Working Towards Health Equity-Related Policymaking in Ontario

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Equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige.¹

Introduction

Working towards health equity is about creating the circumstances where avoidable differences or inequalities in health – that is health inequities -- among groups are reduced and eventually eliminated (Braveman & Gruskin, 2003). There is increasing consensus that the key path towards health equity is creating public policy that strengthens and makes more equitable the distribution of the social determinants of health, that is the living and working conditions that are the primary factors that shape health outcomes (World Health Organisation, 2008). Appendix I provides a backgrounder to the concept of health equity and the sources of health inequities.

The term social determinants of health refers to the economic and social conditions that have been shown to be the primary factors that shape health and create health inequities (Raphael, 2009). Social determinants such as amount of income, quality of employment and working conditions, and features of housing have been shown to “get under the skin” to influence health in three main ways. Social determinants lead to the experience of material advantage or disadvantage, a sense of psychosocial control versus lack of control, varying levels of stress, and likelihood of adoption of health threatening coping behaviours (Raphael, 2010c). Social determinants of health are also related to access to quality health care with those already experiencing material disadvantage, lack of control, high stress, and health threatening coping behaviours having more barriers to access than others (McGibbon, 2009).

Of particular importance are findings that particular groups in Canadian society are at risk for the experience of health threatening social determinants of health and the adverse health outcomes that result from these experiences (Galabuzi, 2009). These groups include persons of Aboriginal status, those living on low incomes, recent immigrants, and those living in rural rather than urban areas. Table 1 provides the set of social determinants of health developed for the Canadian scene. Importantly, their quality is strongly shaped by public policies instituted by governing authorities (Graham, 2004).

The sources of health inequities – in health status and access to health care – are the social inequalities that result in differing exposures to a variety of social determinants of health. People who are healthier are generally wealthier, have more secure employment with better working conditions, and have enough economic resources to avoid housing and food insecurity. They are also less likely to experience social exclusion and have better access to health care. It is recognized that the distribution of the social determinants of health in a society is the key issue that shapes the presence of health inequities (Health Council of Canada, 2010) (see Appendix II). Data is available concerning the distribution of the social determinants of health in Canada over time as is analysis of the public policies that create these distributions (Raphael, 2009).

Canada lags behind other jurisdictions in having these health equity concepts implemented through public policy activity such that Canada’s distribution of the social determinants of health is among the most unequal of wealthy developed nations (Bryant, Raphael, Schrecker, & Labonte, 2011; Senate Subcommittee on Population Health, 2008). Not surprisingly, there are significant health inequities among Canadians that result from this skewed distribution of the social determinants of health (Butler-Jones, 2009). Analyses of the federal government’s approach towards promoting health equity are available as is initial work on how Canadian provinces and territories do so (Health Council of Canada, 2010; Raphael, 2011b). But to date there has not been a systematic examination of how the Province of Ontario promotes health equity through public policy action on the social determinants of health nor has there been an examination of means by which such activities could be enhanced.

This paper carries out such an analysis against the backdrop of four major reports and statements that recommend means of strengthening the social determinants of health and making

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Table 1. The Social Determinants of Health

<table>
<thead>
<tr>
<th>Aboriginal Status</th>
<th>Health Services</th>
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<tr>
<td>Disability Status</td>
<td>Housing</td>
</tr>
<tr>
<td>Early Life</td>
<td>Income and Income Distribution</td>
</tr>
<tr>
<td>Education</td>
<td>Race</td>
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<tr>
<td>Employment and Working Conditions</td>
<td>Social Exclusion</td>
</tr>
<tr>
<td>Food Security</td>
<td>Social Safety Net</td>
</tr>
<tr>
<td>Gender</td>
<td>Unemployment and Employment Security</td>
</tr>
</tbody>
</table>

their distribution more equitable. The final report of the World Health Organisation’s Commission on Social Determinants of Health *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* is especially pertinent as it was a major international initiative that saw significant Canadian involvement (Public Health Agency of Canada, 2007; World Health Organisation, 2008).

Also germane to this analysis is the *Rio Political Declaration on the Social Determinants of Health* which commits Canada as a signatory to various actions pertinent to the social determinants of health (World Health Organisation, 2011). Suggestions are also provided by the *Fair Society, Healthy Lives* report that outlines means of implementing the Commission’s recommendations in England (Marmot et al., 2010) and *Protecting the Right to Health through Action on the Social Determinants of Health* which is a statement from various civil society organisations from Canada and elsewhere on what should be done to address the social determinants of health (People's Health Movement, 2011).

In this paper, these recommendations are examined in relation to: a) evidence of Ontario’s current performance in addressing health equity issues and b) what Ontario could be doing to further promote health equity. Such an analysis is especially timely as Ontario – like governments around the world – is re-examining its public policy in light of the recent global recession and subsequent recovery. In Ontario, the report of the Commission on the Reform of Ontario's Public Services calls for a retrenchment in service provision (Commission on the Reform of Ontario's Public Services, 2012), a direction which appears to be at odds with many recommendations emanating from these social determinants of health initiatives.

**Closing the Gap in a Generation**

The World Health Organization undertook a major effort to promote health equity by establishing a *Commission on Social Determinants of Health* (World Health Organization, 2004). Two of its knowledge hubs -- *Early Child Development* and *Globalization and Health* -- were placed in Canada and the Public Health Agency of Canada provided funding support. One of its Commissioners was the former Minister of Health and Welfare Monique Begin. Its final report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* and the reports of its various knowledge hubs provide numerous recommendations for promoting health equity by strengthening the social determinants of health and making their distribution more equitable (World Health Organisation, 2008).
The Commission’s recommendations were focused on three main areas: a) improve daily living conditions; b) tackle the inequitable distribution of power, money, and resources, and c) measure and understand the problem and assess the impact of action. Specific action areas are provided in Table 2.

**The Health Gap in Ontario**

Prior to considering these recommendations and their implications for public policymaking in Ontario, a brief overview of inequities in health status in Ontario is provided. This overview sets the stage for examination of the specific recommendations provided by the Commission.

**Table 2. Specific Action Areas of the Closing the Gap in A Generation Report**

1. **Improve Daily Living Conditions**
   - Equity from the Start
   - Healthy Places, Healthy People
   - Fair Employment and Decent Work
   - Social Protection across the Lifecourse
   - Universal Health Care

2. **Tackle the Inequitable Distribution of Power, Money, and Resources**
   - Health Equity in All Policies, Systems, and Programmes
   - Fair Financing
   - Market Responsibility
   - Gender Equity
   - Political Empowerment – Inclusion and Voice
   - Good Global Governance

3. **Measure and Understand the Problem and Assess the Impact of Action**
   - The Social Determinants of Health: Monitoring, Research, and Training
   - Actors


There is an extensive literature on health inequities in Ontario (Gardner, 2010; Project for an Ontario Women's Health Evidence-Based Report, 2012). Health inequities exist for life expectancy, infant mortality, and mortality rates from a number of diseases among those differing in income and urban versus rural settings. There are also income-related inequities in
incidence and prevalence of various diseases and injuries. Two illustrative examples of such inequities are provided here: a) premature mortality prior to age 75 as a function of income, and b) differences in incidence of injuries among Ontarians of differing ages and income.

Differences in Mortality Prior to Age 75

One study provides data on premature mortality (percentage of the population who died before age 75) by gender and neighbourhood income quintile in Ontario for the year 2001 (Project for an Ontario Women's Health Evidence-Based Report, 2012) (see Figure 1). Premature mortality is distinctly higher among residents of the poorest 20% of Ontario neighbourhoods. The lowest income men have a 41% chance of dying before age 75 while the best-off men have a 28% chance. This 13% absolute difference translates into a relative greater risk of dying prior to age 75 for the lowest income men of 45% using the best-off group as a base-line. For women, the absolute difference of 7% between the lowest income women (26%) and best-off women (19%) converts into a 35% greater risk of dying prior to age 75 for the lowest income women.

Source: Power Study (2012).
Differences in Injuries as a Function of Age and Income

Profound differences in injuries are seen in Ontario between those of differing incomes. Figure 2 provides rates of injury-related hospitalizations per 100,000 population, by age group and income quintile in Ontario for the period 2002/03 (Macpherson et al., 2005). Amongst the youngest age group, the rate for hospitalizations for the lowest income group (287/100,000) is 35% higher than for the most well-off group (213/100,000). Among the oldest group, the hospitalization rate for the lowest income group (566/100,000) is 42% higher than for the most well-off group (1269/100,000). These inequities in health status as a function of income are seen for just about every disease or affliction. There are also profound differences in educational and social outcomes among young Ontarians of differing incomes (Raphael, 2010b). Appendix III provides further examples of health inequities in Ontario including inequities in access to health care.


Closing the Gap Action Area 1: Improve Daily Living Conditions

The Closing the Gap recommendations are consistent with a long-standing literature of what is known about promoting the health of the population. The Commission’s concern with equity involves a special emphasis on promoting the well-being of girls and women. For
children, there is focus on improving the living circumstances in which they are born and supporting early child development and education. For adults, it is important to improve living and working conditions and promote social protection across the life-span from childhood to old age. The actors working to implement these actions should be civil society, governments, and various global institutions.

The importance of providing health promoting living conditions has been recognized by Canadian health authorities (Butler-Jones, 2009, 2010, 2011; Epp, 1986; Lalonde, 1974) such that Canada achieved an international reputation for developing such concepts (O'Neill, Rootman, Dupere, & Pederson, 2012; Restrepo, 2000). Unfortunately, there is evidence that Canada lags behind other healthy developed nations in actually implementing these concepts through public policy activity (Bryant et al., 2011; Hancock, 2011; Raphael, 2008). The next sections provide a synopsis of how Ontario is doing in a) providing the daily living conditions necessary for health identified by the Closing the Gap report and b) implementing its recommendations. The sections then go on to suggest means of enhancing these activities.

**Equity from the Start**

A fundamental aspect of health promoting public policy is providing individuals with the economic and social conditions necessary for health. This is especially important for children as living conditions during childhood are not only related to health outcomes during childhood, but are also good predictors of health outcomes during adulthood (Raphael, 2011g). This is particularly the case for cardiovascular disease and adult-onset diabetes (Raphael, Anstice, & Raine, 2003; Raphael & Farrell, 2002). The Closing the Gap report’s recommendations for action in equity from the start are contained in Table 3.

**Equity from the Start: How is Ontario Doing?**

There are numerous indicators of living conditions that indicate extent of equity, but the most fundamental concern the distribution of income and wealth (Wilkinson & Pickett, 2009). One which has a profound significance for health, especially during childhood, is the incidence of poverty. The research literature on the relationship between income and health is extensive and there is a strong relationship between living in poverty and experiencing adverse health outcomes across the life span (G. Davey Smith & Gordon, 2000; Phipps, 2002).
Table 3. The Commission’s Recommendations for Promoting Equity from the Start

A comprehensive approach to the early years in life requires policy coherence, commitment, and leadership at the international and national level. It also requires a comprehensive package of ECD and education programmes and services for all children worldwide.

*Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.*

- Set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on.
- Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay.

*Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).*

- Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay. Identify and address the barriers to girls and boys enrolling and staying in school and abolish user fees for primary school.


Additionally, poverty during childhood is not only related to adverse health outcomes among children, but is also a good predictor of the onset of various chronic diseases (G Davey Smith, 2003; Raphael, 2011f). A variety of measures of low income developed by Statistics Canada are in use in Canada, but Ontario has adopted one of these – the Low Income Measure or LIM – as its primary poverty indicator (Government of Ontario, 2010). The LIM is an indicator of the percentage of individuals or families having an after-tax income of 50% or less of the median individual or family income, adjusted for family sizes (Statistics Canada, 2009) (see *Appendix IV* for Statistics Canada’s detailed description of the LIM).

One important aspect of the LIM is that it is virtually identical to the primary measure of poverty used by numerous international organizations (Innocenti Research Centre, 2012; Organisation for Economic Co-operation and Development, 2011b). It is a useful measure of poverty because having access to less than half of the median income is indicative of inability to carry out the generally accepted activities of a given society (Smeeding, 2005; Townsend, 1993). Living below the LIM has been shown to be related to various indicators of mortality and morbidity in Canada (Auger & Alix, 2009). Use of the LIM allows Ontario’s poverty rates to be...
placed in an international perspective. The data for Ontario provided in this report are all from Statistics Canada’s CANSIM data base (Statistics Canada, 2012a). Figure 3 provides evidence of the extent of poverty among Ontarians across the life span using the after-tax LIM.

Poverty rates for Ontario children are above 14% and rates across all age groups have increased since the mid-1990s. The trend for those over 65 years is particularly striking with their rates growing at close to 10% after the lows of 4% seen during the mid 1990s. Canada – including Ontario -- is one of the very few wealthy developed nations whose poverty rates for children are higher than for the general population, a finding noted by UNICEF in its most recent report on child poverty (Innocenti Research Centre, 2012).

An important question concerns how much on average those identified as living in poverty are below the poverty line. Are poor people in Ontario just below the poverty line or are they very much below? Figure 4 provides a measure of how far below the poverty line people in Ontario living in poverty are as a percentage of the poverty line. The gap is rather large. For poor children the gap is currently 24%, for adults aged 18-65 it is 33%, and for those older than 65 years, it is less, at 17%. For adults aged 18-65, these figures show little change since 1980, but
for children there has been a lessening of the poverty gap. For seniors there is a slight decline during this period, but note that the poverty rate for seniors has been increasing. Poverty rates are closely related to the extent of income inequality within a jurisdiction and evidence provided in Appendix V shows that income inequality is on the rise in Ontario. Appendix V also provides further details concerning both poverty rates and income inequality rates for families and unattached individuals in Ontario. These findings suggest that means should be found to make the distribution of income more equitable.

![Figure 4. Low Income Gap, using the Low Income Measure, After Tax, by Age Group, Ontario, 1980-2010](image)

**Equity from the Start: Focus on Children**

Overviews of the situation of children in Canada are available and generally Canada falls behind many other wealthy developed nations on indicators of children’s health and well-being. These comparative studies do not breakdown the data by Province so we do not know exactly how well Ontario is doing. However, poverty rates among the provinces can be compared and the latest data shows that the child poverty rate for children in Ontario at 14.2% is very close to the Canadian rate of 14.5% (Figure 5). This suggests that findings for Canada from these international studies are generally applicable to the situation in Ontario.
Regarding these comparative findings, the Innocenti Research Centre reports on children’s health (Innocenti Research Centre, 2007) and well-being as well as extent of inequality on various indicators (Innocenti Research Centre, 2010). In terms of children’s overall well-being, Canada obtained the following ranks out of 18 wealthy developed nations where 1st is best and 18th worst: Material well-being (6th), Health and safety (13th), Educational well-being (2nd), Family and peer relationships (18th), Behaviours and risks (17th), and subjective well-being (15th) (Innocenti Research Centre, 2007). In terms of extent of inequality among children where 1st is least and 24th the most, Canada ranked 17th of 24 wealthy developed nations in equity of material well-being, 9th of 24 for health well-being, and 3rd of 24 for equity in educational outcomes. Evidence in support of the validity of these findings is seen in data which places Canadian (and Ontario) poverty rates for children in relation to other wealthy developed nations (Figure 6) (Innocenti Research Centre, 2012).
Early Childhood Education and Care

Provision of childcare as a universal right is one of the hallmarks of societies where children do very well in health and other outcomes (Innocenti Research Centre, 2007, 2008). Not surprisingly, provision of such services is highlighted in the recommendations of the Closing the Gap report (see Table 3). Canada is not among the wealthy developed nations that provide childcare as a matter of right for citizens. In Canada, Friendly and Prentice have made the
argument that universal affordable child care has the following effects: a) enhancing children’s well-being, healthy development, and lifelong learning; b) supporting parents in education, training, and employment; c) building strong communities; and d) providing equity (Friendly & Prentice, 2009). Such provision is a key component of providing *Equity from the Start*.

A 2009 report provides data on the childcare situation in Ontario (Beach, Friendly, Ferns, Prabhu, & Forer, 2009). In 2007, there were 402,800 children in Ontario, aged 0-2 years and 409,000 aged 3-5. For these aged groups, 68.3% or 240,800 of mothers of 0-2 year olds were employed and 78.6% or 193,700 mothers of those aged 3-5 were employed. Yet the total number of regulated childcare spaces available for these age groups in Ontario was only 159,604 providing a percentage of 19.6% availability.

Ontario has instituted full-day kindergarten which was a recommendation from the Report to the Premier by the Special Advisor on Early Learning (Government of Ontario, 2012). However, it also decided not to support other recommendations that called for Boards being responsible for organizing a seamless program of child care and elementary school activities (CUPE Ontario, 2010).

**Healthy Places, Healthy People**

Table 4 provides the Commission’s recommendations for the action area of *Healthy Places, Healthy People*. In this report focus is on provision of housing and food in Ontario as well as dealing with issues related to rural living.

**Housing**

Ontario continues to be in an affordable housing crisis as prices for houses and rents rise well beyond the inflation level. The Canadian Mortgage and Housing Corporation provides ongoing reports on the state of affordable housing in cities across Canada. Its most recent report finds a significant problem across Canada in terms of what is called core housing need (Canadian Mortgage and Housing Corporation, 2011). Core housing need is defined as not having housing that is adequate, suitable, or affordable (see Box 1).
Table 4. The Commission’s Recommendations for Healthy Places, Healthy People

Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being and that are protective of the natural environment are essential for health equity.

*Place health and health equity at the heart of urban governance and planning.*

- Manage urban development to ensure greater availability of affordable housing; invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay.
- Ensure urban planning promotes healthy and safe behaviours equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets.

*Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes.*

- Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants.

*Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity.*

Incidence of core housing need refers to the percentage of households in core housing need. As shown in Table 5, in urban households across Canada, 13% of households are seen as being in core housing need. The figures for Ontario are above the Canadian average tied with Nova Scotia for second worst compared to Newfoundland and Labrador. Among those in core housing need in Ontario the average household pays 45.9% of income on housing well above the acceptable rate of 30%. The gap between affordable housing and income is on average $2100 in Canada but is $2400 in Ontario, representing a 28.7% gap. The Canadian Mortgage and Housing Corporation notes that core housing need is concentrated among lower income Ontarians.
Box 1. Acceptable Housing and Core Housing Need

The term acceptable housing refers to housing that is adequate in condition, suitable in size, and affordable.

- Adequate housing does not require any major repairs, according to residents. Major repairs include those to defective plumbing or electrical wiring, or structural repairs to walls, floors or ceilings.

- Suitable housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements. Enough bedrooms based on NOS requirements means one bedroom for each cohabiting adult couple; unattached household member 18 years of age and over; same-sex pair of children under age 18; and additional boy or girl in the family, unless there are two opposite sex children under 5 years of age, in which case they are expected to share a bedroom. A household of one individual can occupy a bachelor unit (i.e., a unit with no bedroom).

- Affordable housing costs less than 30% of before-tax household income. For renters, shelter costs include rent and any payments for electricity, fuel, water and other municipal services. For owners, shelter costs include mortgage payments (principal and interest), property taxes, and any condominium fees, along with payments for electricity, fuel, water and other municipal services.

A household is in core housing need if its housing does not meet one or more of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its before-tax income to pay the median rent (including utility costs) of alternative local market housing that meets all three standards.

Table 5. Housing Conditions of Urban Households, by Province, 2008

<table>
<thead>
<tr>
<th>Province</th>
<th>Incidence of Core Housing Need %</th>
<th>Median Shelter-to-Income ratio (STIR) %</th>
<th>Median Depth ($)</th>
<th>Average Depth Ratio (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>13.7</td>
<td>49.3</td>
<td>2,680</td>
<td>30.2</td>
</tr>
<tr>
<td>Alberta</td>
<td>10.3</td>
<td>43.8</td>
<td>2,400</td>
<td>24.3</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>10.5</td>
<td>47.8</td>
<td>1,560</td>
<td>25.2</td>
</tr>
<tr>
<td>Manitoba</td>
<td>8.9</td>
<td>44.9</td>
<td>1,440</td>
<td>26.8</td>
</tr>
<tr>
<td>Ontario</td>
<td>15.1</td>
<td>46.1</td>
<td>2,400</td>
<td>28.7</td>
</tr>
<tr>
<td>Quebec</td>
<td>11.1</td>
<td>43.8</td>
<td>1,350</td>
<td>24.2</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>7.7</td>
<td>40.5</td>
<td>1,240</td>
<td>25.0</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>15.1</td>
<td>50.2</td>
<td>2,500</td>
<td>34.6</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>7.4</td>
<td>43.8</td>
<td>1,250</td>
<td>22.6</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>16.7</td>
<td>44.5</td>
<td>2,150</td>
<td>29.0</td>
</tr>
<tr>
<td>All Provincial Urban Households</td>
<td>13.0</td>
<td>45.9</td>
<td>2100</td>
<td>27.6</td>
</tr>
</tbody>
</table>

Source: CMHC (SLID-based Housing Indicators and Data).

Shapcott summarizes the situation in Ontario as follows:

There are a record 152,077 households on provincial affordable housing wait lists, according to the latest survey from the Ontario Non-Profit Housing Association. That’s up 7.4% over the previous year and up 17.7% since 2009. The latest report from the City of Toronto puts the wait list at 82,138 households – an all-time record. Ontario budget 2012 provides virtually no hope for those households anxious to find a good place to call home. An estimated 630,000 Ontario households are “in core housing need,” the official definition from Canada Mortgage and Housing Corporation of those who are precariously housed. That represents about one in every seven households across the province (Shapcott, 2012).

Food Insecurity

In March of 2011, 395,106 Ontarians were assisted by food banks (Food Banks Canada, 2011). This represents an increase of 25.7% since 2008. Of these individuals, 37.5% were under the age of 18. Of these 395,106 individuals, 63% of households receiving food were rental market tenants while 25% lived in social housing. Only 10.5% were gainfully employed and a
full 44.5% depended on social assistance, with 27.5% receiving disability-related income supports. Since those on social assistance and receiving disability payments are already more likely to be ill, the situation of being in need of food has especially dire health implications (Raphael et al., 2012).

**Fair Employment and Decent Work**

Employment and working conditions are key determinants of the presence of health inequities and this is recognized by the recommendations of the Commission that are contained in Table 6. In Ontario, there is data available on employment and underemployment rates and differences in salaries between unionized and non-unionized workers, but rather less on specific working conditions. One common indicator of employment and working conditions is the percentage of workers identified as being low waged. Another indicator is percentage of workers receiving employment benefits such as vision and dental care, pensions, and employment training.

*Unemployment Rates.* In March 2012, Ontario’s unemployment rate was 7.4%, slightly higher than Canada’s rate of 7.2%, and reported by Statistics Canada as being its lowest level in three years (Statistics Canada, 2012b).

*Low-waged Workers.* In 2006, about one in six workers were considered low waged (earning less than $10 an hour). The overall rate was 15.7% in Canada and for Ontario 14.9%. Note that in the Scandinavian nations comparable figures are 5% or less (Canadian Union of Public Employees, 2007).

*Percentage Working for Minimum Wage.* It is well established that minimum wages in most provinces place individuals working full time below the poverty line. Data from Statistics Canada’s 2009 Labour Survey found that across Canada, 5.8% of workers were earning the minimum wage (Statistics Canada, 2010). In Ontario however, the figure was 8.1% which is second only to Newfoundland and Labrador’s 9.3% rate. The Ontario rate was as low as 3.9% in 2002 but took a major jump between 2008 and 2009 from 6.6% to the current 8.1%.
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Table 6. The Commission’s Recommendations for Fair Employment and Decent Work

Through the assurance of fair employment and decent working conditions, government, employers, and workers can help eradicate poverty, alleviate social inequities, reduce exposure to physical and psychosocial hazards, and enhance opportunities for health and well-being. And, of course, a healthy workforce is good for productivity.

*Make full and fair employment and decent work a central goal of national and international social and economic policy-making.*

- Full and fair employment and decent work should be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work.

*Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all.*

- Provide quality work for men and women with a living wage that takes into account the real and current cost of healthy living.

- Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work-home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements.

*Improve the working conditions for all workers to reduce their exposure to material hazards, work-related stress, and health-damaging behaviours.*

*Union Membership.* Union membership or union density has been related to poverty rates and income distribution across nations in that greater union density is related to lower poverty rates and more equitable distribution of income. Within Canada union membership has been related to higher wages, lower poverty rates, and provision of more benefits. Coverage rates refer to percentage covered by collective agreements that are negotiated through union employer bargaining.

Unionization rates for Ontario in 2011 (26.6% -- coverage rates 28.2%) are very low in international comparison and lower than in every other province except Alberta (22%). The Provinces of Newfoundland (38.1%), Quebec (36.3%), and Manitoba (35.1%) are the highest. The Canadian average is 29.7% with coverage being 31.7% (Statistics Canada, 2011b).

Union membership is strongly related to average earnings in Ontario. In 2010, among all employees union members earned on average $27.49 an hour while non-union members earned $21.57 an hour (Statistics Canada, 2011a). Broken down into full time and part time workers,
union members earned $28.51 and $21.34 an hour respectively, while non-union workers earned $21.34 and $14.12 respectively.

**Social Protection Across the Lifecourse**

The Commission recognized the responsibilities of governments to ensure that citizens not be allowed to fall below living standards that allow for health as a result of circumstances beyond their control (see Table 7). The rather large percentages of Ontarians living in poverty have been noted and in this section the quality of Ontario’s social safety nets are examined.

**Table 7. The Commission’s Recommendations for Social Protection Across the Lifecourse**

Reducing the health gap in a generation requires that governments build systems that allow a healthy standard of living below which nobody should fall due to circumstances beyond his or her control. Social protection schemes can be instrumental in realizing developmental goals, rather than being dependent on achieving these goals – they can be efficient ways to reduce poverty, and local economies can benefit. 

*Establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.*

- Progressively increase the generosity of social protection systems towards a level that is sufficient for healthy living.
- Ensure that social protection systems include those normally excluded: those in precarious work, including informal work and household or care work.

Data is available concerning levels of benefits available to Ontarians unable to work because of a disability or an inability to find work (National Council of Welfare, 2010). Social assistance rates are consistently below levels needed to remove individuals and families from living in poverty. In many cases, these rates do not even come close to the poverty-leaving levels. In Ontario, a single person considered to be employable received support at 41% of the low income (or poverty) cut-off line. If the person is deemed unable to work because of a disability, they received support that is 70% of the poverty line amount. A lone parent with one child is at 77% of the poverty line and a couple with two children is at 65% of the poverty line.

There is evidence that the gap between benefits and the poverty line has been growing over time in Ontario where the decline has been especially great. In 1988 social assistance benefits were reduced by 22%. In real dollar values, current benefits are now -- as compared to 1992 in constant dollars -- 40% less for a single person considered employable, 20% less for a
person with a disability, 12% less for a single parent with a child, and 29% less for two parents with two children.

**Universal Health Care**

It is in the area of Universal Health Care that Ontario has expended significant effort in developing a health equity approach. The Commission’s recommendations are contained in Table 8.

**Table 8. The Commission’s Recommendations for Universal Health Care**

*Build health-care systems based on principles of equity, disease prevention, and health promotion.*

- Build quality health-care services with universal coverage, focusing on Primary Health Care.

- Strengthen public sector leadership in equitable healthcare systems financing, ensuring universal access to care regardless of ability to pay.

*Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health.*

- Invest in national health workforces, balancing rural and urban health-worker density.

- Act to redress the health brain drain, focusing on investment in increased health human resources and training and bilateral agreements to regulate gains and losses.

A concern with promoting equity in health care is seen in numerous provincial documents related to healthcare policy. Ontario has seen the creation of a “Health Equity Unit” in its Ministry of Health and Long-Term Care and in its organization of Local Health Integration Networks (LHINs), these units are required to create “Health Equity Plans” (Wellesley Institute, 2012). Ontario has also developed a health impact assessment framework for these health care units and is expanding its reach to public health units (Ministry of Health and Long-Term Care, 2012). To date, these initiatives have not been evaluated for their effectiveness.

**Improving Living Conditions: Recommendations for Action**

The *Closing the Gap Report* recommendations for *Improve Daily Living Conditions* are remarkably similar to those that have been advanced by various Ontario advocacy groups concerned with specific social determinants of health such as income, housing, food security, and
transportation, among others. There appears to be no shortage of areas where action is required (Campaign 2000, 2011; Food Banks Canada, 2011; Shapcott, 2012).

The Ontario government itself has recognized the need for action in its adoption of an anti-poverty strategy, a summary of which is provided in Box 2. Ontario’s Poverty Reduction Act was passed in 2009. The title of Ontario’s anti-poverty strategy, *Breaking the Cycle*, indicates “focus on breaking the cycle of intergenerational poverty by improving opportunities through education” (Government of Ontario, 2008). Consistent with this intergenerational emphasis, the strategy is primarily focused on families with children and sets a goal of reducing the child poverty rate by 25% in five years. The success of reaching this target will be assessed through use of Statistics Canada’s after tax-low income measure.

The components of the strategy in the initial 2008 document include increases to the Ontario Child Benefit to provide additional resources to 1.3 million children, tripling the number of Parenting and Family Literacy Centres, investing in an After School Program, and instituting all-day junior and senior kindergarten. There are plans to invest in a Community Opportunities Fund and Youth Opportunities Strategy, and to fund a Provincial Rent Bank Program.

**Box 2. Ontario’s Poverty Reduction Plan**

As an over-all goal, Ontario’s strategy set a target to reduce child poverty by 25 per cent in five years. The strategy sets out directions and goals in three broad areas:

- **Education and Early Learning**
- **Stronger Communities**
- **Smarter Government**

Initiatives include increasing the number of child care spaces and parenting and literacy centres across the province, funding student nutrition and dental care programs, working with school boards so that all students can take part in activities regardless of income, and helping non-profit groups have access to schools, so that the schools can become community hubs.

Affordable housing and a provincial rent bank, to help families stay in their homes, received renewed support. There were changes to several income support programs and the Ontario Child Benefit program. The poverty reduction strategy included a commitment to increase Ontario’s minimum wage; the 2010 rate is $10.25, which is almost a 50% increase since 2003. The government also proposed a tax package that will exempt many low-income Ontarians from personal income tax.

The poverty reduction strategy also established a Social Assistance Review Advisory Council. Some immediate, short-term changes to social assistance programs have already been implemented. The council has a mandate for a longer term transformation of Ontario’s social assistance system that will increase people’s opportunities for work and guarantee security for those who cannot work.
Unfortunately, the effects of this strategy in reducing poverty rates and dealing with the issues described above have been modest and poverty rates for children first increased and are now at the levels seen at the beginning of the Strategy. Appendix VI provides further details concerning the Strategy and an evaluation of its effects.

Like many of the anti-poverty programs initiated in other provinces, these strategies and programs are focused on reducing poverty among families with children by providing them with benefits that bring them up to or above the poverty line. The high poverty rates seen among unattached adults have for the most part been neglected. This is not to suggest that anti-poverty strategies and programs are not of value, but rather to argue for the importance of identifying additional means by which poverty rates can be reduced in Canada.

These anti-poverty strategies and programs have modest poverty-reducing effects because they fail to address the sources of the unequal distribution of resources. These broader issues are intricately related to existing inequalities in influence and power associated with public policy that skews the distribution of economic resources amongst the population. Interestingly, these inequitable distributions of power and influences were recognized by the Commission and constitute its second Action Area: Tackle the Inequitable Distribution of Power, Money, and Resources.

**Recommendations for Action**

There are two general sets of recommendation by which Ontario could move to promote health equity. The first set is the more traditional one in which numerous public policy recommendations are laid out that would strengthen the social determinants of health through public policy action. These types of recommendations have been the mainstays of organizations concerned with reducing poverty, and strengthening specific social determinants of health such as early child development, housing, food security, employment, and working conditions.

The second direction is one that recognizes that government structures in Ontario and elsewhere in Canada are not aligned with promoting health equity by strengthening the social determinants of health through public policy action. This direction outlines the governmental structures that would be necessary for such a realignment to occur. These recommendations are similar to the ones provided by the Health Council of Canada in its recent *Stepping it Up* report.
which seeks to move governments in Canada towards addressing health equity as a public policy goal (Health Council of Canada, 2010).

The task for those concerned with promoting health equity in Ontario through action on the social determinants of health is therefore a difficult one. What is required is implementing public policy that will improve living and working conditions for Ontarians right across the life span. This seems like a daunting task and it is probably is. But there are some clear issues that should be addressed and these concern the key social determinants of health of income, early child development, and employment and working conditions. Interestingly some means of addressing these issues such as making unionization of workplaces easier to do would not cost the province anything. Raphael (2011) recently outlined some means by which these issues and additional related issues of housing and food security could be addressed.

Recommendations for Improving the Distribution of Income

Anti-poverty groups such as Campaign 2000, Make Poverty History, and the Canadian Association of Food Banks – including their Ontario chapters -- have all put forth recommendations, for making the distribution of income more equitable, that are relevant to the Ontario scene. These organizations urge an increase in the minimum wage and a boost in assistance levels for those unable to work, measures that would provide immediate benefits for people who are at the bottom of the income distribution ladder. They also call for increased child benefits similar to levels provided in other nations.

Another way of reducing income and wealth inequalities in Ontario would be to make it easier for workplaces to unionize. Creating a fairer tax system would also help halt the growth of income inequality in Canada. Interestingly, the Ontario government has just implemented a 2% surtax on those with incomes greater than $500,000 a year. They did this only under the pressure of saving their minority government by agreeing to this NDP demand.

Recommendations for Improving the Quality of Early Childhood Education

An improvement in the quality of early child development would have health repercussions for Ontarians across the socio-economic spectrum, from the most vulnerable members of society to well-off Canadians, who would benefit through a better quality of life in their communities, reduced social problems, and enhanced Canadian economic performance. All of these potential areas of improvements are important determinants of health (Mikkonen and Raphael, 2010),
Proposals for improving early child development are virtually the same as those for reducing poverty in general and child poverty in particular with the specific addition of establishing an affordable regulated childcare system similar to what is being done in Quebec. Not only are these recommendations similar to those of other Canadian policy organizations, but they are also similar to the policy directions that have been effective in bettering early child development in wealthy industrial nations (Innocenti Research Centre, 2008).

While the Ontario government provides significant support for early childhood care and education, affordable regulated childcare is only available to a small percentage of Ontario families who need it. In contrast, Quebec has allocated significant resources in its efforts to provide $7/day child care and move towards the goal of providing this care for all those who need it.

Recommendations for Improving Working Conditions

Jackson (2009) suggests that governments must intervene to help shape and improve workplace conditions. He directs attention to numerous recommendations that have been made over the years to improve working conditions. The Donner Task Force (Report of the Advisory Group on Working Time and Redistribution of Work) and the Report of the Collective Reflection on the Changing Workplace called for action not only to “regulate working time by limiting long hours and by making precarious work more secure” but also to implement changes to employment standards and to enhance collective representation of workers.

The report of a federal task force on employment standards, *Fairness at Work: Federal Labour Standards for the 21st Century*, called for “limits on long working-time and arbitrary work schedules, more paid time off the job, and measures to secure respect for human rights in the workplace.” Jackson concludes that making it easier for workers to organize is essential because: “It is unlikely that there will be significant positive changes in the workplace if everything is left to employers, and if governments do not help equalize bargaining power between workers and employers.”

One way of dealing with a variety of problems associated with working conditions is to equalize the balance between employers and employees. About 30 percent of Ontario workers are members of unions, and the magnitude of differences in working conditions, wages, and benefits between unionized and non-unionized workplaces is quite striking. Employees who
work under collective agreements negotiated by unions receive numerous benefits and have a greater ability to influence working conditions.

Unionized workers covered under collective agreements enjoy higher wages than do those not covered (Jackson, 2010). While benefits are seen across all occupations, the union advantage is especially great for blue-collar and mainly low-wage private services. The union advantage is also especially great for women; in unionized workplaces women earn wages that are 36 percent higher.

Unionized workplaces lead to increased equality of power between employers and employees, greater opportunities for training and advancement, and even greater productivity. Jurisdictions with a greater incidence of unionized workplaces also show less income inequality and lower poverty rates, Jackson notes, and the incidence of lower-paying jobs is less. In 2004 Canada had the highest rates of low-paid workers — defined as earning less than two-thirds of the median national full-time wage — among a number of wealthy developed nations (Jackson, 2010).

**Recommendations for Improving Food Security in Canada**

If public policy is to fully address food insecurity, the first item on the agenda must be to ensure an increase in the incomes of those experiencing food insecurity, which means, as a start, legislating increased minimum wages or social assistance rates. Governments must also make sure that healthy foods, especially staples such as milk, are affordable. As McIntyre and Rondeau assert: “Community based food-assistance programs such as food banks do not support the achievement of healthy diets among recipients. These initiatives represent a poor policy alternative to the family purchase of healthy foods” (McIntyre & Rondeau, 2009).

The availability of affordable housing has to be a key governmental priority. Too often families are forced to decide between paying the rent or feeding the kids. A lack of affordable child care is another barrier that often keeps mothers out of the workforce: a universal, publicly funded (which means affordable) child-care system must be set in place. Finally, governments should expand on programs that have been shown to reduce poverty and food insecurity, providing an integrated slate of work-related supports, health and recreation provisions, and other transition assistance.
Recommendations for Improving Housing Security and Reducing Homelessness

Researchers have noted that it is well within the reach of Canadian governments to end the homelessness crisis by increasing their budgetary allocation for housing by 1% of total overall spending. Shapcott notes that in September 2005, the federal, provincial, and territorial housing ministers met in White Point, Nova Scotia and created “principles for a new Canadian Housing Framework” (Shapcott, 2009)

They promised to “accelerate work” on the new housing framework, but “then didn’t even schedule another meeting until February 2008, more than two and a half years later.” Remarkably, the federal housing minister refused to even attend the meeting, but under significant pressure agreed to meet with his provincial and territorial counterparts two months later. These meetings have led to a collection of agreements being released, but Shapcott argues that these moves do not come close to replacing the massive reductions made to housing programs during the 1990s. Even before the onset of the current recession, the possibility of the One Percent Solution being implemented seemed unlikely — and it seems even less likely now.

Labour Law and Regulations

As noted unionization rates are low in Ontario and some of this has to do with the rules by which workplaces can become unionized. In Ontario workplaces became unionized by having a majority of workers sign a card calling for a union. During the Harris regime this process was changed such that it became more difficult to unionize the workplace in that a formal vote was needed. This process provided opportunities for management to mobilize its considerable influence and power over employees to make the success of such a vote more problematic.

While in opposition, the Liberal Party promised to repeal this change, but once in power, they reneged on this promise.

Reducing Social Exclusion

There have been some efforts to reduce social exclusion especially for recent immigrants of colour but these have been scattered. As one example, Ontario funds a nursing program at York University that upgrades the qualifications of foreign-educated nurses that have come to Canada. The ruling Liberals had promised during the last election campaign to provide a $10,000 tax credit for firms who hired new Canadians. However since then it has been noted:
Nowhere in the post-election budget tabled last week by Finance Minister Dwight Duncan is there any mention of a new tax credit for employers who hire skilled immigrants – the Liberal promise that briefly took on a life of its own. In fact, insiders say, the issue was barely even on the government’s radar as that budget was prepared (Radwanski, 2012).

**Social Services**

Supports for those on Ontario Works or the Ontario Disability Support program fall well below the poverty lines, however measured. In the recent Budget the Ontario government intended to freeze increases for both these programs. It was only under threat of the NDP not supporting this budget and causing the government to fall that the government agreed to a 1% increase for both these programs. This will lead to these individuals falling even further behind as the 1% increase is well below the annual inflation rate.

*Closing the Gap Action Area 2: Tackle the Inequitable Distribution of Power, Money, and Resources*

The Commission’s report recognized that the addressing of health inequities and the inequitable living conditions that spawn these requires consideration of the manner in which society is organized. It clearly points out the need for a strong public sector that can address these issues. It also requires, in addition to a strengthened government, support for civil society and accountability of the private sector for its actions. It calls for commitments to the concept of collective action that include governance dedicated to equity from the community level to the global level.

Following an overview of the Commission’s recommendations, a plan for instituting a broad government-wide approach for addressing health equity is presented. The plan is based on the recommendations provided by the Health Council of Canada in its recent report *Stepping It Up* (Health Council of Canada, 2010).

*Health Equity in All Policies, Systems, and Programmes*

The recommendations contained in Table 9 are consistent with the *Health in All* approach which is a hallmark of public policy approaches in many northern European nations. The Health Council’s report specifically outlines what would be necessary to implement such an approach.
The issue of Fair Financing is particularly controversial as it involves issues of taxation and government expenditures. It is well documented that nations that collect and then distribute a greater proportion of national economic resources have more developed welfare states and evidence of better population health, fewer health inequities, and a better quality of life. Table 10 provides the Commission’s recommendations concerning financing issues.

**Table 9. The Commission’s Recommendations for Health Equity in All Policies, Systems, and Programmes**

<table>
<thead>
<tr>
<th>Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all policies.</th>
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<tbody>
<tr>
<td>• Make health and health equity corporate issues for the whole of government, supported by the head of state, by establishing health equity as a marker of government performance.</td>
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<tr>
<td>• Assess the impact of all policies and programmes on health and health equity, building towards coherence in all government action.</td>
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<tr>
<td><strong>Adopt a social determinants framework across the policy and programmatic functions of the ministry of health and strengthen its stewardship role in supporting a social determinants approach across government.</strong></td>
</tr>
<tr>
<td>• The health sector itself is a good place to start building supports and structures that encourage action on the social determinants of health and health equity. This requires strong leadership from the minister of health, with support from WHO.</td>
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**Table 10. The Commission’s Recommendations for Fair Financing**

<table>
<thead>
<tr>
<th>Strengthen public finance for action on the social determinants of health.</th>
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<tr>
<td>• Build national capacity for progressive taxation and assess potential for new national and global public finance mechanisms.</td>
</tr>
<tr>
<td><strong>Increase international finance for health equity, and coordinate increased finance through a social determinants of health action framework.</strong></td>
</tr>
<tr>
<td>• Honour existing commitments by increasing global aid to the 0.7% of GDP commitment, and expand the Multilateral Debt Relief Initiative; enhance action on health equity by developing a coherent social determinants of health focus in existing frameworks such as the Poverty Reduction Strategy Paper.</td>
</tr>
<tr>
<td><strong>Fairly allocate government resources for action on the social determinants of health.</strong></td>
</tr>
<tr>
<td>• Establish mechanisms to finance cross-government action on social determinants of health, and to allocate finance fairly between geographical regions and social groups.</td>
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To date Canadian governments – with one exception – have not considered the health impacts of economic policy. Quebec’s public health law requires such assessment. To do so would require an explicit recognition by government that economic policy impacts health but such explicit commitments have not been made.

**Table 11. The Commission’s Recommendations for Market Responsibility**

*Institutionalize consideration of health and health equity impact in national and international economic agreements and policy-making.*

- Institutionalize and strengthen technical capacities in health equity impact assessment of all international and national economic agreements.
- Strengthen representation of health actors in domestic and international economic policy negotiations.

*Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food).*

Ontario does have a Pay Equity Commission (Ontario Pay Equity Commission, 2012). The Ontario government website provides this description:

The Pay Equity Commission (PEC) is composed of two separate and distinct bodies; the Pay Equity Office (PEO) and the Pay Equity Hearings Tribunal (PEHT).

The Pay Equity Office is responsible for enforcing the Pay Equity Act. The Pay Equity Office investigates, attempts to settle, and resolves pay equity complaints and objections to pay equity plans by Order or Notice of Decision. The Pay Equity Office also provides programs and services to help people understand and comply with the Pay Equity Act.

The Pay Equity Hearings Tribunal is responsible for adjudicating disputes that arise under the Pay Equity Act. The Pay Equity Hearings Tribunal has exclusive jurisdiction to determine all questions of fact or law that arise in any matter before it. The decisions of the Tribunal are final and conclusive for all purposes.

The Commission provides annual reports on the gender wage gap and earnings ratio in Ontario, provides ongoing monitoring of these issues and has a complaints bureau established. In many ways these activities could serve as a prototype for ongoing monitoring of health equity issues in Ontario should the Province decide to do so.
Table 12. The Commission’s Recommendations for Gender Equity

Gender inequities are unfair; they are also ineffective and inefficient. By supporting gender equity, governments, donors, international organizations, and civil society can improve the lives of millions of girls and women and their families.

Address gender biases in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and the way in which a country’s economic performance is measured.

- Create and enforce legislation that promotes gender equity and makes discrimination on the basis of sex illegal.
- Strengthen gender mainstreaming by creating and financing a gender equity unit within the central administration of governments and international institutions.
- Include the economic contribution of housework, care work, and voluntary work in national accounts.

Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation.

- Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies. Increase investment in sexual and reproductive health services and programmes, building to universal coverage and rights.

Ontario has a Human Rights Code and a Human Rights Commission that deal with some of the issues related to Inclusion and Voice (see Table 13). (Ontario Human Rights Commission, 2012). The Ontario Human Rights System in Ontario is made up of three separate agencies:

- The Ontario Human Rights Commission works to promote, protect and advance human rights through research, education and policy development.
- The Human Rights Legal Support Centre gives legal help to people who have experienced discrimination under the Code and
- The Human Rights Tribunal is where human rights applications are filed and decided.

But this Commission is primarily one that allows complaints of human rights violations to be heard. It does not represent an ongoing process by which citizen voice can be heard in the making of public policy. Since achieving health equity has not been made an explicit component
of public policy in Ontario, no such process for inclusion and voice on these issues can be said to exist.

Table 13. The Commission’s Recommendations for Inclusion and Voice

Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making.

- Strengthen political and legal systems to protect human rights, assure legal identity and support the needs and claims of marginalized groups, particularly Indigenous Peoples.
- Ensure the fair representation and participation of individuals and communities in health decision-making as an integral feature of the right to health.

Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.

The recommendations related to Global Governance (Table 14) do not fall under Provincial jurisdiction.

Table 14. The Commission’s Recommendations for Good Global Governance

Make health equity a global development goal, and adopt a social determinants of health framework to strengthen multilateral action on development.

- The United Nations, through WHO and the Economic and Social Council, to adopt health equity as a core global development goal and use a social determinants of health indicators framework to monitor progress.
- The United Nations to establish multilateral working groups on thematic social determinants of health – initially early child development, gender equity, employment and working conditions, health-care systems, and participatory governance.

Strengthen WHO leadership in global action on the social determinants of health, institutionalizing social determinants of health as a guiding principle across WHO departments and country programmes.
What would a Tackling Health Inequalities Governmental Agenda look like in Ontario?

The Health Council of Canada recently provided an analysis of what is needed to have governments address the “determinants of health” through what it is called “a whole of government” approach (Health Council of Canada, 2010). The Health Council’s emphasis on the determinants of health is rooted in sometimes explicit, other times implicit, concern with promoting “health equity” and reducing “health inequities.”

The Health Council’s “Checklist for Whole-of-Government or Intersectoral Work”. was developed to address the determinants of health and it can be taken as specifying what values, information, and government infrastructure would be needed to tackle health inequalities (see Table 15).

Table 15. The Health Council of Canada’s Checklist for Whole-of-Government or Intersectoral Approach to promoting health Equity

<table>
<thead>
<tr>
<th>Values and Commitment</th>
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<tbody>
<tr>
<td>An overriding philosophy that health initiatives will be viewed through a population health lens.</td>
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<tr>
<td>Leadership at the top from the prime minister, premiers, ministers, cabinet secretaries, and others.</td>
</tr>
<tr>
<td>Recognition and awareness among elected representatives of the importance of the determinants of health for promoting population health and reducing health inequities.</td>
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<tr>
<td>Recognition that it may take years, even decades, for benefits to materialize.</td>
</tr>
<tr>
<td>Willingness to name the difficult problems and barriers that exist, and to provide the resources necessary to transcend them.</td>
</tr>
<tr>
<td>Commitment of civil servants to undertake a broader approach to addressing population health and reducing health inequities.</td>
</tr>
<tr>
<td>Willingness and commitment to ensure a structural approach to placing health projects on the public policy agenda.</td>
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<tr>
<td>Allocation of significant funding that allows for governmental commissioning of research, analysis, and policy implementation.</td>
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<table>
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<tr>
<th>Information and Data</th>
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<tbody>
<tr>
<td>Decisions should be made and actions taken based on available evidence without necessarily waiting for conclusive evidence.</td>
</tr>
<tr>
<td>Information and evidence on the state of population health and the presence of health inequities is presented in a government-instigated integrative report or statement.</td>
</tr>
</tbody>
</table>
- Development of clear, identifiable, and measurable goals and targets.
- Focusing on explicit concrete objectives and visible results. Ensuring transparency in governmental efforts and activities.
- Messaging to the public, including media support, about the importance of dealing with population health and reducing health inequities through action on the determinants of health.
- Development of practical models, tools, and mechanisms, such as health impact assessment, to support the implementation.
- Setting of realistic timelines.
- Support for academic and agency researchers who provide data and evaluation.
- Provision of ongoing public reports that document successes and challenges.

**Governmental Infrastructure**

- Governments must establish the means for society’s participation in the initiatives.
- Establishment of an independent authority within government that will be responsible for coordinating activity across ministries and departments.
- Cross-ministry structures and processes that provide a basis for these kinds of whole-of-government or intersectoral approaches.
- Contacting and drawing support from various external organizations that would be responsive to governmental action on the determinants of health.
- Government civil servants’ capacity to carry out the task.
- Ensuring that leadership, accountability, and rewards are shared among partners.
- Provision of adequate resources to sustain activities beyond the tenure of the present governing authority.
- Establishment of a balance between central direction and discretion of local authorities to implement goals and objectives.
- Establishment of accountability and evaluation frameworks.
- Building of stable teams of people who work well together, with appropriate support systems.


While the Health Council identifies targets for action, it is important to consider that there are numerous barriers to having these components implemented in Canada. And these barriers are generally neglected in most Canadian governmental and institutional reports that address issues of promoting health equity and tackling health inequalities, instead seeing failure to address these issues as involving a lack of information on health inequalities and/or a failure of bureaucratic organization. The following section recognizes these significant barriers and suggests how three key public policy models could – under the right circumstances – overcome these barriers and lead to Ontario taking on the task of developing a public policy that promotes health equity through action on the social determinants of health.
Closing the Gap Action Area 3: Measure and Understand the Problem and Assess the Impact of Action

In order to acknowledge that these issues are important and in many cases need addressing, it is necessary that national governments and international organizations commit to establishing health equity surveillance systems. These would monitor the extent of health inequity and the state of the social determinants of health and provide assessments of the effects of public policy. These processes require the training of policy-makers and health practitioners and means of improving public understanding of the social determinants of health. Public health research must refocus on examining issues related to the social determinants of health research.

Table 16. The Commission’s Recommendations for the Social Determinants of Health: Monitoring, Research, and Training

<table>
<thead>
<tr>
<th>Ensure that routine monitoring systems for health equity and the social determinants of health are in place, locally, nationally, and internationally.</th>
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<tbody>
<tr>
<td>• Ensure that all children are registered at birth without financial cost to the household.</td>
</tr>
<tr>
<td>• Establish national and global health equity surveillance systems with routine collection of data on social determinants and health inequity.</td>
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<table>
<thead>
<tr>
<th>Invest in generating and sharing new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants.</th>
</tr>
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<tbody>
<tr>
<td>• Create a dedicated budget for generation and global sharing of evidence on social determinants of health and health equity.</td>
</tr>
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</table>

Provide training on the social determinants of health to policy actors, stakeholders, and practitioners and invest in raising public awareness.

| • Incorporate the social determinants of health into medical and health training, and improve social determinants of health literacy more widely. Train policy-makers and planners in the use of health equity impact assessment. |
| • Strengthen capacity within WHO to support action on the social determinants of health. |

The Ontario Public Health Standards call for local health units to monitor and report on the social determinants of health (Ontario Ministry of Health and Long-Term Care, 2008). Evidence exists that such a process is only carried out in a minority of local health units (Joint OPHA/ALPHA Working Group on the Social Determinants of Health, 2010). At the provincial
level, the Province’s Chief Medical officer issues an annual report on public health, but these reports fall far short of the call for systematic monitoring of the state and impacts of the social determinants of health (King, 2010, 2011).

In order to acknowledge that these issues are important and in many cases need addressing, it is necessary that the government of Ontario commit itself to establishing health equity surveillance systems. These would monitor the extent of health inequity and the state of the social determinants of health and provide assessments of the effects of public policy. These processes require the training of policy-makers and health practitioners and means of improving public understanding of the social determinants of health. Public health research must refocus on examining issues related to the social determinants of health research.

Analysis

It has been noted that most if not all of these recommended activities are more likely to be already occurring in jurisdictions where an explicit commitment has been made to promote health equity through a “Health in All Policies” approach (Health Council of Canada, 2010). There are some excellent examples of governments having done just that in Finland, Norway, and Sweden (Raphael, 2012). Germany, France, Belgium and Holland have also implemented public policies that are consistent with these overall recommendations, though these are not as explicitly identified as being related to promoting health equity through strengthening the social determinants of health. The UK and many states in Australia have also instituted such activities.

What is common to all of these situations is the awareness by governments and the making of explicit commitments to promote health equity (Health Council of Canada, 2010). The activities of other jurisdiction are available and can provide a model for such activities in Ontario (Raphael, 2012). The checklist provided by the Health Council of Canada and reproduced in Table 15 provides a roadmap for Ontario for doing so.

Rio Political Declaration on the Social Determinants of Health

In October 2011, the World Health Organisation organized an international conference in Rio de Janeiro that was attended by heads of government and ministers of health to follow up upon the recommendations of the Commission on Social Determinants of Health. Its purpose was to secure governmental commitments to various strategies to promote health equity through action on the social determinants of health. Canada contributed to the lead-up work of this conference and its Chief Health Officer attended with staff and endorsed the Political
Declaration on the Social Determinants of Health on behalf of Canada (World Health Organisation, 2011).

The Declaration outlined five key action areas for addressing health inequalities. These were: (i) adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) further reorient the health sector towards reducing health inequities; (iv) strengthen global governance and collaboration; and (v) monitor progress and increase accountability (World Health Organisation, 2011, p. 2). The document contains no less than 50 specific commitments for promoting health equity through action on the social determinants of health. Appendix VII contains the first five commitments from each section. The following sections contain recommendations of what the implementation of these commitments might look like in the Province of Ontario. The full Declaration is available at www.who.int/sdhconference/declaration/Rio_political_declaration.pdf (World Health Organisation, 2011).

It is important to note at the start that reducing health inequities through action on the social determinants of health is not on the public policy agenda of the federal or any provincial government except for Quebec. Quebec does have a law that calls for assessing the health impact of public policies but “It’s difficult to analyze the impact of health impact assessments on cabinet deliberations because those discussions are secret,” (Eggertson, 2012)

Adopt Better Governance for Health and Development

As shown in Appendix VII, Canada has committed itself to a broad agenda of working across different sectors and levels of government to develop a range of strategies to promote health. These policies are supposed to take both a population health approach in that they are directed to the entire population as well as take into account special needs groups. These activities are to be informed by programs of research that will inform public action.

These activities are to be supported by promoting awareness and increasing the accountability of policymakers to these issues. And these governmental authorities are to seek means of engaging roles for a range of sectors in these activities. These kinds of activities are usually termed intersectoral activities to promote health.

As noted in the Health Council of Canada’s report the first step in carrying out these kinds of activities requires an explicit commitment on the part of governments that achieving health equity is a priority. Once this priority is announced then structures need to be developed
to facilitate these actions. The second set of commitments in the Rio Declaration are concerned with establishing these structures.

*Promote Participation in Policy-Making and Implementation*

These sets of commitments involve the promotion of participatory processes to ensure action on the social determinants of health. The means by which this will occur is through the promotion of “inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation.” This will involve a range of activities that will allow members of civil society to “take action in advocacy, social mobilization and implementation on social determinants of health.”

Such activity will only be possible if governmental authorities place these issues on their public policy agenda. It will also require that governments commit to carrying out public education activities. These activities are absolutely essential as surveys indicate little awareness on the part of the Canadian public as to the concept and importance of the social determinants of health (Canadian Population Health Initiative, 2004).

*Further Reorient the Health Sector Towards Reducing Health Inequities*

To its credit Ontario has recognized the importance of equity in health care. Local health Integration Units are required to produce Health Equity Plans. The Ministry of Health and Long-Term care has developed a Health Equity Impact Assessment Tool for use by these Units and has now extended its use to local public health units.

Ontario however has not adopted a broad social determinants of health perspective that is consistent with the commitment to “Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities.” To do so requires recognition of the public policy importance of the social determinants of health as predictors of health and illness. Without such recognition, health equity concerns are limited to the health care sector.

*Strengthen Global Governance and Collaboration*

These issues are beyond provincial jurisdiction. Readers however should review these recommendations (see Appendix VII) and consider means of having the federal government address these issues.
To Monitor Progress and Increase Accountability

These commitments are similar to those provided by the Commission on the Social Determinants of Health’s final report. Meeting these commitments would require Ontario to develop a systematic program that would establish monitoring systems for assessing inequities in health outcomes as well as in allocation and use of resources. These systems would need to provide measures of health and well-being in Ontario and be used for research on the relationships between social determinants and health equity outcomes. The results of these studies would need to be systematically provided to policymakers and the public in order to inform policy implementation.

Again, we see an ambitious agenda of government action, public participation, and public health research activity in support of health equity. There is little evidence that Canadian governments, including authorities in Ontario or elsewhere are prepared to have these issues placed at the forefront of a public policy agenda. There has certainly been activity on promoting equity in health care access in Ontario and health equity issues have been raised by Ontario’s Chief Medical Officer, but generally action consistent with these commitments is absent.

Fair Society, Healthy Lives (Marmot Report)

In England, the Chair of the World Health Organisation’s Commission on Social Determinants of Health was charged by the English government to provide a guide towards implementing many of the Commission’s recommendations. These recommendations are organized along a series of policy objectives focused on providing the living and working conditions necessary for health. They are provided as Appendix VIII to show how one jurisdiction undertook a systematic review of health equity issues and came up with a series of policy recommendations,

Perusal of Appendix VIII reveals that many of these recommendations are consistent with those discussed above. The report contains comprehensive recommendations that would require significant political will and governmental commitments. Most of these issues concerned as they are with promoting health equity by strengthening the social determinants of health are not on the policy screen in Ontario, or for the most part, the rest of Canada. they could form a template against which Ontario-based approaches could be compared.
Protecting the Right to Health through Action on the Social Determinants of Health

At the end of the Rio Conference a coalition of public interest civil society organisations and social movements offered an alternative declaration which more explicitly outlined some of the challenges to achieving health equity through action on the social determinants of health (People’s Health Movement, 2011). The declaration outlined ten specific recommendations, some of which were focused on global health issues which seem to be outside of the mandates of provincial governments in Canada. Most however seem to be relevant to Ontario. These recommendations are provided in *Appendix IX*.

These recommendations explicitly outline the need to implement equity-based social protection systems. They also recognize a need to “maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities” (People’s Health Movement, 2011).

In terms of financing, there is an explicit call for use of “progressive taxation, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health” (People’s Health Movement, 2011). There is also a specific concern with monitoring and regulating the economic system to control global speculation and assess the health impacts of unregulated and unaccountable corporations and financial institutions.

The likelihood of implementing these recommendations are exceedingly slim given that addressing the social determinants of health has not been recognized by the Ontario government as a public priority goal. This conclusion suggests there need to be a systematic effort to build a consensus to promote health equity among Ontario policymakers and the public.

**Implementing these Kinds of Policy Shifts in Ontario**

Raphael (2012) suggests that there are three clusters of structures and processes that make the promotion of health equity in Canada difficult. The first set of these are structural and include the fact that Canada, being a liberal welfare state regime has historically produced public policy that favours the dominance of the marketplace as opposed to the State as the primary means of distributing economic resources amongst the population (Raphael & Bryant, 2006). Canada is also a federal system whereby it is difficult to align federal and provincial public policy in the service of providing citizens with economic and social security (Banting & Corbett, 2002). Finally, the first-past-the-post electoral system makes it difficult for political parties of the left to implement public policy that promotes health equity (Raphael, 2011b).
The second set of structures and processes that make the promotion of health equity difficult concerns existing power relations. In Canada, electoral behaviour has tended to provide power to political parties that have not seen the promotion of health equity as a public policy priority. Trade union strength and collective agreement coverage of workers is also low providing less pressure for governments to implement health equity promoting public policy. Finally, civil society coalitions are weak in comparison to the situation in other nations and have recently come under further pressures from governments to scale back their advocacy and education activities (Raphael, 2012). The recent dismantling of the National Council of Welfare by the federal government is only one such example of these developments.

The third set of structures and processes that influence health equity are the actual public policies that are in place. These include Social Determinants of Health-related public policy areas such as disability policy, family policy, income and taxation policy, labour policy, and pension policy. In every area, Canada’s – and Ontario’s -- approaches are underdeveloped in relation to other wealthy developed nations (Raphael, 2011b). To shift these towards a health equity focus would require significant policy change. Appendix X provides a detailed discussion of some of the barriers to such change and the means by which these could be overcome.

Implications for Action

The political context in Ontario is not one that easily aligns with the promotion of health equity through public policy action. None of the political parties in Ontario have demonstrated a willingness to tackle health inequalities. Support for such an approach is present through organizations that are concerned with specific social determinants of health such as income and poverty, food security, housing, early child development, and others. In addition, researchers investigate and demonstrate these issues, but governments and their political cultures and institutions resist these ideas.

An important component of any future action will be public awareness and support for a health equity agenda. A government of any political stripe will be hesitant to move forward on a public policy agenda that is not well understood and supported by the public. Without such citizen knowledge and support, it seems unlikely that the health equity agenda in Ontario will be moved much forward. One extremely promising development in the promotion of health equity in Ontario has been local public health units developing public education tools that raise the issues of health equity. The most noteworthy effort has been carried out by a local Ontario health
unit that created an animation entitled *Let's Start a Conversation About Health . . . and Not Talk About Health Care at All* (Sudbury and District Health Unit, 2011). This animation has been picked up and modified for use by at least four other local health units in Ontario with at least another ten considering it.

Together with the wide dissemination of the public education documents such as the *Social Determinants of Health: The Canadian Facts*, (Mikkonen & Raphael, 2010) and the work of these local health units, there remains the possibility of developing a public policy agenda in Ontario that will respond to many of the daunting issues outlined in this report (Raphael, 2011e).
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Appendix I: The Concept of Health Equity

Defining Health Equity

Health equity is achieved through the reduction of avoidable differences in health outcomes. What exactly does this mean? Health inequalities are differences in health outcomes among individuals, specific groups, communities, and regions (Kawachi, Subramanian, & Almeida-Filho, 2002). Among Ontarians, health inequalities are apparent at all stages of the life-course from birth until old age. Among children in Ontario, health inequalities exist for infant mortality rates, low birthweight rates, asthma, functional health, incidence of injuries, and numerous other indicators of physical, mental, and social health (Raphael, 2010b). Among adults in Ontario, health inequalities exist in life expectancy and premature years of life lost prior to age 75. These adult health inequalities are a result of varying incidence and mortality from a wide range of diseases and afflictions that include cardiovascular disease, adult-onset diabetes, mental illness, respiratory disease, suicide, and many cancers, among others (Hux, Booth, & Laupacis, 2002; Naylor & Slaughter, 1999; Project for an Ontario Women's Health Evidence-Based Report, 2012).

Some health inequalities among Ontario residents are “natural” in the sense that they result from biological characteristics such as a genetically-determined disease such as Huntington’s chorea, a choice to engage in a high risk recreational activity such as automobile racing, aging, or just plain bad luck (Whitehead, 1985). But the overwhelming proportion of health inequalities – including those between specific groups, communities and regions in Ontario are not natural and result from exposures to adverse living circumstances that threaten health (Public Health Agency of Canada, 2007). Since much of these health inequalities are preventable through governmental action, the failure to address them therefore makes their presence unfair and unjust. They are therefore health inequities, the term used from now on (Kawachi et al., 2002).

Health inequities also seen between specific groups of individuals in Ontario and these result from particular groups being more likely to experience adverse living circumstances than others. And since these groups of individuals cluster in particular locations, inequities in health are seen among differing communities and regions in the province. Importantly, however, there are also specific aspects of the environments of communities and regions that either support or threaten health thereby creating the conditions that impede the achievement of health equity such as lack of employment opportunities, lack of affordable housing, or presence of low-waged employment.
Sources of Health Inequities

Promoting health equity by reducing health inequities requires identifying and addressing differences in living circumstances that create these health inequities. These circumstances have come to be called the social determinants of health and include income and wealth, early child development, employment and working circumstances, housing and food security, social exclusion, and health and social services, among others (Mikkonen & Raphael, 2010). These social determinants of health are not themselves health outcomes, but they are rather good predictors of the incidence of all the afflictions for which health inequities have been identified (Raphael, 2009). The fact that some individuals are exposed to social determinants that enhance health while others are exposed to health threatening ones had led to examination of how these social determinants of health are distributed among groups, communities, and regions (Graham, 2007).

The extent of inequality among a population in income and wealth, education, employment and working circumstances, housing and food security, social exclusion, and access to health and social services is responsible for many health inequities (World Health Organisation, 2008). The concern with inequality in the distribution of these social determinants of health has led to focus on the public policies that shape these distributions (Raphael, 2010a). Analysis of the economic and political forces that underlie these public policies is also necessary. Rather than simply examine the health effects of the social determinants of health, inquiry becomes focused on the social determinants of health inequities, the public policies that spawn them, and the societal forces that shape these health enhancing or health threatening public policies (Raphael, 2011c).

Identifying Health Inequities

Two tasks must be undertaken prior to identifying and reducing health inequities. The first is to formulate the bases upon which health inequities are defined (Braveman & Gruskin, 2003). The second is to formulate the causes of these health inequities (Bartley, 2003). As noted, these health inequities exist at the individual, group, community, and regional levels in Ontario. But on what basis of comparison is a health inequity identified? Inquiry is not made into whether health inequities exist between persons with blue versus brown eyes nor do we look for health inequities between people who play board games versus those who engage in solitary play. Inquiry is undertaken to identify health inequities between individuals, groups and residents of regions who differ on what are judged to be important dimensions of their identities or situations.
One useful concept which identifies some of the dimensions upon which individual and group health inequities exist is that of social location(s): “An individual's social locations consists of her ascribed social identities (gender, race, sexual orientation, ethnicity, caste, kinship status, etc.) and social roles and relationships (occupation, political party membership, etc.)” (Anderson, 2011). As it turns out, health inequities are present among Ontarians who differ in these and other social locations such as social class and disability status. This is the case since people who differ on these dimensions experience very different life circumstances. These life circumstances lead to differing exposures to the social determinants of health and raise two important questions: Why do these individuals experience such different life circumstances? and How do these life circumstances become translated into health inequities?

The same kinds of questions can be asked when health inequities between communities in Ontario are looked at. What are the important dimensions upon which communities differ that result in health inequities? At the very minimum, communities consist of different numbers of people of varying social locations. Health outcomes of working-class communities are worse than health outcomes of middle-class communities. Middle-class communities fare worse than wealthy communities (Tremblay, Ross, & Berthelot, 2002). In Canada, rural areas have worse health outcomes than urban ones (Canadian Population Health Initiative, 2006). Communities with higher numbers of Aboriginal peoples show worse outcomes than communities where their numbers are lower (Smylie, 2009).

There are also specific structural characteristics of communities such as presence or absence of parks, employment opportunities, affordable housing, polluting industries, public transportation, or even responsive elected officials that can translate into health inequities (Raphael et al., 2001). Health inequities among communities therefore may represent either the differing prevalence of individuals of differing social locations, differences in the characteristics of these communities, or both.

**Jurisdictional Determinants of Health Inequities**

Finally, jurisdictions (i.e., cities, regions, and even nations) also differ in their aggregate health outcomes (Organisation for Economic Co-operation and Development, 2011a). At this level of analysis it is usually more common – though not universal -- to look to differences in public policy approaches towards the social determinants of health as the sources of these health inequities than might be the case for health inequities among individuals and communities. Does a jurisdiction’s public policy approach towards income distribution, employment security and
working circumstances, availability of housing and quality of health and social services account for the health inequities that exist? (Navarro & Shi, 2002). Can these differences in public policy be traced to differing ideological approaches that reflect the influence of governing political parties? (Bryant, 2010a).

In the case of Ontario, are there systematic policy differences among cities and regions that lead to health inequities? And from a broader comparative perspective, are there differences among Canadian provinces, and differences between Canada and other nations that can explain the state of health equity in Ontario? These public policies play a key role in explaining health inequities between individuals and communities. Individual differences in health outcomes that result from differing social locations do so because existing public policy leads these individuals to experience differing life circumstances (Raphael, 2011f). For example, receiving less income by itself, should not guarantee differing life circumstances that result in adverse health outcomes. But since public policy in Ontario, like the situation in most wealthy developed nations, requires that health maintaining or promoting resources be purchased, findings that income is first related to differing life circumstances and then related to differing health outcomes should not be surprising. Similarly, higher level of education by itself may not determine health outcomes, but rather can serve as a pathway to higher paying and more secure employment, thereby leading to experiencing social determinants of health that support health.

Inequities in health among communities reflect the fact that public policy is such that both the social locations of individuals within communities and structural aspects of these same communities lead community members to experience differing life circumstances. Again, there is nothing that guarantees that some communities should be more or less health supporting than others. Community characteristics and their effects upon health are strongly related to public policy that shapes the distribution of the social determinants of health among individuals and the communities in which they live.

Therefore, it must not be forgotten that at whatever level health inequities are explored, social locations and community characteristics are embedded within a jurisdiction’s approach to governance and distribution of economic and social resources. The focus upon how Ontario’s public policy approaches – and the economic and political imperatives that shape these approaches -- both influence the occurrence and response to health inequities that exist between individuals, groups, and regions is a key feature of this report.
Appendix II:
The Social Determinants of Health Equity

How can the presence of health inequities be explained? It is the position taken in this report – and amply supported by accumulated evidence – that health inequities are primarily a result of exposures to varying quality living and working circumstances – including health care – which have come to be known as the social determinants of health. Wealthy, high-income Ontarians enjoy the best health because their living and working circumstances and health care are better than those experienced by other Ontarians. These circumstances affect individuals’ health through pathways associated with material advantage versus deprivation, psychosocial sense of control versus lack of control, experience of low versus high stress, adoption of adaptive versus maladaptive coping behaviours, and access to quality health care (Benzeval, Judge, & Whitehead, 1995). These differences in living and working circumstances and their manifestation in health inequities occur all the way from the top to the bottom of the socioeconomic ladder in Ontario.

Health Care

Health inequities among individuals, communities, and regions in Ontario exist in some part from the organization and delivery of health care. Individuals of different social locations who reside in different communities and regions may have less access to health care services or these services may be of less than optimal quality. There is evidence of inequities in access to health care in Ontario. In Canada, much of these inequities result from the health care system not covering costs associated with drugs, rehabilitation services, and home care services which put individuals of lower income at risk (Raphael, 2011d). There are also geographic inequities in access to health care services.

If this is the case, then an appropriate policy approach response would be to strive to reduce barriers to care and improve the quality of these services (McGibbon, 2009). These activities are important but access to health care and quality of services are not the primary causes of health inequities in Ontario. Health care can respond to disease and illness when they appear but problems with health care are not the primary causes of disease and illness. Living circumstances are the primary determinants of health, illness and health inequities (World Health Organisation, 2008).
Living and Working Conditions

According to the World Health Organisation, “Where we live, learn, work and play—the social determinants of health—can have a great impact on how long and how well we live” (World Health Organization, 2008). The primary determinants of health and health equity are therefore the living circumstances we experience. These circumstances operate through material, psychological, and behavioural pathways to “get under the skin” to shape health (Brunner & Marmot, 2006). Benzeval and colleagues argue for three key mechanisms that link living circumstances to health inequities: (1) differing experience of material living circumstances; (2) differing experience of psychosocial stress that result from experiencing these different living circumstances; and (3) differing take-up of health supporting or health-threatening behaviours associated with these differing living circumstances (Benzeval et al., 1995).

Individuals, specific groups, and residents of differing communities and regions in Ontario experience differing exposures to positive and negative living circumstances throughout their lives. These different exposures accumulate to produce adult health outcomes (G Davey Smith, 2003; Shaw, Dorling, Gordon, & Smith, 1999). The experience of material advantage or disadvantage also determines the extent of stress experienced (part 2 of the Benzeval et al. thesis) and the take-up of either health supporting or health threatening behaviours (part 3 of the Benzeval et al. thesis).

Social locations in Ontario such as class, gender, and race, and Aboriginal or disability status, are powerful predictors of health as these are important indicators of material advantage or disadvantage over the lifespan (Raphael, 2011h). These material circumstances of life include childhood advantage or deprivation related to quality of nourishment and housing, and adult issues of employment or unemployment, occupational quality and hazards, and access to resources such as health and social services, among others (Raphael, 2009). At the individual level, material circumstances of life determine health by influencing the quality of individual development, family life and interaction, and community environments (Brooks-Gunn, Duncan, & Britto, 1998).

And the quality of material life circumstances—in a finely stepped pattern from poverty through to tremendous wealth—are associated with the likelihood of physical problems (infections, malnutrition, chronic disease, and injuries), developmental problems (delayed or impaired cognitive, personality, and social development), educational problems (learning disabilities, poor learning, early school leaving), and social problems (socialization,
preparation for work, and family life) (Raphael, 2010c). These differences in living circumstances then go on to contribute to group differences as those of particular social locations experience advantage or disadvantage in the aggregate. These differences are multiplied at the community level as these aggregate differences in living circumstances may be influenced by additional factors associated with the characteristics of particular neighbourhoods. That is, particular communities with greater proportions of disadvantaged individuals may also suffer from weak physical and social infrastructure (e.g., lack of employment opportunities, inadequate public transit, air and water pollution, or crime and unsafe areas). These advantages or disadvantages can be compounded at the regional level where these aggregations of health threats become associated with health inequities.

In the sections that follow evidence will be provided of how these distributions are shaped by public policymaking in Ontario in a wide range of areas that influence income and income distribution (e.g., taxation and benefits), employment and working circumstances (e.g., unionization and labour legislation), housing and food policy, presence of a social safety net, and provision of health and social services. Even further, this report concerns itself with the political and economic forces that are shaping public policymaking in Ontario related to the social determinants of health inequities.

Defining Public Policymaking

Public policy plays a key role in determining the extent of health inequities within a jurisdiction (Graham, 2004). Public policy concerns courses of action or inaction taken by public authorities -- usually governments -- to address a given problem or set of problems (Briggs, 1961). The Ontario Government constantly makes decisions about a wide range of issues, such as the organization and delivery of health, social welfare, and other services. But it also makes decisions in other areas that are the special concern of this report: How economic and social resources are distributed among the population.

The Ontario Government influences these distributions by establishing provincial tax levels, the nature and quality of employment and other benefits -- whether these benefits are universal or targeted—and how workers’ employment conditions and working benefits are negotiated. Provincial governments are also responsible for establishing housing policies, maintaining the social safety net, enacting labour regulations and laws, and providing training related to employment and education.

This approach recognizes the important role material living circumstances play in
producing health inequities but then goes on to consider how these circumstances are shaped by public policy decisions made by governing authorities. The importance of public policy in creating health inequalities is becoming increasingly apparent but remains relatively unspoken of among many Ontario health researchers. In many ways this approach states the obvious: *The distribution of economic and social resources that influence health and is responsible for creating health inequities results from public policy decisions made by governing authorities.* This is most obvious when examining the key drivers of health inequalities: the differences among individuals, groups, and residents of different communities and regions in access to the social determinants of health.

The World Health Organisation states this conclusion rather more strongly: “This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics” (World Health Organisation, 2008). According to this approach, the presence of health inequalities is shaped by access to material resources such as income, housing, food, and educational and employment opportunities, among others. These resources are related to parents’ employment security, wages, and the quality of their working circumstances and availability of quality, regulated childcare, all of which are shaped by public policy decisions (Raphael, 2009a).
Appendix III: The Health Gap in Ontario

Data collection on the presence of health inequities is generally not sanctioned by governments in Canada nor organized on a systematic basis. In Ontario, there are a variety of resources that provide these kinds of data – usually Statistics Canada data bases -- and these are usually analyzed and reported on by specific agencies, organizations, or academic researchers. The Ontario Ministry of Health and Long-Term Care does provide support for these activities through funding of organizations such as the Population Health Intervention Research Network, but these activities do not operate under the mantle of government endorsement common in many other jurisdictions (Raphael, 2012).

The most recent and rather extensive analysis of health outcomes and how these are related to the distribution of the social determinants of health is the POWER Study (Project for an Ontario Women’s Health Evidence-Based Report, 2012). The POWER study is a multi-year project that is funded by Echo: Improving Women’s Health in Ontario, an agency of the Ontario Ministry of Health and Long-Term Care. All reports from the project contain the disclaimer: “The POWER Report does not necessarily reflect the views of Echo or the Ministry.”

A concern with promoting health equity is seen in numerous provincial documents related to healthcare policy. Ontario has seen the creation of a “Health Equity Unit” in its Ministry of Health and Long-Term Care and in its organization of Local Health Integration Networks (LHINs), these units are required to create “Health Equity Plans” (Wellesley Institute, 2012). Ontario has also developed a health impact assessment framework for these health care units and is expanding its reach to public health units (Ministry of Health and Long-Term Care, 2012). Ontario’s Chief Medical Officer of Health has concerned herself with health equity issues in her last two annual reports to the Ontario legislature (King, 2010, 2011).

Public Health Ontario – the agency concerned with promoting public health in Ontario – has been engaging with public health units across the Province to address the social determinants of health. And last year the province provided funding for 72 public health nurses whose primary role is to address the social determinants of health across Ontario’s 36 public health units (Government of Ontario, 2011). The province’s anti-poverty strategy has been linked by the Chief Medical Officer of Health to the achieving of health equity and the prevention of health inequities (King, 2011). And as noted, the Province is responsible for numerous strategies and programs that impact the social determinants of health.
Prior to discussing these developments, an overview of health inequities in the province is provided. These include indicators of inequities in health care access as well as health status. Following this, public policy activities that drive the extent of these inequities will be examined.

Indicators of Inequities in Health Status

There is an extensive literature on health status inequities in Ontario. These include differences in life expectancy, infant mortality, and mortality rates for a number of diseases. There are also inequities in incidence and prevalence of various diseases and injuries. The POWER report provides a range of data on these issues (Project for an Ontario Women's Health Evidence-Based Report, 2012).

Self-Rated Health

There are profound differences among Ontarians of differing incomes in their self-rated health. Twenty-five percent of low income Ontarians report having fair or poor (as opposed to good, very good, or excellent) health as compared to only 7.5% of higher income Canadians, more than a three times difference. The difference between these same groups in reporting having poor or fair mental health is 13.5% versus 3.5%, more than a three times difference.

Differences in Mortality

The POWER Study provides data on premature mortality (percentage of the population who died before age 75), by gender and neighbourhood income quintile, in Ontario for the year 2001 (see Figure Appendix III.1). Rates are distinctively higher among residents of the poorest 20% of Ontario neighbourhoods.
Differences in Specific Conditions

There are also income-related differences in prevalence of diabetes and cardiovascular disease. The POWER Study shows differences between lower and higher income Ontario women in prevalence of diabetes of 8% versus 3% and for heart disease or stroke, 9% versus 4%. There is also the case for hypertension (30% versus 21%), arthritis (32% versus 21%), back problems (28% versus 18%), and obstructive lung disease (15% versus 11%). Similar differences are apparent for men (Alter, Naylor, Austin, & Tu, 1999; Dinca-Panaitescua et al., 2011).

There are also strong differences in reports of activity limitations. The Power Study reports 37% of low income Ontarians report having a limitation while only 22% of higher income Ontarians do so. When specifically asked about limitations related to pain or discomfort, the figures were 25.5% for lower income and 8.5% for higher income Ontarians. Similar findings are seen for reports of depression (8.7% versus 6.3%).

Similar findings of profound differences are reported by the POWER study between the lowest and highest quintiles of income earners in Ontario for incidence of lung cancer (65/100,000 versus 37/100,000). Finally, the percentage of low income Ontarians 25-64 years of age who report two or more chronic diseases is 31% for the lowest income group while for the higher income group, it is 18.5%. Among Ontarians aged 65 or older, the figures are 65.5% versus 53.5%.

Source: Power Study (2010).
Differences in Injuries

Profound differences in injuries are seen in Ontario between those of differing incomes. Figure Appendix III.2 provides rates of injury-related hospitalizations per 100,000 population, by age group and income quintile in Ontario for the period 2002/03 (Macpherson et al., 2005). Similar differences are seen in detailed analyses of children’s injuries in Ontario.


These differences in injury rates are also seen between regions with rural and Northern regions having higher hospitalization rates. In summary, there are profound inequities in health status among Ontarians of differing incomes and regions across Ontario.

Indicators of Health Inequity in Health Care Services

There is an extensive Canadian literature on inequities in access to health care. This literature shows that numerous inequities are present between Canadians of differing incomes, gender, and racial status. Many of these equities are related to receiving care that is not covered by the Canadian Health Act such as prescription drugs and rehabilitation services (Raphael, 2011d). There are also consistent differences in ability to access specialized care between those of differing incomes (Schoen & Doty, 2004) Access to care has also been shown to be related to location with those in rural settings less likely to receive health care when needed than Canadians living in urban areas (Canadian Population Health Initiative, 2006).
The most recent data on these issues is contained in one of the chapters from the POWER Project reports which specifically concerned itself with issues of health care access in Ontario and provides an overview of these issues (Bierman et al., 2010). This report looked at ten access to care indicators: 1) Access to a primary care doctor; 2) Satisfaction with the experience getting an appointment for a regular check-up; 3) Difficulties accessing routine or ongoing care; 4) Difficulties obtaining monitoring of ongoing problems from a family doctor; 5) Difficulties with access to primary care for an urgent, non-emergent health problem; 6) Satisfaction with access to primary care for an urgent, non-emergent health problem; 7) Satisfaction with care for urgent, non-emergent health problem; 8) Difficulties accessing health information or advice; 9) Percentage of the population reporting unmet health care needs; and 10) Dental care. The following sections examine a selection of these issues.

Access to a Primary Care Doctor

Differences are seen between Ontario residents of neighbourhoods of differing income in their reporting of having a primary care physician. Residents of the lowest income quintile of neighbourhoods were less likely to report having a physician (92% of women and 87% of men) as compared to those in the highest income quintile (96% of women and 94% of men).

There are also differences between White Ontarians and those of differing ethnicities. White Ontarians were more likely to have a family physician (93%) than those who are Aboriginal (89.5%), Black (90.5%), and South and West Asian or Arab (91.5%). Interestingly, East and Southeast Asian descent report similar access to primary care (93.5%) for White Ontarians. Immigrant status is also related to access. Canadian born Ontarians (93%) have greater access than do immigrants who arrived within the past four years (87%) and within 5-9 years ago (90.5%). However 94.5% of immigrants who arrived 10 or more years ago report having a primary care physician. There is also evidence of regional differences. As one example, Ontarians in the Northwest and Northeast Local Health Integration Networks report less access, 87.5% and 88% respectively, than do residents of the Hamilton-Niagara (95.5%) and Mississauga-Halton (93.5%) regions.

Satisfaction with the Experience Getting an Appointment for a Regular Check-Up

Interestingly, satisfaction with getting an appointment for a check-up differed among Ontarians of differing education levels with less education being associated with greater satisfaction. Among those with a bachelor’s education, only 53% were very satisfied with their
experiences. In contrast, 75% of those with less than secondary school graduation were very satisfied with their experiences. There are also differences as a function of ethnicity. Among White Ontarians 63% were very satisfied but only 48.5% of people of South and Southwestern Asian descent were very satisfied.

Difficulties Accessing Routine or Ongoing Care

Findings indicate that similar to issues of satisfaction with primary health care with a physician, those of higher income were less satisfied (82.5%) than those with low incomes (84.5%). There are fewer differences in regards to ethnicity. Among White Ontarians 83.5% were very satisfied with accessing routine care while 81.5% of Aboriginals were satisfied. In fact Ontarians of Black, and South and West Asian descent reported higher satisfaction than White Ontarians.

Percentage of the Population Reporting Unmet Health Care Needs

This is probably the best indicator of access to health care and there are strong differences among differing groups. Among Ontarians of low income 16.5% reported having an unmet health care need but among higher income Ontarians this was the case for only 11.5% of them. But when differences are looked at as a function of education, only 8.5% of those with less than secondary education report an unmet need while 13.5% of those with higher education report such a need. Twelve percent of White Ontarians report an unmet health care need as compared to 19% of Aboriginal Ontarians, 13.5% of Blacks, 11% of South and West Asian, and 9.5% of East and Southeast Asian Ontarians. Lower income rather than less education seems to be a good predictor of the presence of health care access issues.

Access to Health Care Treatments across Regions in Ontario

In addition to the data provided above, a 2006 report provides evidence of differing access to health care in Ontario as a function of region (Tu, Pinfold, McColgan, & Laupacis, 2006). Wait times are consistently higher in rural and especially Northern regions of Ontario for procedures such as large bowel resection for cancer, mastectomy for cancer, coronary angiography performed within recommended maximum wait times, bypass surgery performed within recommended maximum wait times, planned primary total hip replacement, and planned primary total knee replacement.
Summary of Issues Related to Health Care Equity

There are certainly differences in access to health care among different groups and across regions in Ontario and as will be shown, addressing these issues has been a significant focus of health care authorities in Ontario. In terms of satisfaction, these differences however are generally not of great magnitude. Inequities are of more importance when related to life-saving procedures such as angioplasty. For example for angioplasty the range is from <2.3 days to >3.9 days between the best and worst performing regions. More importantly however, in terms of the broad issue of promoting health equity, it is well established that the primary determinants of health and health inequities lie outside of the health care system in the living and working conditions which people experience. These issues are considered in the following sections.
Appendix IV. Statistics Canada Low Income Measure (LIM)

What is the LIM?

For the purpose of making international comparisons, the LIM is the most commonly used low income measure. The use of the low income measure (LIM) was suggested in 1989 in a discussion paper written by Wolfson, Evans, and the OECD\(^1\) which discussed their concerns about the Low Income Cut-offs. In simple terms, the LIM is a fixed percentage (50\%) of median adjusted economic family\(^2\) income, where “adjusted” indicates that family needs are taken into account. Adjustment for family sizes reflects the fact that a family’s needs increase as the number of members increases. Most would agree that a family of five has greater needs than a family of two. Similarly, the LIM allows for the fact that it costs more to feed a family of five adults than a family of two adults and three children.

The LIMs are calculated three times; with market income, before-tax income, and after-tax income using the Survey of Labour and Income Dynamics (SLID). They do not require updating using an inflation index because they are calculated using an annual survey of family income. Unlike the low income cut-offs, which are derived from an expenditure survey and then compared to an income survey, the LIMs are both derived and applied using a single income survey.

How is the LIM calculated?

In order to calculate the LIMs, first determine the “adjusted size” of each family. The first person is counted as 1.0 and the second person is counted as 0.4, regardless of age. Additional adults count as 0.4 and additional children count as 0.3 (where a child is defined as being under age 16). See the following section on adjustment for family size for more information. Next, calculate “adjusted family income” for each family by dividing family income by “adjusted family size”. Then determine the median of this “adjusted family income”, such that half of all families will be above it and half below. The LIM for a family of one person with no children is 50\% of this median “adjusted family income”, and the LIMs for other kinds of family are equal to this value multiplied by their “adjusted family size”.

Adjustment for family size

When comparing family incomes to study such things as income adequacy or socio-economic status, one often wants to take family size and composition into account—the income
amount itself is not sufficient to understand a family’s financial well-being without knowing how many people are sharing it. In general, two approaches have been used to help with the analysis of family income. One is to produce data by detailed family types, so that within a given family type, differences in family size are not significant. In fact, many income measures have been crossed by detailed family types in the published tables. The other way to take into account family size and composition is to adjust the income amount by an adjustment factor.

The simplest method is to use per capita income, that is, to divide the family income by the family size. A limitation of per capita income, however, is that it tends to underestimate economic well-being for larger families as compared to smaller families. This is due to the fact that it assumes equal living costs for each member of the family, but some costs, primarily those related to shelter, decrease proportionately with family size (they may also be lower for children than for adults). For example, the shelter costs for an adult married couple with no children are arguably not much more than those for an adult living alone.

To take such economies of scale into account, it is common to use an “equivalence scale” to adjust family incomes. Instead of implicitly assuming equal costs for additional family members as the per capita approach does, the equivalence scale is a set of decreasing factors assigned to the first member, the second member, and so on. The adjusted income amount for the family is obtained by dividing the family’s income by the sum of the factors assigned to each member.

There is no single equivalence scale in use in Canada. The one used in the published income tables and in concepts such as the LIM has, however, achieved a high degree of acceptance. In this equivalence scale, the factors are as follows:

- the oldest person in the family receives a factor of 1.0;
- the second oldest person in the family receives a factor of 0.4;
- all other family members aged 16 and over each receive a factor of 0.4;
- all other family members under age 16 receive a factor of 0.3.

Other equivalence scales in use include: Organization for Economic Co-operation and Development (OECD) scale

- the oldest person in the family receives a factor of 1.0;
- all other family members aged 15 and over each receive a factor of 0.5;
- all other family members under age 15 receive a factor of 0.3.
Square root of family size (this is a close approximation to the LIM equivalence scale, particularly for families with 6 members or less).

1. ‘Statistics Canada’s Low Income Cut-offs: Methodological Concerns and Possibilities’ (Wolfson, Evans, and OECD).

2. All persons living in the same dwelling and related by blood, marriage, common-law relationship or adoption.

Appendix V: Poverty and Income Inequality in Ontario

Statistics Canada provides various indicators of low income as well as overall income inequality in Ontario across time. While Statistics Canada takes pains to note that low income is not necessarily an indicator of poverty, the metrics it used to calculate low income are very similar – as are the figures obtained – to international measures of poverty (Raphael, 2011f). In addition, the Province of Ontario has adopted one of Statistics Canada’s measures – the LIM – which is similar to the primary international measure of poverty -- as its primary indicator of poverty rates in the province (Raphael, 2011a). The data provided below are all from Statistics Canada’s CANSIM data base (Statistics Canada, 2012a).

Figure Appendix V.1 provides an overview of poverty rates for all Ontarians considered as living in families from 1980-2009 (the Market Basket Measure was developed in 2000). The most striking aspect of these data is the increases over the past three years such that poverty rates are at or higher than rates seen in 1980. Using the LIM – which provides the closest estimate to international conventions of the percentage of the population receiving less than 50% of the median income – the rate is higher than was the case in 1980. Figure Appendix V.2 provides similar data for Ontarians identified as being unattached. The key trend again is the gradual increase in the LIM rates which make the latest poverty rates comparable to what was seen in 1980. A somewhat more positive picture is provided in Figure Appendix V.3 where poverty rates for female lone family parents have declined from rates close to 50% down to still very high rates of around 30%.
Figure Appendix V.1. Percentage Living in Low Income, All Families, Ontario, 1980-2010

Figure Appendix V.2. Percentage Living in Low Income, Unattached Individuals, Ontario, 1980-2010
Focusing on use of the LIM provides a portrait of a continuing trend of growing poverty in Ontario. Figure 6 shows that poverty rates for children are close to 15% and rates are increasing for both adults 18-65 years of age and adults over 65 years. The trend for those over 65 years is particularly striking with their rates growing to close to 10% after the lows of 4% seen during the mid 1990s. Poverty rates for unattached adults 18-65 years are close to 25% with a convergence occurring between male and female rates.

An important question concerns how much on average those identified as living in poverty are below the poverty line. Are poor people just below the poverty line or are they very much below? The data indicate that they are very much below. Figure Appendix V.4 shows that on average families living in poverty have a 32% or so gap between their incomes and the poverty line. Figure Appendix V.5 provides these data for unattached adults between 18-65 years of age where the gap is much higher at over 40%. Unattached Ontario residents living in poverty are very poor and their depth of poverty is growing.
Figure Appendix V.4. Percentage Living in Low Income, After-Tax Low Income Measure, By Age Group, Ontario, 1980-2010

Figure Appendix V.5. Low Income Gap, all Families, using Various Low Income Measures, Ontario, 1980-2010
All of these trends indicate a growing trend in income inequality among Ontario residents. Figure Appendix V.6 shows that among families inequality in market income, total income, and income after taxes has been growing since 1980. A similar trend is seen for unattached adults in general and for non-elderly adults aged 18-65 (Appendix V.7). In contrast, inequality has remained stable among those living in elderly families.

The POWER Report provided data on the distribution of income among Ontario residents that provides an overlay for these findings. The report used a four category scheme to identify those of lowest income, lower middle income, upper middle income, and highest income. Using a “lower income” category consisting of the two lower categories, they identified 21% of adults aged 25 years and older as living in lower incomes. It then provided analyses of which groups are most likely to be identified as being of lower income.

Not surprisingly, those with less than secondary education are more likely to be of low income (33.5%) than those with a bachelor’s degree (12.5%). More importantly, percentage of those living on low income differed widely among differing racial and ethnic groups. While 18% of White Ontarians are of lower income, the figures for Aboriginal people are 39%, for Blacks, 41.5%, South and West Asian and Arabs, 42.5%, and for East and Southeast Asians 29.5%.
Figure Appendix V.7. Inequality in Income, All Family Units, Ontario, 1980-2010

Figure Appendix V.8. Inequality in Income, Unattached Adults, Ontario, 1980-2010
Extent of low income differed by immigrant status. Seventeen percent of Canadian born Ontarians are of lower income. But among Ontarians who have immigrated within the last ten years the rate is 44%, and among immigrants of more than ten years is 24%. Among English-language Ontarians the rate is 17%, among French-language Ontarians, 44%, among those who speak French and English, 15%, and among those without French or English, 44%. Interestingly, the lower income rate for those living in urban areas is 21% and for those in rural areas, 19.5%
Appendix VI: Ontario’s Anti-Poverty Strategy

Ontario’s Poverty Reduction Act was passed in 2009. The title of Ontario’s anti-poverty strategy, *Breaking the Cycle*, indicates “focus on breaking the cycle of intergenerational poverty by improving opportunities through education” (Government of Ontario, 2008).

The document outlines a plethora of programs and services that are seen as assisting in the poverty-reduction plan. These include a Healthy Schools Strategy, a Student Nutrition Program, a Children in Need of [Dental] Treatment Program, a Mental Health and Addictions Strategy, an Ontario-focused Intervention Partnership, the establishment of Student Success Teams, a Ministry of Education Parent Engagement Office, and so on. In fact, there are over 60 programs listed in *Breaking the Cycle* that demonstrate the Government of Ontario’s commitment to poverty reduction. These programs range in focus from providing housing to meeting the needs of persons with disabilities, women, Aboriginal peoples, and others.

The strategy document outlines an impressive set of indicators of progress. These include the low income measure, depth of poverty, school readiness using the Early Development Instrument, educational progress using scores on Ministry of Education tests and high-school graduation rates, birth weights, an Ontario Housing Measure, and a standard of living measure that applies the Ontario Deprivation Index.

A 2010 publication, *Breaking the Cycle: The Second Progress Report*, reviews the poverty reduction strategy, provides details of expenditures, and describes initial assessments of progress (Government of Ontario, 2010). For example, the Ontario Child Benefit now provides up to $1,100 per child to low-income families and now reaches over one million children. The minimum wage has been increased to $10.25 an hour and tax relief worth $12 billion has been provided to Ontarians.

Full-day kindergarten began in September 2010 for 35,000 children and half of children of this age will be receiving this by the fall of 2012 with full implementation by 2015. An investment of $63.5 million dollars in 2010 was able to maintain 8,500 licensed child care spaces that would have been lost as a result of a funding gap left by the federal government’s investment withdrawal. Similar information is provided for almost all of the 60-plus programs mentioned above.

Indicators of progress are provided. High-school graduation rates have increased, and scores on the Ministry achievement tests have shown improvement. Unfortunately, poverty rates using the low income measure increased from 2007 to 2008 with 15.2% of Ontario children now
living in poverty. The depth of poverty also increased during this period, from 7.5 to 8.5%. The Ontario Housing Measure showed that the percentage of households with children that have incomes below 40% of the median household income, and spend more than 40% of their incomes on housing, increased from 4.6% in 2007 to 5.4% in 2008.
Appendix VII: First Five Commitments from Main Sections of the Rio Political Declaration on the Social Determinants of Health

To Adopt Better Governance for Health and Development

(i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
(ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
(iii) Support comprehensive programmes of research and surveys to inform policy and action;
(iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
(v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;

Promote Participation in Policy-Making and Implementation

Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health; we pledge to:

(i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
(ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
(iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
(iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;
(v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
Further Reorient the Health Sector Towards Reducing Health Inequities

Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities; we pledge to:

(i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;

(ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;

(iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;

(iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;

(v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;

Strengthen Global Governance and Collaboration;

Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being; we pledge to:

(i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter-alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;

(ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of
the International Labour Organization;
(iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;
(iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;
(v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;

To Monitor Progress and Increase Accountability

Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts; we pledge to:
(i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;
(ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;
(iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;
(iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;
(v) Improve access to the results of monitoring and research for all sectors in society

Appendix VIII. Policy Objectives from the *Fair Society, Healthy Lives Report*

**Policy Objective A: Give Every Child the Best Start in Life**

Priority objectives

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
3. Build the resilience and well-being of young children across the social gradient.

**Policy Objective B: Enable All Children, Young People and Adults To Maximise Their Capabilities and Have Control Over Their Lives.**

Priority objectives

1. Reduce the social gradient in skills and qualifications.
2. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.
3. Improve the access and use of quality lifelong learning across the social gradient.

**Policy Objective C: Create Fair Employment and Good Work For All**

Priority objectives

1. Improve access to jobs and reduce long-term unemployment across the social gradient.
2. Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
3. Improve quality of jobs across the social gradient.

**Policy Objective D: Ensure a Healthy Standard Of Living for All**

Priority objectives

1. Establish a minimum income for healthy living for people of all ages.
2. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
3. Reduce the cliff edges faced by people moving between benefits and work.

**Policy Objective E: Create and Develop Healthy and Sustainable Places and Communities**

Priority objectives

Develop common policies to
1. to reduce the scale and impact of climate change and health inequalities.
2. Improve community capital and reduce

Policy Objective F: Strengthen the Role and Impact of Ill-Health Prevention
Priority objectives
1. Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
2. Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Again, these policy objectives appear to be strongly related to the presence of a strong welfare state as discussed above. On a more concrete immediate level, these objectives show many similarities with recommendations provided by numerous Ontario anti-poverty organizations such as Campaign 2000, 25% in 5 Poverty Reduction Group, Food Banks Ontario and others. The objectives are a combination of goals and processes with some of these having explicit public policy implications, with others less obvious.

Concerning Policy Objective A of giving every child best start in life, the specific policy recommendations are to:
1. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
2. Support families to achieve progressive improvements in early child development, including: Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy.
3. Providing paid parental leave in the first year of life with a minimum income for healthy living by providing routine support to families through parenting programmes, children’s centres and key workers, delivered to meet social need via outreach to families. It also proposes developing programmes for the transition to school.
4. Provide good quality early years education and childcare proportionately across the gradient. This provision should be combined with outreach to increase the take-up by children from disadvantaged families and provided on the basis of evaluated models and to meet quality standards.
Policy Objective B which calls for enabling all children, young people and adults to maximise their capabilities and have control over their lives could be advanced as follows:

1. Ensure that reducing social inequalities in pupils’ educational outcomes is a sustained priority.
2. Prioritise reducing social inequalities in life skills, by extending the role of schools in supporting families and communities and taking a ‘whole child’ approach to education, consistently implementing ‘full service’ extended school approaches, and developing the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being.
3. Increase access and use of quality lifelong learning opportunities across the social gradient, by providing easily accessible support and advice for 16–25 year olds on life skills, training and employment opportunities, providing work-based learning, including apprenticeships, for young people and those changing jobs/careers, and increasing availability of non-vocational lifelong learning across the life course.

Policy Objective C calls for creating fair employment and good work for all and suggests this can be accomplished by prioritising active labour market programmes to achieve timely interventions to reduce long-term unemployment, encouraging incentivising, and, where appropriate, enforcing the implementation of measures to improve the quality of jobs across the social gradient, by ensuring public and private sector employers adhere to equality guidance and Legislation, implementing guidance on stress management and the effective promotion of wellbeing and, physical and mental health at work and developing greater security and flexibility in employment, by prioritising greater flexibility of retirement age, encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

Policy Objective D is about ensuring a healthy standard of living for all by developing and implementing standards for minimum income for healthy living, removing ‘cliff edges’ for those moving in and out of work and improve flexibility of employment, and reviewing and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and pathways for moving upwards.

Policy Objective E of creating and developing healthy and sustainable places and communities could be accomplished by:

1) prioritising policies and interventions that reduce both health inequalities and mitigate climate change, by improving active travel across the social gradient, improving the availability of good
quality open and green spaces across the social gradient, improving the food environment in local areas across the social gradient by improving energy efficiency of housing across the social gradient.

2. Fully integrating the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

3. Support locally developed and evidence-based community regeneration programmes that: Remove barriers to community participation and action and reduce social isolation.

Finally, Policy Objective F is concerned with strengthening the role and impact of ill-health prevention. It calls for:

1. Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.

2. Implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient by: Increasing and improving the scale and quality of medical drug treatment programmes, Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient, and Improving programmes to address the causes of obesity across the social gradient, and

3. Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient.
Appendix IX: Recommendations Contained in the Declaration by Public Interest Civil Society Organisations and Social Movements at the WHO Rio De Janeiro Conference

1. Implement equity-based social protection systems and maintain and develop effective publicly provided and publicly financed health systems that address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities.

2. Use progressive taxation, wealth taxes and the elimination of tax evasion to finance action on the social determinants of health.

3. Recognise explicitly the clout of finance capital, its dominance of the global economy, and the origins and consequences of its periodic collapses.

4. Implement appropriate international tax mechanisms to control global speculation and eliminate tax havens.

5. Use health impact assessments to document the ways in which unregulated and unaccountable transnational corporations and financial institutions constitute barriers to Health for All.

6. Recognise explicitly the ways in which the current structures of global trade regulation shape health inequalities and deny the right to health.

7. Reconceptualise aid for health from high income countries as an international obligation and reparation legitimately owed to developing countries under basic human rights principles.

8. Enhance democratic and transparent decision-making and accountability at all levels of governance.

9. Develop and adopt a code of conduct in relation to the management of institutional conflicts of interest in global health decision making.

10. Establish, promote and resource participatory and action oriented monitoring systems that provide disaggregated data on a range of social stratifiers as they relate to health outcomes.

Appendix X: An Analysis of Barriers to Change and Means of Overcoming These Barriers

What models of policy change are available and what would each suggest as means of moving a health policy supporting agenda forward? This section draws upon recent work by Bryant (2012) that concerns itself with affecting health equity related public policy in Canada. It outlines three models of public policy change that are relevant for the promotion of health equity. One form of policy change is called *incremental* and involves small changes to existing public policy. Such changes do not usually involve change in the overall goals and objectives of a policy area. Policy change can also be *paradigmatic* in that it involves a significant shift in policy goals and objectives. Clearly Ontario adopting the promotion of health equity through action on the social determinants of health would involve a paradigmatic change in public policy.

There are three models of public policy implementation and change that would be relevant to such a shift. *Pluralism* is a model of democratic participation that focuses on how interest groups influence governments to make policy. In this model governments make public policy on the basis of an analysis of benefits and costs. The *policy paradigms model* is concerned with the role that established government and other institutions play in the public policy process (P. Hall, 1993). Also known as an *historical institutionalism* model, it argues that policy ideas are embedded in institutions and that these institutions structure the public policymaking process. The *political economy* model of policy change conceives politics as flowing from how the economy distributes power and resources. It focuses on political ideology and how the powers of the market and the State shape public policy making (Armstrong, Armstrong, & Coburn, 2001; Bryant, 2005; Coburn, 2000). All three models provide insights into how to advance health equity in Ontario.

**Pluralism**

Pluralism considers interest groups as key societal influences on the public policy process. Citizens join groups to promote their preferences and interests. Politics is seen as the competition among interest groups to influence public policy. Citizens can belong to a number of groups that advance their concerns such that memberships among interest groups frequently overlap (Howlett, Ramesh, & Perl, 2009). The role of the State is to mediate this competition among different groups and the ideas they bring to the political process. Pluralists recognize that not all groups are equal in their ability to influence the political process or to access government (Howlett et al., 2009). These inequalities in influence are attributable to their lack of financial and other resources. Nevertheless, on this point, McLennan argues, “It is impossible to read the
standard works [on pluralist theory] without getting the sense that resources, information and the means of political communication are openly available to all citizens, that groups form an array of equivalent power centres in society, and that all legitimate voices can and will be heard” (McLennan, 1989), p. 32. Indeed, pluralism implies that citizens and citizen groups can present their ideas to government with the assumption that they will receive a fair hearing (Bryant, 2010b).

Clearly, this is not necessarily the case and the Canadian scene provides ample evidence of this where despite decades of document and report making containing evidence on the importance of tackling health inequalities by government civil servants and various professional public health associations, governmental authorities have resisted taking on these issues through public policy activity. In spite of the limitations of pluralism for explaining and addressing the Canadian scene, it does provide some useful insights for those concerned with tackling health inequities (see below).

Policy Paradigms and Historical Institutionalism

Historical institutionalism has a concern with how established structures of government implement policy activities (P. A. Hall & Taylor, 1996). According to this definition, policy change is integrally related to learning from previous experiences. Social learning emphasizes the role of ideas and their interpretation in policy making. This social learning process is dominated by officials and highly placed experts, and this is especially the case when the issues at hand are highly technical policy fields.

“Policy makers work within a framework of ideas and standards that specify not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems” they are intended to address (P. Hall, 1993), p. 279. The interpretive framework or policy paradigm involves ideas embedded within existing political, social and economic institutions. The terms “policy legacies” and “path dependency” refer to how past policies shape policies being made in the present. In terms of the present inquiry, this refers to some of the reasons why some nations find it so difficult to think differently about tackling health inequalities. This is the case because they are following the same approaches that have served them so well in the past -- that is, ignoring these issues.

These shifts from one paradigm to another -- although supposedly based on ideas -- may be more politically than scientifically determined. While arguments mounted by competing factions, positional advantages within a broader institutional framework, resources of various
competing political actors, and external factors all play a role, their adoption is primarily determined by the politics of the day and the ideology of governing authorities.

The Political Economy of Policy Change

In the political economy approach, politics and economics are considered to be interrelated and fundamentally shaping public policy outcomes (Armstrong et al., 2001). The State, the market, political power, political ideology, and civil society are considered to be constituent parts of the whole (Armstrong et al., 2001).

The approach also focuses on the effects of neo-liberalism, an ideology that advocates unfettered free enterprise as the means to foster economic growth and social well-being (Coburn, 2001; Coburn, 2004). The political economy perspective also looks at the social determinants of health, and how political, and economic environments shape the distribution of social and economic resources within a society.

Societies in which the market is the most important institution tend to have more pronounced social and health inequalities (Grabb, 2007; Leys, 2001). Differences between individuals as a function of social class, gender, and race are accentuated. A political economy perspective enables consideration of dominant economic interests influence policy change, often impeding the tackling of health inequalities. In liberal nations such as Canada the market economy is the dominant institution, government intervention is minimized.

Pluralism also offers some helpful analysis of the current situation in Ontario by highlighting the importance of information on health equity which governments can use to take action. This suggests continuing advocacy for health equity in order to keep this issue on the public policy agenda. The historical institutionalist approach suggests taking account of governmental structures and the need to support elected representatives and government officials supportive of a health equity approach and removing those opposed to such an agenda. The political economy approach calls for a profound shift in the power dynamics of a society. In relation to the three clusters of factors described, these would be the suggestions offered by each policy change model.

The State

Table Appendix 10.1 provides some suggestions as to how aspects of the State could be influenced to promote the tackling of health inequalities. Those suggested by a pluralist approach
would emphasize the development and strengthening of citizen groups in order to build support for and pressure governing authorities to tackle health inequalities.

The historical institutionalist approach suggests taking account of governmental structures and the need to maintain those supportive of health equity and remove those opposed to such an agenda. In Ontario such a shift will require a paradigmatic change in public policymaking which is not to be taken lightly. Finally, in a federal state such as Canada, means must be identified to enhance the ability of the Central government to shape public policymaking across all levels of government. In Canada this was the case when the central government guided policy development during the 1970s and 1980s by making available to the provinces and territories funding for Medicare and social assistance.

Power Relations

A pluralist analysis would identify differences in tackling health inequalities as reflecting differences in public support and group advocacy for such an approach. The clear implication is to strengthen these activities with the goals of influencing public policymaking.

The historical institutional approach points out the barriers to institutional change in Ontario. Clearly, the model suggests the need to strengthen political parties of the left through shifting electoral behaviour and strengthening the ability of unions to organize the workplace.

Both this model and the political economy approach make clear that the tackling of health inequalities is a profoundly political activity that requires more than the collection of evidence and advocacy in favour of such an approach. The importance of shifting electoral behaviour and strengthening labour unions in order to shift public policy in social determinants of health-related policy areas seems essential.

Health-Equity-Related Public Policy

Finally, Table Appendix 10.1 outlines how each model of policy change would make sense of the differing public policy profiles present in the nations of this inquiry. In Canada significant efforts must be undertaken to educate the public in order to shift the economic and political structures that have shaped public policymaking. These are not easy tasks.
Table Appendix 10.1. Suggestions offered by Three Policy Change Models for Promoting Health Equity-Supporting Public Policy in Ontario

<table>
<thead>
<tr>
<th>Policy Model</th>
<th>Shifting State Institutions</th>
<th>Shifting Power Relations</th>
<th>Implementing Health Equity-Related Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pluralism</td>
<td>Public education and advocacy for policymakers to make health equity a public policy priority.</td>
<td>Plurality of interests can be mobilized around the promotion of health equity through public policy action.</td>
<td>Educate the public as to the benefits of implementing specific public policies that will promote health equity.</td>
</tr>
<tr>
<td>Historical Institutionalism</td>
<td>Recognize that long-established policy approaches make a paradigmatic shift to addressing health equity very difficult.</td>
<td>Shift the reward structure such that government ministries and agencies will make health equity a public policy priority.</td>
<td>Build popular consensus for health equity promoting public policy that forces government ministries and agencies to implement specific public policies.</td>
</tr>
<tr>
<td>Political Economy</td>
<td>Elect political parties that will shift long-standing policy approaches of government ministries and agencies.</td>
<td>Strengthen health equity supporting sectors such as the labour movement, various advocacy and social democratic political parties.</td>
<td>Mobilize the public and health equity supporting sectors behind specific health equity supporting public policies.</td>
</tr>
</tbody>
</table>
References


Sudbury and District Health Unit. (2011). *Let's Start a Conversation About Health... and Not Talk About Health Care at All*. Retrieved June 25, 2011, from [http://tinyurl.com/7t8476f](http://tinyurl.com/7t8476f)


