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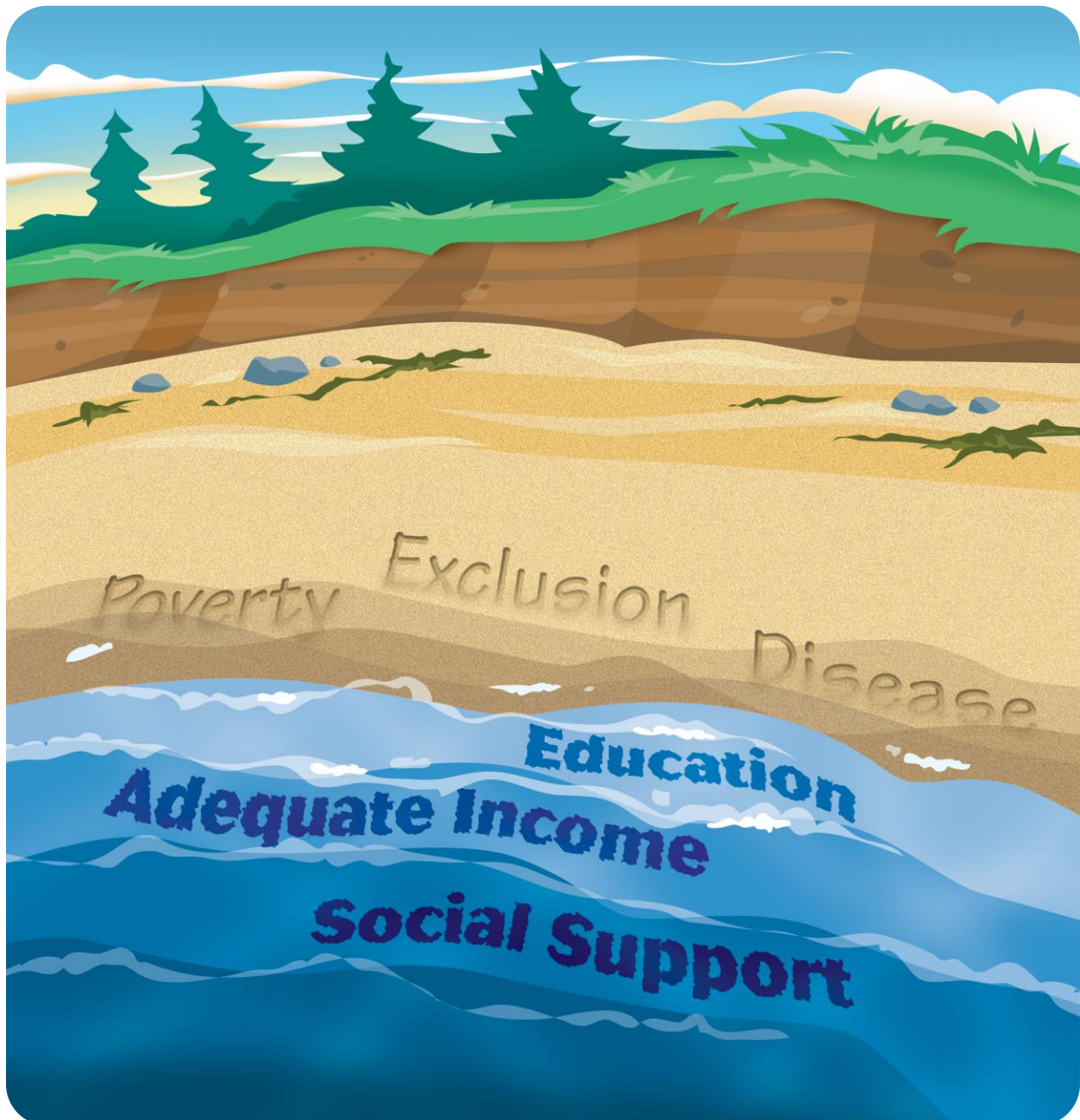
Atlantic Region

# The Tides of Change

## Addressing Inequity and Chronic Disease in Atlantic Canada Annotated Bibliography

Karen Hayward, Researcher

Ronald Colman, Executive Director, GPI Atlantic





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**Atlantic Canada**

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

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## BIBLIOGRAPHIC NOTE

This annotated bibliography is an addendum to the discussion paper, *Inequity and Chronic Disease in Atlantic Canada*. The reference choices, for the most part, are broad, conceptual, and practical with relevance for taking the equity and health study further. The focus is primarily on strategy, rather than on backing up the discussion paper with more evidence. Almost all of the reports and articles are very recent and available online. The two books included are new and should be easily accessible as well. The bibliography is organized into four sections that are not rigid but actually overlap. These are:

- **Atlantic Canada:** includes a report on the costs of chronic disease, examples of qualitative research, and examples of government initiatives.
- **Foundations for Strategy:** includes methods for monitoring and measuring health inequity, practical information on Health Impact Assessments, and a new best practices manual from Nova Scotia.
- **Strategies for Population Health Promotion:** includes examples from the United Kingdom, Sweden, and Minnesota (example of a state-level strategy based on population health), a new book from Europe, a general article from one of the architects of the United Kingdom policy (Whitehead), and a new article on the costs of non-social policy.
- **Pathways to Chronic Disease:** includes overviews of pathways and policy implications from different perspectives and a study exploring cardiovascular disease and socioeconomic status in Ontario.

## ATLANTIC CANADA

**Colman, R., *The Cost of Chronic Disease in Nova Scotia*, prepared for the Population and Public Health Branch, Atlantic Regional Office, Health Canada, and the Unit for Chronic Disease Prevention and Population Health, Dalhousie University, Halifax, 2002, [www.hearthealth.ns.ca/hpc/downloads/chronic\\_costs.pdf](http://www.hearthealth.ns.ca/hpc/downloads/chronic_costs.pdf)**

Colman presents a very detailed statistical analysis of both direct medical costs and the indirect costs of productivity loss caused by chronic disease in Nova Scotia. These costs, of which 40% are estimated to be preventable, exceed over \$3 billion a year. Chronic illness accounts for at least 70% of premature deaths and 60% of medical care and disability costs. The author looks specifically at seven types of noncommunicable chronic diseases including cardiovascular disease, cancer, and diabetes, as well as mental illness, lifestyle risk factors, and medical screening. A major part of the report examines the socioeconomic causes of chronic illness such as poverty, inequality, poor education, environmental causes like exposures to toxic pollutants, and social exclusion.

Colman suggests that there are two choices in dealing with escalating health care costs: either to increase the supply side of medical services to meet the rising costs or to reduce demand for services by reducing the prevalence of chronic illness. He says that the first alternative may contribute to the economy and increase the Gross Domestic Product through growth of the medical services industry. The second alternative, however, can save both lives and money. This is the approach of the Genuine Progress Index (GPI), which assesses progress by the positive health status and well-being of society rather than by growth that is harmful to the population. The report suggests that health promotion initiatives, which reduce inequitable conditions and improve the health of the population, can significantly reduce the need and demand for medical care. The final section looks at the effectiveness and cost-effectiveness of chronic disease prevention and discusses key elements of an effective, comprehensive health promotion strategy. It also offers practical suggestions for interventions toward this end.

**Dechman, M. K., *The Family Mosaic. Executive Summary, Family Mosaic Project: A longitudinal study of lone-parent and two-parent families*, Nova Scotia Department of Community Services, Halifax, 2002, [www.gov.ns.ca/coms/files/fm.asp](http://www.gov.ns.ca/coms/files/fm.asp)**

The Family Mosaic Project (FMP) is remarkable as one of the few longitudinal research studies in Canada to date. Supported by the Social Development Partnerships Program of Human Resources Development Canada and the Nova Scotia Department of Community Services, it followed the lives of 500 Nova Scotia families from 1978 to 1999. It provides a wealth of information on the educational attainment, employment, income, health, and well-being of mothers and children from birth to adulthood in both one- and two-parent families. The project started with a sample of 716 mothers who gave birth to their first child in a Nova Scotia hospital in 1978. Half of the mothers were married and half were single. Data collections and interviews with the mothers were conducted when the children were approximately 6 weeks, 9 months, and 18 months old. It continued when the children were age 10 with psychological assessments of a sample of 223 of the children as well as personal interviews with the mothers. At age 20, the mothers and their children were interviewed again. The data also included health records and information from teachers. Seventy per cent of the mothers who started the project in 1978 were involved in the 1999 data collection.

Reports from the Nova Scotia Department of Community Services based on the data, mostly written by the project coordinator, Margaret Dechman, include: *Leaving School or Continuing: What Makes the Difference*; *Social Exclusion and Social Assistance*; *Youth Employment: Entering the Labour Market*; *The Dynamics of Family Life*; *Educational Profiles of Mothers*; *Employment Profiles of Mothers*; *Psychological Outcomes and Coping Strategies*; and *Social Exclusion and the Health of Mothers and Young Adults*. The FMP web site states that the project should provide “policymakers, practitioners, and the public with information about the ever-changing realities of life.” This study was project-funded and designed to be used internally by the Nova Scotia



Department of Community Services. According to the project coordinator, since the project is now complete, there is no internal process in place for continued access to the data. Also, there is no money available to make the data accessible for external use

**Eyles, J., *Making Resource Shifts Supportive of the Broad Determinants of Health – the P.E.I. Experience*, Canadian Health Services Research Foundation, 2001, [www.chsrf.ca/docs/finalrpts/2002/funding/eyles\\_e.pdf](http://www.chsrf.ca/docs/finalrpts/2002/funding/eyles_e.pdf)**

This is an evaluation summary of a cross-sectoral resource allocation in the human services system in Prince Edward Island undertaken, in part, to support some of the social determinants of health. To increase integration and coordination of services, Prince Edward Island established five health regions that each included health care, social services, income security, public housing, and other services, but excluded education and physician and pharmaceutical resources. These health regions were given block funding so that resources could be shifted to address broad determinants of health. Of the 74 cross-sectoral resource allocations identified, two-thirds involved staff, space, equipment, and information, rather than financial transfers. The financial transfers that did take place mostly moved money from community programs to health care. Barriers were mostly seen to be structural and involved the “political nature of health care, public perceptions and preferences, union agreements, physician opposition and the level of funding.” The report finds that policy change takes time and gives key implications for decision makers to consider.

**Forgues, E., M. -T. Seguin, O. Chouinard, G. Poissant, and G. Robinson, “The Trials of New Brunswick's Emerging Social Economy,” in Vaillancourt, Y. and L. Tremblay (eds.), *Social Economy: Health and welfare in four Canadian Provinces*, Fernwood Publishing, Halifax, 2002.**

The term “social economy” refers to the non-profit, voluntary sector of the economy. It is used to distinguish this sector of society from the market economy, the public economy of the state, and the informal sectors of family and natural helpers. This chapter is part of a larger research project that focused on the fields of health and welfare in four Canadian provinces in the contexts of the social determinants of health policy. Looking at the social economy of New Brunswick, it first surveys its historical, social, and political contexts and discusses the impact that neo-liberal (market-based) policies have on health and welfare systems and community organizations. It then considers examples of New Brunswick's social movement projects, such as the environmental and women's movements and a union/community organization movement, the Common Front for Social Justice, which comprises nearly 20% of the province's population. These movements often are decisive in developing the social economy. The final section describes the forms the province's social economy is taking in the health and welfare area.

The authors see the government's interest in the social economy as a strategy to withdraw from health and welfare and shift responsibility to volunteer resources such as community groups and natural helpers in households. They contend that social economy and community projects are at a crossroads. The individualistic philosophy of privatization and the market are prevailing over a collective, democratic, and solidarity-based philosophy. However, the social economy is strong, and public consultations revealed the public's desire to retain values of the welfare state. The choice is between intensifying the competition of participants or uniting forces to secure a regulatory framework that furthers the well-being of the general population. The chapter concludes with, "The progress which New Brunswick's social economy is able to make in the area of health and welfare will depend on its ability to generate a new model based on public debate."

**Government of Newfoundland and Labrador, *People, Partners, and Prosperity. A Strategic Social Plan for Newfoundland and Labrador*, Government of Newfoundland and Labrador, St. John's, 1998, [www.gov.nf.ca/ssp/ssp.pdf](http://www.gov.nf.ca/ssp/ssp.pdf)**

In 1998, the Government of Newfoundland and Labrador launched an unprecedented new social policy initiative, based on equity and social justice, called *A Strategic Social Plan for Newfoundland and Labrador* (SSP). The plan is based on work by the Social Policy Advisory Committee that conducted public consultations and prepared foundation reports. The SSP transforms governmental strategy to one that links social and economic development for the first time in Canada. It creates a policy framework focused on an integrated, holistic, and population health approach to well-being. This document presents the SSP framework, which requires central coordination of all governmental structures and processes around the directions, goals, and objectives of the SSP. The plan relies on community participation to identify and address community needs, builds on community and regional strengths, and invests in people. The plan works directly with the social determinants of health and creates processes for social inclusion. It re-orientes social and economic programs and services from remedial, crisis-solving approaches, to strategies that address the root causes of problems and emphasize prevention. It views "social programs not as a drain on financial resources but as a critical investment in people."

One of the key elements in the SSP is the process of "asset mapping," which identifies and builds on assets, resources, and formal and informal networks within communities. This process makes an inventory of individuals, organizations, successful projects, places of value, and other community strengths to use as a basis for community building.

Another major innovation, among many in the SSP, is its commitment to social audits and monitoring, through a system of Community Accounts. These accounts provide statistical information for use by individuals, communities, and governmental departments as tools to create community profiles and to develop policy. The

Community Accounts are broken down by community and focus on factors such as employment, income, health status, and demography.

As the framework document states, “The Strategic Social Plan will provide an opportunity to position Newfoundland and Labrador as a leader in social policy development ... [It] marks a major milestone in the social development history of Newfoundland and Labrador.” This is also a milestone within Atlantic Canada and Canada in general.

**Neis, B., and B. Grzetic, *From Fishplant to Nickel Smelter: Policy Implications, Policy Development and the Determinants of Women's Health in an Environment of Restructuring*, prepared for the Health Promotion and Programs Branch, Atlantic Regional Office, Health Canada, 2000, [www.yorku.ca/nnewh/english/pubs/23.pdf](http://www.yorku.ca/nnewh/english/pubs/23.pdf)**

This paper reports on a multi-phased project that took place in 1999/2000 and investigated the health impacts of restructuring in resource-dependant areas of Newfoundland and Labrador. It was concerned with establishing partnerships with representatives from communities, unions, industry, health professionals, university, and government departments necessary for policy and institutional changes. The initiatives undertaken included research on industrial restructuring within the fisheries in the 1990s and the anticipated restructuring within nickel mining and smelting, a panel presentation on women's health and industrial restructuring, a teleconference for rural health professionals on shellfish occupational asthma, meetings with relevant government departments, and a two-day workshop on industrial restructuring and rural health. The workshop explored the health issues of women affected by restructuring in the fishery and oil, gas, and mining industries; small business and home care; and access to training and employment.

The study is especially important as an example of gender-based analysis that looks at the different health risks and benefits for both men and women and for recommending a gender-based approach to policy development. It states that gender-based analysis is required in order to fully understand the relationship between restructuring and health and points out that the 1995 *Federal Plan for Gender Equality* commits all federal departments and agencies to conduct gender-based analyses of all new policies and legislation. Gender-based analysis is based on the view that social and economic issues are not separate and that policy must consider the social and economic context of women's and men's lives.

The initiatives found that most industry and policy decisions associated with environmental, industrial, and political restructuring are made without consideration for human health. As well, restructuring emphasizes job creation and the generation of wealth without considering the social and economic forces that produce poverty and inequality. They point to the need for institutional and policy change that does not

separate concerns about health from other policy areas. The conclusion of the report offers over 100 recommendations for these changes in a variety of areas.

**Travers, K. D., “The Social Organization of Nutritional Inequities,” *Social Science & Medicine*, 43(4), 1996.**

This is an excellent example of the importance of qualitative, participatory research in understanding the real experiences of vulnerable groups. This understanding is necessary to break through discriminatory and unrealistic underlying views of the dominant population. Using participant observation, as well as individual and group interviews, the research explored the everyday lived experience of feeding a family. This was a starting point to connect the particular to broader social and economic contexts. These contexts include social constructs such as gender, class, commerce, policy, and underlying discourses or views. Oppressive social constructs were found to increase inequities that could not realistically be changed by an alteration in individual behaviour. The research then looked at the nutritional inequities of socially and economically disadvantaged women and their families, 80% of whom were dependant on social assistance, living in an urban centre in Nova Scotia. The study observed that nutritional inequities are the result of social processes that can be changed.

The research found a number of inequities including limited access to inexpensive stores, supermarkets geared to the more affluent who had cars and resources to stock up on “specials,” inadequate subsistence welfare policies, and reliance on private food banks. With the help of the researcher, the women initiated and participated in a pricing comparison between supermarket chains in the inner city and suburbs and found prices in the inner-city stores to be approximately 5 to 10.7% higher than in the middle-class suburbs. The women initiated a campaign that resulted in a decrease in this percentage. Welfare food budgets were found to be 17% to 35% lower than what was needed to comply with Agriculture Canada's recommendation for a basic nutritious diet. Private support of food banks was found to remove the responsibility of government to find more permanent solutions to poverty.

Analysis of social policies found that the underlying view was informed by an individualistic ideology. This view does not have an adequate understanding of the experiences of the women involved. It “blames the victim” for not working hard enough and for not taking advantage of opportunities. It does not recognize the inequities within the social order. The effect of this view was seen in professional practices that attempt to assist individuals in adapting to an oppressive situation. For example, this was seen when professionals tried to teach the women to budget when the women did not have enough money for food and rent in the first place. The study also pointed out that the women worked extremely hard to overcome obstacles and provide food and nutrition for their families. They had an excellent understanding of nutrition, were trying their best to make ends meet, but blaming themselves for not managing better.

The research illuminated a variety of policies that are oppressive and contribute to perpetuating nutrition and health inequities. It called for a more social orientation toward understanding inequities.

## **FOUNDATIONS FOR STRATEGY**

**Carr-Hill, R., and P. Chambers-Dixon, *A Review of Methods for Monitoring and Measuring Social Inequality, Deprivation and Health Inequality*, SEPHO, Centre for Health Economics, University of York, 2002, [www.ihs.ox.ac.uk/sepho/publications/carrhill/](http://www.ihs.ox.ac.uk/sepho/publications/carrhill/)**

This is an online tool, produced by the South East Public Health Observatory (SEPHO), to assist in understanding and measuring health inequalities. Although it is geared toward the United Kingdom, it has much information that is generally useful, although technical. It is designed to be an easily usable guide to define terms and methods, to access information for analyzing patterns of social inequality, and to use existing instruments and organizational and administrative data. The tool kit manual is divided into 11 sections that discuss, in part, measuring inequality by social categories; health and disease categories; methods; data sources, and the context, history and theories of inequality. Broadly speaking, the sections address the following questions: What groups or areas are thought to be unequal? In what respects are they unequal? What is an index and how is it tested? What methods are used to measure, represent, and interpret inequalities? What are the historical and theoretical contexts of health inequalities?

**Frankish, C. J., L. W. Green, P. A. Ratner, T. Chomik, and C. Larsen, *Health Impact Assessment as a Tool for Population Health Promotion and Public Policy. A Report Submitted to the Health Promotion Development Division of Health Canada, Institute of Health Promotion Research, University of British Columbia, 1996, [www.ihpr.ubc.ca/pdfs/healthimpact.pdf](http://www.ihpr.ubc.ca/pdfs/healthimpact.pdf)***

This report provides a background and rationale for the use of health impact assessment as a tool for population health and public policy. The authors define health impact assessment as “any combination of procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population.” Any policy or program, whether health-related or non-health-related, may directly or indirectly affect the health of a population through the social and economic determinants of health. The report recommends that government program and policy initiatives in all sectors should be assessed for their impact on the health and quality of life of Canadians. Health impact assessment is, therefore, a means to develop public policy and to decide among different program options. The report looks at current approaches to health impact assessment and offers examples at international, national, provincial, territorial,

regional, and municipal levels. It describes, in part, specific models and tools to link proposed programs and policies to their health impact.

The appendix contains an abstract called, “Working Toward Health Impact Assessment in Nova Scotia.” It is a brief discussion of a 1989 paper, *Report of the Nova Scotia Royal Commission on Health Care*. At that time, the Royal Commission recommended that “all policy initiatives undertaken by the government include an assessment of their impact on the health of the population.” Fourteen years later, researchers are still making this recommendation.

**Health Canada, *A Best Practices Approach to Health Promotion, 2nd version of the Nova Scotia Best Practices Framework*, Health Canada, 2002,  
[www.heart-health.ns.ca/hpc/downloads/framework.pdf](http://www.heart-health.ns.ca/hpc/downloads/framework.pdf)**

A well-researched and conceptualized approach to health promotion, this framework document was designed for programs and policies in Nova Scotia; however, it should be useful for all of Atlantic Canada. Rather than giving a list of best practices, the tool leads the practitioner through the process of developing a workable approach to health promotion. The Best Practices Approach has three main elements. First, it uses a process of critical reflection to look at underlying beliefs and assumptions and then draw out group insights and vision. As a tool for examining current approaches, the critical reflection process uses a list of questions to focus thinking that can lead to effective future practices. Second, the Best Practices Approach supports an evidence-based approach that uses research information to inform all aspects of health promotion. Third, it acknowledges the uniqueness of every situation and recognizes that every program and policy must be adapted to that situation. The framework is a tool to aid in this process.

The framework is systematically divided into six units: foundations, scientific underpinnings, planning process, approaches, context, and results. These units are further divided into 16 components such as values, theories, strategies for action, and processes. These 16 components each have definitions, examples, and questions for critical reflection. The framework can be used, for example, as a tool for team building, to enhance planning projects and activities, or to reflect on work in progress. It will enable continued improvement and enhancement of health promotion practices by helping to develop solutions and insights to challenges and by clarifying steps needed to work toward a common vision.

**Mittelmark, M. B., “Promoting social responsibility for health: Health impact assessment and healthy public policy at the community level,” *Health Promotion International*, 16(3), 2001.**

(See also: Gillis, D., “The ‘People Assessing Their Health’ (PATH) Project: Tools for Community Health Impact Assessment,” *Canadian Journal of Public Health, Supplement*, November/December, 1999).

Abbreviated from a technical report prepared for the 2000 Fifth Global Conference on Health Promotion, this brief paper is a recommendation for the use of non-technical health impact assessments at the local level by ordinary citizens. A health impact assessment is a tool that can be used in a variety of areas. For example, it can identify community needs; policies that may have negative or positive health impacts; or how specific situations, such as proposed housing development, might affect health. A health impact assessment asks, “How are existing or planned policies, programs, or projects actually affecting, or likely to affect, people’s health, for good and for bad?”

The author claims that health impact assessments are necessary to promote healthy policy making at both the local and macro levels. It is especially important at the local level since macro levels may not be sensitive to the diversity of local conditions that affect the health of the population. He points out a number of reports and examples from countries using health impact assessments as a central strategy to include social determinants of health in multisectoral analysis. At the community level, he briefly mentions the Newfoundland and Labrador Heart Health Program guidebook that citizens and community groups can use to create, support, or oppose local policies.

The paper looks at details of a case study from eastern Nova Scotia, the People Assessing Their Health (PATH) project as “a particularly stimulating exemplar” of core principles for community health impact assessment. The PATH project involved community members in a four-stage process to enable them to develop Community Health Impact Assessment Tools (CHIATs) to determine what factors were influencing their health. The CHIAT typically included a “statement of values and principles that guided the work, a vision statement for a healthy community, a summary of key determinants of health, a list of factors important in building and sustaining a healthy community, and priorities for action”. It shifted thinking from illness problems to the social determinants of health and involved work with community leaders to ensure governmental groups used the tools in decision making – a process that has not had sufficient governmental support to date. The PATH project exemplifies how a participatory community process can illuminate socioeconomic inequities and community capacity to improve conditions for a healthier community.

## STRATEGIES FOR POPULATION HEALTH PROMOTION

**Acheson, D., *Independent Inquiry Into Inequalities in Health*, Stationary Office, 1998, [www.official-documents.co.uk/document/doh/ih/contents.htm](http://www.official-documents.co.uk/document/doh/ih/contents.htm)**

The “Acheson Report” is the major governmental document that forms the background and framework for the United Kingdom's comprehensive population health policy. The government commissioned Sir Donald Acheson to undertake an independent review of inequalities of health in the United Kingdom. He formed a small group of leaders in the field, including Sir Michael Marmot and Dr. Margaret Whitehead, to oversee the process that took approximately one year. In addition, the group commissioned a series of 17 foundation papers from researchers such as Richard Wilkinson, George Davey Smith, David Blane, and Sally Macintyre. These papers explored aspects of the life course and vulnerable groups, the social and economic determinants of health, and health-related behaviours. Many more researchers and almost 80 organizations contributed to the process of identifying key issues, reviewing the evidence, and developing recommendations.

The final report is divided into two sections. Part One summarizes the inequalities in health and provides the background. Part Two identifies 12 areas for future policy action: poverty, income, tax and benefits; education; employment; housing and environment; mobility, transport, and pollution; nutrition and common agricultural policy; mothers, children, and families; young people and adults of working age; older people; ethnicity; gender; and inequalities within the National Health Service. This section includes a review of the evidence, benefits that can be expected to result from policy changes, and almost 150 recommendations which address the social and economic determinants of health. The report gives priority to mothers and young children and recommends, in part, that:

- All policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities.
- All those policies should be formulated to favour the less well-off and so, wherever possible, reduce health inequalities.
- Further steps should be taken to reduce income inequalities and improve the living standards of poor households.

In addition, as the policy recommendations are interrelated and reinforce each other, the inquiry team recommended that they should be implemented on a broad front.

“Cherry-picking’ a few specific areas to implement will not achieve very much.”



**Fouarge, D., *Costs of Non-social Policy: Towards an economic framework of quality social policies and the cost of not having them*, Directorate General for Employment and Social Affairs, European Commission, 2003,**  
**[http://socialpolicy.ucc.ie/EU-docs-socpol/Fouarge\\_costofnonsoc\\_final\\_en.pdf](http://socialpolicy.ucc.ie/EU-docs-socpol/Fouarge_costofnonsoc_final_en.pdf)**

This paper was released by the French governmental organization, Council for Employment, Income and Social Cohesion (CERC), formed to “contribute to the knowledge on income, social inequalities and links between employment, income and social cohesion.” One of the basic goals of the European Union is to increase social inclusion, and in 2002 the European Council requested member states to draft action plans against poverty and social exclusion. This was seen as a challenge since social policy is often viewed as thwarting the ability to achieve high economic growth. However, the European Commission is making a comprehensive effort to show that social policy contributes to economic performance.

Adding to this effort, the paper uses theoretical and empirical economic literature to look at the equity versus efficiency debate, the roles of the market and welfare states, and then to assess the social and economic costs of “non-social policy.” It presents the alleged trade-off between economic efficiency and equity as a “short sighted understanding of economic mechanisms” and states that “more equity can go hand in hand with more efficiency. In other words, a generous level of social protection does not necessarily lead to lower economic achievements.” Rather, it concludes that investing in social policy has high social and economic returns. Not investing in social policy leads to a high cost in terms of social and economic efficiency.

**Labonte, R., and P. Thompson, *Promoting Heart Health in Canada. A focus on heart health inequalities*, Heart Health Inequalities Project, 1988, updated 1998,**  
**[www.hcsc.gc.ca/hppb/ahi/hearthealth/pubs/phhcfhhe/phhi01.htm](http://www.hcsc.gc.ca/hppb/ahi/hearthealth/pubs/phhcfhhe/phhi01.htm)**

Raphael (see below) called this a “landmark work” that is “as fresh and relevant today as it was [in 1988] ... Unfortunately it has been languishing on book shelves – and now on the internet – since 1988 with nary any effective implementation of its recommendations.” In part, it concerns community development and mobilization as approaches for health promotion. Raphael suggests that the paper be read carefully by those working with community-based health promotion approaches.

The paper discusses socioenvironmental and psychosocial risk factors that relate to the social and economic determinants of health. It calls for health organizations to support community groups and organizations in their work on these determinants. A major section of the report defines the principles and practice of community development. Community development, called the most promising approach to reducing health inequalities, is defined as “the process that links the health-enhancing aspects of social networks and social support with community action on the determinants of health.”

Community refers not only to “geographical proximity (e.g., neighbourhoods) but also to shared interests or activities.”

Key aspects in the paper that Raphael suggests have been largely overlooked include:

A fundamental premise of a Heart Health Inequalities program protocol is that communities have the power to define their own “health problems.” These problems may or may not include physiological and behavioural risk factors, but actions on these risk factors will follow actions on risk conditions or psychosocial risk factors.

Community self-determination of issues and solutions is not a one-time, static process of asking groups about their concerns. Rather, it is an honest, respectful, critical and open dialogue between community members, groups and professionals in which problems are discussed, defined and redefined until all participants are satisfied that the best possible “problem definition” has been made.

This step in the community development process is extremely important because the definition of the problem often defines the nature of the actions that will be taken by individuals, groups, professionals and agencies.

The third section of the paper looks at elements of the Heart Health Inequalities Project protocols and includes practical suggestions for protocol organization. It incorporates an inequality model that presents risk factors identified within industrial Cape Breton, Nova Scotia, and categorizes them according to health approach.

**Mackenbach, J. P., and M. Bakker (eds.), *Reducing Inequalities in Health. A European Perspective*, Routledge, London, 2002.**

This book, which contains a wealth of practical information, comes out of an international collaboration to exchange national interventions and policy experiences to reduce socioeconomic inequalities in health and collaborative research to evaluate such interventions and policies. The collaboration, the European Network on Interventions and Policies to Reduce Socioeconomic Inequalities in Health, presently has over 40 members from almost all European countries and two non-European ones, New Zealand and the United States. The main purpose of the book is to describe the available evidence of successful interventions and policies to reduce socioeconomic inequalities in health. Twenty-four articles, written by well-known experts in the field, are included.

The book is divided into six parts. The first presents an overview on socioeconomic inequalities in health in Europe and general strategies to reduce these inequalities. Part II

describes interventions and policies on national and municipal levels including policies related to income maintenance, work, food and nutrition, smoking, children, and access to health care. Part III details how eight European countries deal with socioeconomic inequalities in health at the research and policy level. The specific countries discussed are England, France, Greece, Italy, Lithuania, The Netherlands, Spain, and Sweden. Part IV deals with evaluation and offers two new promising approaches, health impact assessment and theory-based evaluation, which might solve some of the problems connected with a lack of evidence base in many interventions. The final two sections deal with the gender perspective, reflections from a non-European perspective, and key messages for policy makers.

**Minnesota Department of Health, *A Call to Action: Advancing Health for All Through Social and Economic Change*, Minnesota Department of Health, St. Paul, 2001, [www.health.state.mn.us/divs/chs/hsd/action.pdf](http://www.health.state.mn.us/divs/chs/hsd/action.pdf)**

Minnesota has taken the first step toward basing population health on the social and economic determinants of health instead of the disease model. This is particularly interesting for Atlantic Canada since the initiative is state-level, on a par with provincial-level, rather than national-level, initiatives. An intersectoral team of the Minnesota Health Improvement Partnership (MHIP), the Social Conditions and Health Action Team, published this report to “focus on social and economic change as a strategy for health improvement and as a remedy to health disparity.” The report is structured into two primary sections: key findings and recommendations for action. The key findings especially emphasize income disparity, cohesive communities, worker and workplace health, and racism. Recommendations for action include:

- *Identify and Advocate for Healthy Public Policy.* This recognizes that many policies and programs have health consequences, even though they may not have explicit health objectives. Therefore, the report suggests the goal of assessing the impact on health of all social and economic policies integral to the policy-making process. The beginning strategy for this is to develop and pilot tools for health impact assessment to be applied to Minnesota and to produce briefs on the health impact of social and economic policies. (As a follow-up to this recommendation the MHIP created an ongoing Health Impact Assessment Team to identify potential applications, create pilot programs, and oversee their application.)
- *Increase Civic Engagement and Social Capital.* This is based on creating comprehensive, flexible, and enduring programs that affect health better than those targeted toward a specific disease or risk factor. Specific strategies involve the identification of tools, policies, and approaches that actively engage community members and groups in health improvement and the recognition of communities through incentives for their efforts in building on population health ideas. (The Civic Engagement and Health Disparities Work Group has been created to explore modes of civic engagement as a way to focus on health

- disparities; to identify, pilot, and distribute tools for doing this; and to recommend state- and local-level ways to integrate public health approaches.)
- *Reorient Funding.* This involves moving away from funding that is narrowly focused on fragmented categories to broaden support to communities. It also links funding across state agencies to address social and economic conditions. (The Minnesota legislature targeted \$13.9 million of the 2002/2003 budget to address racial and ethnic health disparities.)
  - *Strengthen Assessment, Evaluation, and Research.* This includes using more sophisticated indicators to provide a comprehensive picture of factors, such as linking health indicators with measures of socioeconomic status and race/ethnicity. (The local public health agencies have started to include social and economic determinants of health, such as housing and transportation, into their plans.)

Important first steps have been taken. The report concludes that the MHIP and the Department of Health assume leadership roles in taking this work to the next stage.

**Östlin, P., and F. Diderichsen, *Equity-oriented national strategy for public health in Sweden. A case study, European Centre for Health Policy, 2001, [www.who.dk/eprise/main/WHO/Progs/HPA/Publications/20020319\\_3](http://www.who.dk/eprise/main/WHO/Progs/HPA/Publications/20020319_3)***

This paper reports the process of the Swedish government to define the objectives of an equity-oriented national health strategy. The general objectives are to reduce inequalities in health among socioeconomic groups, women and men, ethnic groups, and geographical regions of the country. The new health policy will make the social and economic determinants of health a central goal and guiding philosophy for all Swedish government policy. Toward this end, in 1997 the Swedish government appointed a National Public Health Commission consisting of representative of all seven political parties and scientific experts and advisors from national authorities, universities, trade unions, and non-governmental organizations. This was a unique process that moved politicians from an initial confrontational stance about social policy to one based on consensus, sincerity, and respect. The final report by the commission is called a “*political* document based on *scientific* evidence.”

The commission suggested targets in terms of the social determinants of health rather than in terms of reduced mortality and morbidity. Fourteen expert groups were commissioned to write background papers on areas such as employment and work conditions, economic factors, social insurance, mental health, and target groups such as children, elderly people, and immigrants. A vision of the commission is that “environmental factors that cause physical and mental illness, such as inequitable living and working conditions, should be eliminated or reduced to a significant extent.”

Nineteen recommendations are structured around eight general objectives:

- Strengthen social cohesion and solidarity in society.
- Increase opportunities for integration into the labour market and reduce social exclusion.
- Increase the influence and security of people in the workplace.
- Give priority to families with children in economic terms and in respect of the time available for being together.
- Give children and young people equal chances in life by reducing segregation and implementing compensatory measures.
- Give senior citizens and people with long-term illnesses or disabilities opportunities to shape their lives according to their needs.
- Create opportunities for the sustainable enhancement of health.
- Increase solidarity with those who are vulnerable to lifestyle risks.

As this paper points out, “The success of any public health strategy depends greatly on the process by which it has been developed. The process that leads to national goals is just as important as the goals themselves. It is crucial for the strategy to be formed through a democratic process, involving a continuous dialogue with those who will be subject to the strategy as well as those who will have responsibility for its implementation.”

**Whitehead, M., G. Dahlgren, and L. Gibson, “Developing the Policy Response to Inequities in Health: A Global Perspective,” in Evans, T., M. Whitehead, F. Diderichsen, A. Bhuiya, and M. Wirth (eds.), *Challenging Inequity and Health: From Ethics to Action*, Oxford University Press, New York, 2002, [www.rockfound.org/Documents/424/chapter21.pdf](http://www.rockfound.org/Documents/424/chapter21.pdf)**

The results of an international initiative of over 100 researchers from more than 15 countries, called the Global Health Equity Initiative, this book includes analyses of health equity and in-depth country studies. The foundation is that “a nation’s health inequities may be seen as a barometer of its citizens’ experiences of social justice and human rights. Thus remedies for health inequities must come not only from the health sector but also from broad social policies.” Supported by The Rockefeller Foundation and the Swedish International Cooperation Agency, the book includes case studies from Bangladesh, Chile, Japan, Kenya, Mexico, Russia, South Africa, Sweden, Tanzania, the United Kingdom, the United States, and Vietnam. The chapter by Whitehead et al. forms the conclusion to this volume. Its underlying premise is that something can and must be done about inequities in health. Macroeconomic and social policies make a significant difference to the health of a population.

The chapter is divided into four elements or steps that are necessary to build a successful and practical policy response to health inequities. These elements are establishing

values, describing and analyzing causes, tackling the root causes of inequities, and reducing the negative consequences of being in poor health. The first, establishing values, notes that a planned response to health inequities must acknowledge that action involves ethical and political choices. It suggests that an essential first step is to demonstrate the inequities caused by economic and social policies. It is also necessary to make explicit the values on which proposed action is based. As a start, existing and proposed developments should be subject to health equity impact assessment. The second step calls for going beyond statistical averages to look at specific conditions in different groups and areas of society. These would include factors such as “differentials in exposure to health hazards, in behavioural risk factors, in opportunities and barriers to adopting a healthier lifestyle or to gaining access to essential goods and services, and in the costs and benefits of macroeconomic policies.” The third element, tackling root causes, is the next step. It looks to identify points of entry for action such as promoting healthy macro policies, especially concerning poverty, nutrition, housing, the position of women or ethnic minorities, hazards in the physical environment, living and working conditions, social cohesion and support, and creating supportive environments for behavioural changes. The fourth element includes welfare issues concerned with improving the quality of life for people who are already sick.

The final section of the chapter offers strategies to create a climate for policy change, noting that it is important to recognize the “two-way traffic” in ideas from global to local and from local to global. Understanding how other countries are dealing with inequities can be helpful in raising awareness and stirring political response at home. For example, European countries use a diversity of approaches to raise awareness of health equity issues among policy makers. The Netherlands uses a consensus-building approach; the United Kingdom uses a more confrontational strategy; and Sweden builds on arguments of social justice. On the other hand, experience gained locally can help the global community understand origins and create policies to reduce health inequities. Finally, the chapter calls for a concerted effort by “governments, ministries of health, regional organizations, non-governmental organizations, researchers, advocacy groups, and individuals to stem the tide of widening inequities in health. We must collectively seize this unprecedented opportunity for global equity in health.”

## PATHWAYS FOR CHRONIC DISEASE

**Canadian Population Health Initiative, *Poverty and Health: Links to Action. Proceedings of the Canadian Population Health Initiative National Roundtable on Poverty and Health, March 26, 2002*, Canadian Population Health Initiative, Canadian Institute for Health Information, 2003, [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=GR\\_323\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=GR_323_E)**

Addressing the theme of poverty and health, this report is a summary of a roundtable held by the Canadian Population Health Initiative on March 26, 2002, in Ottawa. The objective of the roundtable was to stimulate debate and dialogue on population health among researchers, policy/decision makers, and other stakeholders. Its aim was to identify policy and research issues and new strategies for addressing poverty and health. The consensus from the roundtable was that poverty must be addressed as an underlying cause of ill health if the health status of the population is to improve. As well, there is an “urgent need for a set of principles that can guide policy-making and program development around poverty and health.”

Participants suggested several policy and research strategies:

- Public policy should integrate social issues with health issues.
- A vision and conceptual framework for population health, or a better “story line,” can help develop intersectoral approaches to policy.
- Intersectoral structures are needed to coordinate policies and programs in separate policy areas and jurisdictions.
- A “societal-outcome”/well-being approach might focus activities across sectors and raise health status.
- Long-term strategies and research programs are needed.
- The mainstream of research and policy making needs to include the daily experiences of people living in poverty. A participant explained, “If you simply talk to people a lot they will tell you what matters most. It will help guide you towards finding the solutions you want to develop without designing something that is wonderful scientifically, but doesn’t really reflect people’s lived experience.”
- Research needs to focus on social exclusion and acute versus chronic poverty, in order to clarify causal pathways and links between poverty and health.

The roundtable concluded by acknowledging that determining what programs and policies work requires more evaluation research. The participants agreed, however, that there is enough evidence to act.

**Canadian Public Health Association, *Health Impacts of Social and Economic Conditions: Implications for Public Policy*, Canadian Public Health Association, 1997, [www.cpha.ca/english/policy/pstatem/impact/health\\_e.pdf](http://www.cpha.ca/english/policy/pstatem/impact/health_e.pdf)**

This discussion paper is a good, comprehensive overview of social and economic health inequities in society. The Canadian Public Health Association (CPHA) commissioned the paper from a broad range of experts in order to help the CPHA formulate advocacy positions on specific policies to reduce health inequities. The CPHA takes the position that policy can be an instrument for reducing health inequities and considers social justice and equity as essential to healthy public policy.

The paper presents evidence of the links between the socioeconomic environment and health status. It then reviews the health impact and key trends of specific socioeconomic factors in Canada such as income distribution, poverty, education, unemployment, homelessness, violence, and systemic discrimination, as well as the marginalized groups affected by these inequities. In addition, it discusses biological and psychological pathways and early childhood environments. It also considers policy implications such as changes to income programs and taxes, education and training programs, labour legislation, and social supports and services.

**Central West Health Planning Network, *Exploring the relationship between cardiovascular disease and socioeconomic status in Ontario*, Central West Health Planning Network, 2002, [www.cwhpin.ca/cwhpin/Amy/](http://www.cwhpin.ca/cwhpin/Amy/)**

This 270-page study is an example of provincial-level research to determine whether there is a connection between the social determinants of health and cardiovascular disease (CVD) at the local level. Community partners (regional district health councils and public health units) initiated the study to clarify the relationships between socioeconomic status (SES) and CVD locally in order to obtain information that could assist in the development of heart health programming and policy development.

The report is highly technical but should be of interest to professional investigators. It first reviews the literature concerning various socioeconomic measures and CVD morbidity and mortality. The second section explores statistical associations at the ecological level, between specific SES indicators and CVD morbidity and mortality rates Ontario-wide, controlling for traditional CVD risk factors. Specifically, it looks at the relationship between measures of education, income (including income inequality), occupation, and living conditions and CVD. Descriptive and linear regression modeling was completed for five cardiovascular conditions: angina, congestive heart failure, acute myocardial infarct morbidity, ischemic heart disease, and CVD mortality.



The results show that socioeconomic variables account for a major proportion of the variation in heart disease among counties in Ontario. Living conditions, education, and occupation levels are key predictors of heart disease. Average household income is related to levels of disease at the bivariate level of analysis. As well, increasing hospitalization due to heart disease seems to relate to educational attainment and occupation, and death due to heart disease seems to relate to living conditions and living in urban areas. Overall, counties that have higher home values, less educational inequality, and residents with higher education and occupational levels have lower levels of heart disease. The report recommends that factors influencing these trends demand further inquiry.

**Dunn, J. R., *Are Widening Income Inequalities Making Canada Less Healthy?*, The Health Determinants Partnership, Making Connections Project, Ontario Public Health Association, 2002, [www.opha.on.ca/publications/income\\_inequalities.pdf](http://www.opha.on.ca/publications/income_inequalities.pdf)**

This report reviews the evidence of the influence of social and economic determinants on population health and especially considers the relationship of income inequality and health. It shows a growing trend in Canada toward social and economic inequality and loss of “public goods” (e.g., public infrastructure, health care, education) and provides a very clear warning that, if this trend continues, the health and well-being of Canadians will suffer. The author compares the income inequalities, health, and policies of the United States and Canada and reviews possible hypotheses that might explain the differences. It highlights two key points: the importance of the Canadian universal health care system and the influence of progressive taxation systems and universal public services in redistributing non-cash benefits. It also looks at the direct and indirect costs of the leading illnesses in Canada, with particular emphasis on mental illness.

The final section suggests five public policy responses. These include investing in human capital, improving working conditions and reducing unemployment, enhancing public goods and investing in infrastructure to support a high quality of life for all Canadians, prioritizing “progressive” sources of public finance and reducing dependence on “regressive” sources of revenue, and strengthening programs and services which redistribute cash and non-cash benefits from wealthier households to poorer ones.

The key messages of the report are as follows:

- Social and economic factors strongly influence the health of all Canadians, and such factors can be modified by social and economic policy.
- Societies with a greater gap between rich and poor may have poorer overall health. Canada appears to have some attributes, which protect it from some of the impacts of provincial- and metropolitan-level income gaps.
- Canadians cannot afford to be complacent about income inequality in our society. The 1990s witnessed a dramatic widening of the gap between rich and poor, a

substantial reduction in entitlements to social benefits, and an under-investment in human capital. If the United States can be used as a weather vane, the health effects of population-level inequality may already be on the way.

- A commitment to social and economic equity may enhance economic growth and competitiveness. Research evidence does not support the claim that social policies, which produce equality, undermine economic growth.
- Traditionally, Canada's system of progressive taxation and strong public goods has been instrumental in ensuring an equitable society, providing us with a high quality of life, and producing high standards of health. The United States, by comparison, has a poor record in these areas. The public goods Canadians enjoy are in decline and any further loss may have the potential to undermine our health.
- Poor health, illness, and disease have substantial economic costs, both in terms of direct expenditures on services (health care, etc.) and in terms of indirect costs resulting from lost productivity. These costs may be significantly exaggerated by the existence of strong socioeconomic inequalities in health.
- There are readily identifiable policy levers, which could make a substantial difference to reducing health inequalities and protecting our health advantage over the United States.

**Health Canada, *A Report on Mental Illnesses in Canada*, Health Canada, Ottawa, 2002, [www.hc-sc.gc.ca/pphb-dgspsp/publicat/miic-mmac/](http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/miic-mmac/)**

The stated purpose of this report is “to raise the profile of mental illness among government and non-government organizations, and the industry, education, workplace, and academic sectors.” The report describes five major mental illnesses including mood disorders, schizophrenia, anxiety disorders, personality disorders, and eating disorders. It also has a section on suicide. For each of these, it outlines their incidence and prevalence, causes, impact, stigma, and prevention and treatment.

The first section, an overview of mental illness, briefly discusses stigma and discrimination and the factors that can precipitate the onset or recurrence of mental illness. These include external physical and psychosocial factors, poverty factors, chronic stress, deprivation, family situations, workplace pressures, and the socioeconomic status of the individual. The discussion on poverty says that poor people are at a high risk for mental illness. Lack of opportunity can lead to hopelessness, anger, despair, and chronic stress, which, in turn, may contribute to the development of mental illnesses.

The report suggests that addressing the psychological and social determinants of mental health can promote mental health and possibly prevent some mental illnesses. Also, having strong social supports, adequate income, housing, and educational opportunities are essential to reducing the impact of mental illness.

The report is based mainly on limited hospitalization data. It points out that new information on the distribution of mental illness by age, sex, and other characteristics will be forthcoming from Statistics Canada's Canadian Community Health Survey. The appendix includes the document, *A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health*, prepared by The Canadian Alliance for Mental Illness and Mental Health. It includes goals for public education and awareness, a national policy framework, research, and a national data/information system.

**Kawachi, I., and L. F. Berkman (eds.), *Neighborhoods and Health*, Oxford University Press, New York, 2003.**

A new, groundbreaking textbook, this is a companion volume to *Social Epidemiology*, edited by the same authors. The authors provide convincing evidence that the physical and social characteristics of a neighbourhood can influence the health of its residents. Contributions are from leading researchers, including social epidemiologists, demographers, medical geographers, sociologists, and medical practitioners. Chapters in Part I discuss methodological and conceptual approaches to studying neighbourhood effects on health such as multi-level and contextual analysis and small-area-based measures of deprivation. Parts II and III look at neighbourhoods and health outcomes and the contours of neighbourhood effects on health. Chapters present the case for the importance of neighbourhood effects on health throughout the life cycle: infant health, childhood asthma, and adult infectious diseases. Also discussed are links with residential segregation, social networks, and disabilities. The final chapter looks at health research at the community level and its relevance to public policy.

**Mitchell, A., and E. R. Shillington, *Poverty, Inequality and Social Inclusion*, Laidlaw Foundation, Social Inclusion Series, 2002,**  
**[www.laidlawfdn.org/programmes/children/mitchell.pdf](http://www.laidlawfdn.org/programmes/children/mitchell.pdf)**

This paper takes a fresh and practical look at the related concepts of poverty, inequality, and social exclusion/inclusion with the aim of developing a frame for social policy. The view is that, although income poverty and inequality are important, the broader concept of social inclusion is more useful since it also includes physical and economic dimensions, human assets, social assets, and political processes. It builds on the definition of poverty as "capacity," as developed by Sen in *Inequality Reexamined*. This sees deprivation as not determined by what people possess, but by what it enables them to do in order to participate fully in society with self-respect. This approach implies that we take a more holistic view of well-being, and that we recognize the interrelationship of various forms of exclusion.

An advantage of the concept of exclusion/inclusion is that it encompasses the many different domains of potential deprivation that create exclusion. It also focuses on the

forces or processes that create exclusion rather than only exclusion itself. It sees institutions, policies, and those who create and enforce them as primarily responsible for exclusion. The authors use concrete examples of how policies in the fields of health, education, and housing often accentuate social exclusion, especially by exaggerating the sense of separateness experienced by members of marginalized populations.

The paper looks particularly at policy implications that promote inclusion or prevent exclusion. The processes through which exclusion or inclusion occurs reflect the ideological preferences of policy makers within a social and political context. These preferences determine policy and the types of interventions used. The authors look particularly at three views of social exclusion, based on work by Levitas, including the book, *The Inclusive Society? Social Exclusion and New Labour*. The *social integrationist* model sees employment as most important but ignores the role and value of unpaid work, caring responsibilities, gender, race, and other inequalities in the labour market. The *moral underclass* approach sees dependence on income support as destroying initiative and works to reduce the number of people on social assistance without concern for reducing poverty or increasing inclusion and quality of life. In the *redistributionist* approach, poverty, inequality, and the impacts of exclusion on the lives of the excluded are the focus. The emphasis is on the responsibility of society to create conditions for inclusion.

Policies from Great Britain, France, and North America exemplify these three policy views. The British approach is that of the social integrationist model. The French model is redistributionist. It goes beyond the British model to promote equality in the labour market and to create policies that help balance family and work, for example. The authors are concerned that there is no coordinated inclusion agenda in Canada and see Canada drifting toward the social integration and moral underclass approaches. As an example, they offer a critique of welfare-to-work programs, which increase exclusion.

**Raphael, D., *Social Justice is Good for Our Hearts: Why Societal Factors – Not Lifestyles – Are Major Causes of Heart Disease in Canada and Elsewhere*, Centre for Social Justice Foundation for Research and Education, 2002, [www.socialjustice.org/pubs/justiceHearts.pdf](http://www.socialjustice.org/pubs/justiceHearts.pdf)**

This report is an update of an earlier report, *Inequality is Bad for Our Hearts: Why Low Income and Social Exclusion are Major Causes of Heart Disease in Canada*. It includes new research and adds three new sections that consider side effects of lifestyle approaches to health promotion, reasons for resistance by workers in the field to new ways of thinking about health promotion, and an outline of community-based heart health activities focused on the principles of health promotion. These new additions add to the presentation of clear links between low income and heart disease, the process of social exclusion, and the detrimental effects of government policies that limit resources required for health.

The report outlines the processes that lead to the development of cardiovascular disease and places these processes within the social and economic causal network. Although the report focuses on heart disease, it is clear that the impact of low income and inequality on health also relates to chronic disease in general. The conclusion is that societal conditions are the major determinants of health and illness, rather than lifestyle behaviours. The author includes specific approaches that can be effective in dealing with these problems. Recommendations include reducing the number of Canadians living on low incomes, reducing the social exclusion of citizens from participation in Canadian society, and restoring the social safety nets that support population health.

Key messages contained in this report include the following:

- The current emphasis on medical and lifestyle risk factors as a means of preventing cardiovascular disease in Canada is inadequate, inappropriate, and ineffective.
- Low income is a major cause of cardiovascular disease in Canada and elsewhere.
- Social exclusion – involving material deprivation, lack of participation in common societal activities, and exclusion from decision making and civic participation – is the process that explains how low income causes cardiovascular disease.
- Canadians should be aware that directions in which Canadian society is heading are inconsistent with what is known about reducing the incidence of cardiovascular disease.
- These directions – including greater inequality of distribution of income – undermine the cardiovascular health of Canadians at all income levels.
- Solutions are available to reduce the number of Canadians living on low incomes and to distribute income more fairly, thereby improving the cardiovascular health of all.
- Lifestyle approaches to heart health have side effects that threaten health and well-being.
- The ideological and political barriers to new ways of thinking about cardiovascular disease need to be acknowledged and challenged.
- Community-based heart health activities should be consistent with the best principles of health promotion.

The paper concludes with a call to action to improve cardiovascular health that is required in four areas. “First, there is a need to communicate what is known about the links of low income with cardiovascular disease. Second, research into the causes of cardiovascular disease must consider the role of low income. Third, those concerned with improving cardiovascular health must call upon policymakers at all levels of government to implement policies that will reduce the incidence of low income and social exclusion. Fourth, policymakers must invest in the social infrastructure that helps support Canadians through crucial life transitions.” Finally, the author looks briefly at direct and indirect economic costs associated with cardiovascular disease.

**Ross, D. P., and S. Phipps, *Discussion Paper on Poverty and Health, Canadian Population Health Initiative, and Canadian Institute for Health Information, 2003,* [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=GR\\_323\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=GR_323_E)**

The Canadian Population Health Initiative (CPHI) commissioned this informative and useful paper as a basis for the National Roundtable on Poverty and Health held on March 26, 2002, in Ottawa (see above). The first section assesses the current state of research into poverty and health and suggests areas for further work. It begins with a discussion of alternative methods for conceptualizing and measuring socioeconomic status and then looks at what is known about poverty, health status, causal links between poverty and health, perspectives on why that is important, and suggests extensive research needs. It especially recommends estimating the health costs of poverty and inequality and the associated economic burden. This can be done “by drawing attention to the mounting evidence that underlines the negative health impacts of poverty and highlighting relevant policy experience.” It sees this as laying the groundwork for estimating the savings of poverty reduction to the health care system.

The second section examines what is known about policies – what has been tried and what works, using numerous examples of international and national programs and policies. Directions for policy include estimating the cost effectiveness of interventions, establishing a means of identifying what interventions have been tried and what works and making this information easily available, and intervening in multiple risk factors rather than only a few. The paper points to the need for a central coordinating mechanism that treats raising population health issues as central to policy development. It looks specifically at current United Kingdom initiatives to address health inequities and uses it as an example of a country having both a coherent central strategy and the necessary inter-departmental cooperation to produce a comprehensive program. The final section of the paper concludes with a discussion of further research and policy directions.

**Spigelman, M., *HIV/AIDS and Health Determinants: Lessons for coordinating policy and action, Health Canada, 2002,* [www.hc-sc.gc.ca/hppb/hiv\\_aids/can\\_strat/ministerial/discussion\\_paper/](http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/ministerial/discussion_paper/)**

HIV/AIDS is increasing in Canada, especially in vulnerable, low-income communities. Despite some progress in containing the disease, HIV remains a deadly infection that has no vaccine or cure and limited treatment options. The medical sector has not been able to control its spread. Clearly, different approaches to prevention are needed. As this paper suggests, the population health model offers one such strategy. This strategy needs to expand the view of HIV/AIDS as a health issue and regard it as a legal, human rights, and equity issue. Health Canada initiated this paper to review the literature on HIV/AIDS in a

population health context, to identify the social determinants of health most closely associated with HIV/AIDS, and to look at possible policy directions that consider population health and strengthen the Canadian response to the epidemic.

This is one of very few papers that look at HIV/AIDS from a population health perspective. Indeed, the author points out that such literature is sparse. He identifies the most important social determinants of risk for HIV/AIDS as inequities based on income, gender, racism, and discrimination, as well as emotional, physical, and sexual abuse during childhood. The author reviews the following specific determinants as they relate to HIV/AIDS in some detail: wealth and health, early childhood experience, social support, social cohesion and discrimination, race and gender, housing and homelessness, and health services. For each of these areas, he first gives an overview, then research findings, and finally, conclusions and policy implications.

General policy directions include building leadership, commitment, and public consensus. More research is needed into examining HIV/AIDS from the population health perspective and to determine cost savings and public health benefits that will come from this approach. The author offers specific suggestions for action while pursuing a social justice agenda. Examples include expanding harm-minimization programs, placing addictions in a social and health context rather than in the criminal justice system, and linking the Canadian Strategy on HIV/AIDS with the National Children's Strategy, the Social Union, and other early childhood development efforts.