several jurisdictions, both in Europe, and in other Commonwealth countries such as England, Australia and New Zealand, have already created comprehensive national strategies to reduce health disparities. International agencies including the World Health Organization's Commission on Social Determinants of Health, and the European Union, have committed significant research efforts and resources to the determinants of health and policy (Gardner, 2009). The observations in the Wellesley report uphold other reports by WHO, which maintain that the SDOH driven policies are quite varied, and no one country has accumulated enough experience to be certain what service programs and policy combinations would work effectively everywhere (Gardner, 2009). But given that so much attention is being devoted world-wide to policies bearing on this issue, a consensus is beginning to emerge on the actions necessary for moving forward, and most of this information is freely available. Furthermore, in Canada there has been extensive experience with a wide array of relevant planning tools that could be adapted to Canadian needs. The National Collaborating Centre for Healthy Public Policy does an excellent job of compiling and highlighting the most promising of these tools (Gardner, 2009).

Most importantly, all of these other jurisdictions have learned that coordination across government departments is essential, and there are examples of this approach already in place in several different parts of Canada. For instance, Saskatchewan's Human Services Integration Forum brings together ADMs (Assistant Deputy Ministers) from eight major Ministries (Gardner, 2009). Originally designed to enhance provincial coordination of social policy, the Province has found that having such regional coordinating bodies in place leads to more focused and integrated

local planning and service delivery (Gardner, 2009). Twenty years ago Ontario developed Premier's Councils on Health and other issues, to lead and coordinate cross-government efforts (Gardner, 2009). Similarly, Quebec has developed a sophisticated range of regional cross-sectoral planning forums, and it uses a form of Health Impact Assessment in which legislation from non-health ministries is examined for its potential health implications (Gardner, 2009). Thus, adding health impact measures to other check-offs such as risk-management and cost evaluations that are required by federal and provincial jurisdictions in their Cabinet submissions and draft legislation would be a feasible step in the right direction (Gardner, 2009). At the same time, it is important to integrate such formal requirements with flexible implementation and expert support for the Ministries that do include health impact measures into their planning (Gardner, 2009).

Another clear message from countries that have moved forward with SDOH policy is that the presence of a strong central authority and commitment from high-level leadership is essential for setting priorities, monitoring progress, allocating resources and developing policies (Final Subcommittee Report, 2009; Gardener, 2009). The report (2009) states that for the Canadian government to be serious about developing a comprehensive national SDOH strategy it will need to make these commitments and set out such authority. Canada should begin by addressing the fundamental determinants of health inequality, then develop a coherent strategy that can be achieved in manageable components, organize a coordinated, comprehensive approach that will work across government sectors and community institutions. It should set targets and provide incentives that engage all levels of government, carefully evaluate outcomes, make equity a core objective of equal importance with quality and sustainability, invest in programs that have the greatest impact on health disparities such as community-oriented primary care, especially for the most underserved and disadvantaged populations, and establish integrated child development, employment, settlement and other community-level social services. Following this path can finally lead to a coherent and coordinated national strategy for health equity.

Moreover, Canada needs to address gaps between policy-making and population health outcomes through syntheses of socio-economic and population health data and systematic reviews of studies that evaluate the effectiveness of policies and programs in terms of health outcomes (CIHI, 2004). The Canadian Reference Group (CRG), which was established in 2005 to support Canada's contributions to WHO's Center for Social Determinants of Health, is currently the only national system - albeit a non-governmental system - for inter-sectoral collaborations targeting health inequalities in Canada (CRG, 2011). Given Canada's existing health infrastructure, culturally and geographically appropriate, community-relevant indicators of health can be used for program assessments and evaluations that can be relayed to policy makers (Moloughney, 2004).

In the past, whenever an issue has been of great importance to all Canadians, the federal government has taken the lead, creating legislation and providing financial incentives to influence how health care is delivered in the provinces and territories (e.g. the establishment of Medicare in 1965 and the Canada Health Act in 1984). But unilateral federal action should not be necessary. Concerted efforts to enhance inter- governmental cooperation coordination and communication is the key to overcoming the silo-like functioning of national, provincial and civic governments, so that meaningful and sustainable reductions in health inequalities can be achieved. Inspiration can be taken from the U.S. state of Georgia, which overcame similar barriers over a decade ago in its *Bright From the Start* program, which now administers their nationally recognized Georgia's Pre-K Program, licenses child care centers and home-based child care, administers federal nutrition programs and manages voluntary quality enhancement programs (Georgia Department of Early Care and Learning, n.d). The Bright From the Start program was started by a visionary Governor by bringing all of the concerned national, state and local governmental agencies, volunteer organizations and private providers together to discuss and adopt state-wide developmental and care standards.

4.1 Limitations

In our assessment of Canada's standing in the arena of policy-making related to social determinants of health, we have attempted to provide the most current information available, wherever possible, at the time of submission. We have limited the scope of the paper to fiscal and social policies at the federal level in Canada but provided regional and provincial examples for supportive purposes. We have attempted to inform policy through the multi-faceted, social determinant approach for addressing population health but did not intend to provide a prescription to resolve the intricate social problems in Canada. We recognize that in policy-making, ideologies clash, portfolios compete for resources and there is always a trade-off that occurs when selecting one policy over another.

5. Conclusion

Looking at priorities for action, Canada has made progress in some areas of SDOH policy-formulation and implementation but lags behind several nations in many others. Above all, the living conditions and health status

of many of Canada's aboriginal people should be a serious concern for a country that prides itself on fairness and equity. Canadians enjoy high average levels of educational attainment and a higher employment rate than many other developed countries, but employment security among Canadians is low due to higher prevalence of low-paying jobs. Canada's income distribution policies have been somewhat successful in alleviating poverty among Canadian senior citizens, but largely unsuccessful in reducing child poverty or overall poverty. When they are implemented, the impact of anti-poverty strategies currently underway in some provinces, on income inequalities, social equity and health should be a positive one. Canada does have modestly respectable parental leave policies, but should work with all provinces and regions to standardize its childhood education and development programs and to improve accessibility and quality of day care services for children. Additionally, Canada needs to reconsider its housing policies in light of current economic conditions and low rent affordability, especially in some of the country's largest cities. Critical evaluation of policies and programs introduced to improve socio-economic conditions is imperative and should measure impacts on population health. The academic and research communities should continue efforts to make their expertise available and accessible to decision-makers and policy-makers across all sectors and at all levels of governance.

Table 1. Summaries of Canadian federal policies and programs supporting income redistribution and education

Table 2. Summaries of Canadian Federal Policies and Programs supporting employment and housing

Federal Polices/ Programs	Description
Mimimum Employment Age, Canada Labour Code and Regulations	May be employed only if not required to be at school under provincial legislation and the work involved falls outside certain excluded categories (e.g. underground work in a mine) and is unlikely to endanger health or safety. Never between the hours of 11 p.m. and 6 a.m.
Youth Employment Strategy Programs (YES)	Eleven Government of Canada departments and agencies work in partnership at all levels of government to help young people (aged15-30y), particularly those facing barriers to employment, get the information and gain the skills, work experience and abilities they need to make a successful transition to the workplace.
Employment Insurance Program (EIP)	(EI) program provides temporary income support to those who are between jobs, those who cannot work for reasons of sickness, childbirth, or parenting; or who are providing care or support to a family member who is gravely ill with a significant risk of death.
Career Transition Assistance	As part of its Economic Action Plan, the government of Canada announced temporary Career Transition Assistance initiatives to help long-tenured workers renew or upgrade their skills while receiving regular EI benefits.
Old Age Security (OAS), Guaranteed Income Supplement (GIS) and other Allowances.	OAS provides a modest pension at age 65 to Canadian residents. GIS provides additional money, on top of the OAS, to low-income seniors living in Canada. Allowance is a monthly benefit for low-income seniors (aged 60-64y) whose spouse or common-law partner is eligible, or currently receiving OAS and GIS.
Residential Rehabilitation Assistance Program – RRAP	Provides funding to low-income persons who own or rent and occupy substandard housing so that they can repair the housing to ensure that it meets the minimum federal health and safety standards.
Emergency Repair Program (ERP)	Canada Mortgage and Housing Corporation (CMHC) offers financial assistance to help low-income households in rural areas, for emergency repairs required for the continued safe occupancy of their home.
Home Adaptations for Seniors' Independence (HASI)	The Home Adaptations for Seniors' Independence (HASI) program offers financial assistance for minor home adaptations that will help low-income seniors to perform daily activities in their home independently and safely.

Federal Polices/ Programs	Description
Goods & Services Tax/Harmonized Sales Tax (GST/HST) credit and GST/ HST New Housing Rebate	The GST/HST credit is a tax-free quarterly payment that helps individuals and families with low and modest incomes offset all or part of the GST or HST (sales taxes) that they pay. GST/HST New Housing Rebate may be applied towards most newly constructed or substantially renovated houses used as a primary place of residence.
Resettlement Assistance Program	Financial assistance for refugees and protected persons to help with resettlement in Canada. Covers the cost of accommodations, essential clothing, household effects and other living expenses up to one year.
The Homelessness Partnering Strategy (HPS)	Under the HPS, the Government of Canada has offered all provinces and territories the opportunity to work in partnership to prevent and reduce homelessness in Canada. Relies on communities to determine their own housing needs. Primary focus is on transitional housing.

References

Adamson, P. (2008). *The childcare transition: Innocenti report card 8*. Florence: UNICEF. Innocenti Research Centre.

Baum, F. E. (2009). More than the tip of the iceberg: Health policies and research that go below the surface. *Journal of Epidemiology & Community Health, 63*(12), 957. http://dx.doi.org/10.1136/jech.2009.091595

Bright from the Start: Georgia Department of Early Care and Learning. Retrieved from http://decal.ga.gov/BftS/About.aspx

Brousse, C. (2004). *The production of data on homelessness and housing deprivation in the European Union: Survey and proposals*. Eurostat: European Commission. Retrieved from http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-CC-04-008/EN/KS-CC-04-008-EN.PDF

Bunker, J. P. (2001). The role of medical care in contributing to health improvements within societies. *International Journal of Epidemiology*, *30*(12), 1260-1263. http://dx.doi.org/10.1093/ije/30.6.1260

Canada Mortgage and Housing Corporation (CMHC). (nd). *Programs and financial assistance*. Retrieved from http://www.cmhc-schl.gc.ca/en/co/prfinas/

Canadian Community Health Survey, Cycle 2.2, Nutrition. (2004). *Income-related household food security in Canada.* (2004). Health Canada. Retrieved from www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/index_e.html.

Canadian Institute for Health Information (CIHI). (2004). *Improving the health of Canadians*.

Chantall, C. (2007). *Poverty reduction strategies in Quebec and in Newfoundland and Labrador*. Political and Social Affairs division: Library of Parliament. Retrieved from http://www2.parl.gc.ca/content/LOP/ResearchPublications/prb0722-e.htm

Commission on Social Determinants of Health (CSDH). (2005). *Action on the Social Determinants of Health: Learning from Previous Experiences.* World Health Organization.

Commission on Social Determinants of Health (CSDH). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. World Health Organization.

Council of Ministers of Education, Canada (CMEC). (2008). *Education in Canada: An overview*. http://www.cmec.ca/About/Pages/default.aspx

Evans, R. G., Barer, M. L., & Marmor, T. R. (Eds.) (1994). *Why are Some People Healthy and Others Not? The Determinants of Health of Populations* (1st ed., pp. 378-458). Aldine De Gruyter, New York.

Folland, S., Goodman A. C., & Stano, M. (2009). *Economics of Health and Health Care* (6th Edition). Prentice Hall.

Friendly, M., & Browne, G. (2002). Early childhood education and care as a determinant of health. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/oi-ar/07_ecec-eng.php

Furnée, C. A., Groot, W., & van den Brink, H. M. (2008). The health effects of education: A meta-analysis. *European Journal of Public Health*, *18*(4), 417-421. http://dx.doi.org/10.1093/eurpub/ckn028

Gardner, B. (2009). *Building Action on the Social Determinants of Health*. Subcommittee on Population Health Senate Committee on Social Affairs, Science and Technology. Retrieved from http://wellesleyinstitute.com/files/WISenatesubcomtespknotesMarch1209.pdf

Health Disparities Task Group. (2004). *Reducing health disparities – Roles of the health sector: Recommended policy directions and activities*. Public Health Agency of Canada.

Human Resource and Skill Development Canada (HRSDC). (2011). Homelessness Partnering Strategy: About the Strategy. Retrieved from http://www.hrsdc.gc.ca/eng/homelessness/about_us/index.shtml

Human Resource and Skill Development Canada (HRSDC). (2012). Indicators of Wellbeing in Canada. Retrieved from http://www4.hrsdc.gc.ca/home.jsp?lang=en

Johnson, S., Abonyi, S., Jeffery, B., Hackett, P., Hampton, M., McIntosh, T., ... Sari, N. (2008). Recommendations for action on the social determinants of health: A Canadian perspective. *Lancet*, *372*(9650), 1690-1693. http://dx.doi.org/10.1016/S0140-6736(08)61694-3

Klien, S. (2010). *Poverty reduction: What other provinces are doing.* Retrieved from http://www.policynote.ca/poverty-reduction-what-other-provinces-are-doing/

Low, M. D., Low, B. J., Baumler, E. J., & Huynh, P. T. (2005). Can education policy be health policy? Implications of research on the social determinants of health. *Journal of Health politics, Policy and Law, 30*(6), 1131-1162. http://dx.doi.org/10.1215/03616878-30-6-1131

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*.

Moloughney, B. (2004). *Housing and population health: The state of current research knowledge* . Canadian Population Health Initiative, Canadian Institute for Health Information. Retrieved from http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_284_E&cw_topic=284&cw_rel=AR_1129_E

National Coalition for the Homeless (NCH). (2009). *How many people experience homelessness?* Retrieved from http://www.nationalhomeless.org/factsheets/How_Many.html

OECD. (2010). Income Distribution: Income distribution: poverty, OECD Social Expenditure Statistics (database). http://dx.doi.org/10.1787/data-00200-en

Osberg, L. (2008). *A quarter century of economic inequality in Canada: 1981-2006*. Canadian Centre for Policy Alternatives.

Privy Council Office. Government of Canada. Canadian Federalism. http://www.pco-bcp.gc.ca/aia/index.asp?lang=eng&Page=federal

Public Health Agency of Canada (PHAC). (2003). *What makes Canadians healthy or unhealthy?* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#education.

Public Health Agency of Canada. (2010). *Childhood and adolescence: programs*. Retrieved from http://www.phac-aspc.gc.ca/dca-dea/programs-mes/index-eng.php

Raphael, D. (2003). Addressing the social determinants of health: Bridging the gap between research findings and public policy. *Policy Options*. Retrieved from http://www.irpp.org/po/archive/mar03/raphael.pdf

Raphael, D. (2009). Escaping from the phantom zone: social determinants of health, public health units and public policy in Canada. *Health Promotion International, 24*(2), 193-198.

Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy, 88*(2-3), 222-235. http://dx.doi.org/10.1016/j.healthpol.2008.03.015

Rodney, P., & Copeland, E. (2009). The health status of black Canadians: Do aggregated racial and ethnic variables hide health disparities? *Journal of Health Care for the Poor & Underserved, 20*(3), 817-823.

Scott, K., & Lessard, R. (2002). *Income inequality as a determinant of health*. Health Canada. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/oi-ar/02_income-eng.php

Service Canada. (2010). *Programs and services for you*. Retrieved from http://www.servicecanada.gc.ca/eng/home.shtml

The Canadian Reference Group on Social Determinants of Health. (2011). Draft Background Paper 3 for World Conference on Social Determinants of Health.

The Conference Board of Canada (CBC). (2012). Retrieved from http://www.conferenceboard.ca/hcp/

The Luxemburg Income Study Database (LIS). (2012). Retrieved from http://www.lisdatacenter.org/lis-ikf-webapp/app/search-ikf-figures

The Standing Senate Committee on Social Affairs, Science and Technology. (2009). A Healthy Productive Canada: A Determinant of Health Approach. Final Report of Senate Subcommittee on Population Health.

UNICEF. (2000). *A league table of child poverty in rich nations: Innocenti report card no.1*. Florence, Italy: UNICEF Innocenti Research Centre. Retrieved from http://www.unicef-irc.org/cgi-bin/unicef/series_down.sql?SeriesId=16

World Health Organization (WHO). (nd.). *Social determinants of health*. Retrieved from http://www.who.int.www5.sph.uth.tmc.edu:2048/social_determinants/en/

Notes

Note 1. Relative poverty rate (50%) characterizes children living in households that are below 50% of median household incomes.

Note 2. The adult literacy indicator measures the proportion of the Canadian population 16 years of age and older that is able to understand and use printed information, such as news stories or instruction manuals. Adult literacy is measured on a scale from one to five from low to high. A person should have at least Level 3 literacy to function well in Canadian society.

Note 3. Canada Mortgage and Housing Corporation defines “core housing need“ as households that live in housing that is inadequate, unsuitable, or unaffordable. Adequate housing is housing that is not in need of major repair. Suitable housing is housing that is not crowded, meaning that the number of bedrooms meet the National Occupancy Standard. Affordable housing means housing that costs no more than 30% of household income.