# Promoting Health Equity in the NBPSDHU Region

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School of Health Policy
York University

September 28, 2017

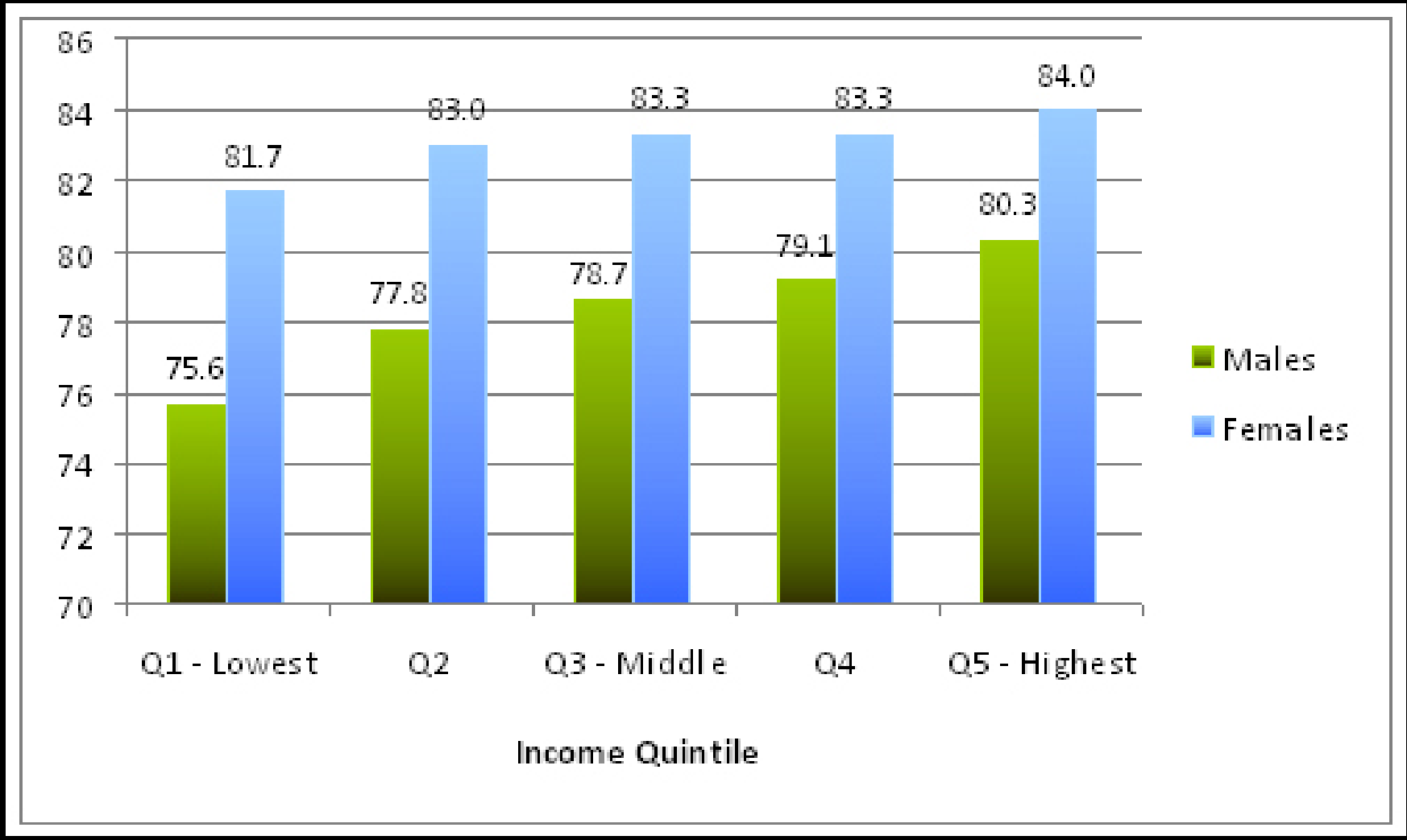
# Part 1: 9:15-10:30

- Overview of Health Equity in the Ontario context
- SDOH, HE and related key concepts
- Situation in NBPSDHU region as it relates to SDOH and HE
- Ontario landscape with perspective on (e.g., BIG, linking of LHINs, Patients First)
- What is PHU & community role in advancing health equity?

# "REDUCING HEALTH INEQUALITIES IS AN ETHICAL IMPERATIVE, SOCIAL INJUSTICE IS KILLING PEOPLE ON A GRAND SCALE."

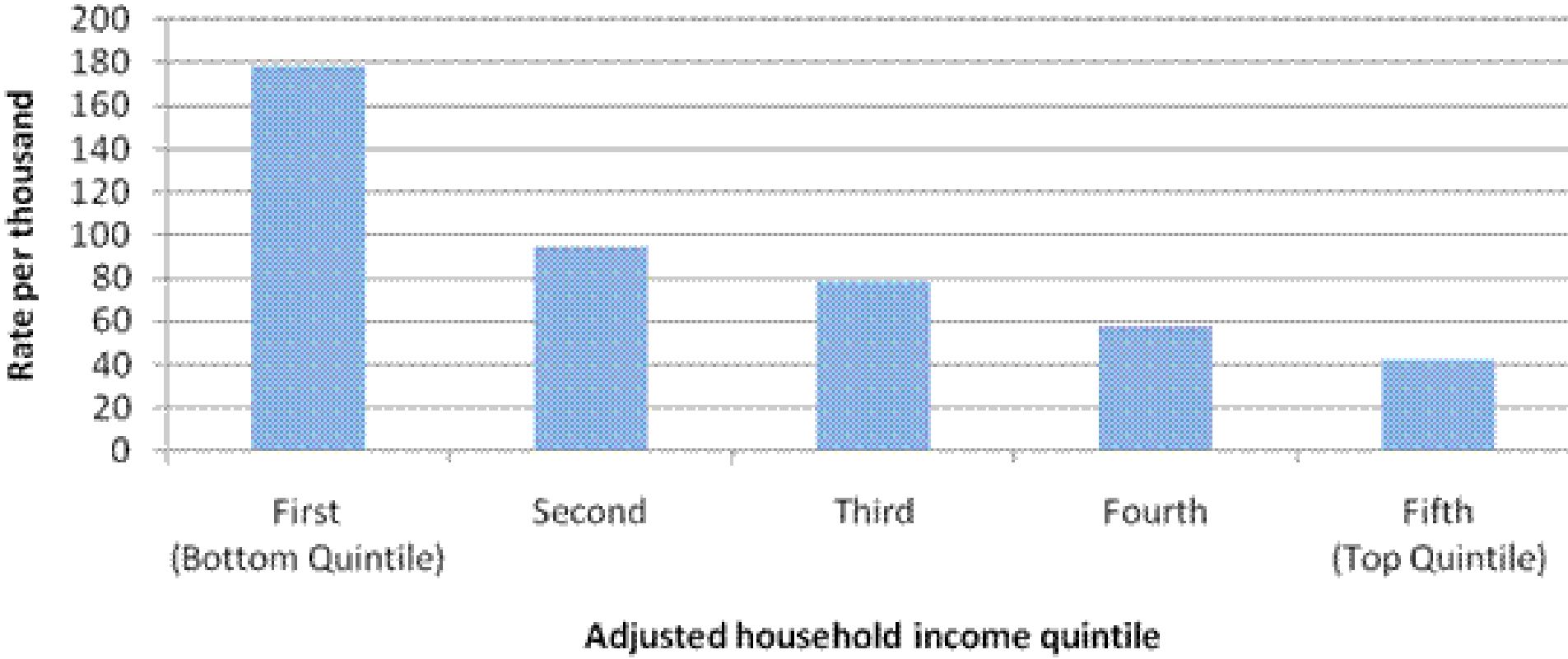
**Commission on Social Determinants of Health (CSDH), Geneva 2008.**

# Life expectancy at birth, by sex, neighbourhood income quintiles, 2005–2007




Source: CANSIM Table 102-0122 (2017). , Health-adjusted life expectancy, at birth and at age 65, by sex and income, Canada and provinces.

## Chart 1.12 - "Poor" or "fair" self-reported health among Canadians 18 to 64 years, 2005




Source: Lightman, Mitchell and Wilson (2008), p. 8.

**Table 1.1: Greater risk of dying associated with being poor as compared to wealthy (RR) and excess deaths associated with income inequality for various diseases and injuries among Canadians**

| | RR[1] | | Excess deaths (%)[2] | |
|---|---|---|---|---|
| **Disease** | **Men** | **Women** | **Men** | **Women** |
| Cardiovascular disease | 1.67 | 1.53 | 19 | 18 |
| Cancers | 1.46 | 1.30 | 16 | 11 |
| Diabetes | 2.49 | 2.64 | 36 | 38 |
| Respiratory disease | 2.31 | 2.11 | 37 | 30 |
| HIV/AIDS | 3.57 | 11.10 | 39 | 69 |
| Injuries | 1.88 | 1.83 | 18 | 17 |

*Notes*: 1. Inter-quintile rate ratio between poorest and wealthiest = (Q1-Poorest)/(Q5-Wealthiest); 2. Percent excess deaths due to differences between wealthy and all other Canadians = 100*(Total-Q5)/Total

*Source*: Adapted from Tjepkema, M., Wilkins, R., & Long, A. (2013). Cause-Specific Mortality by Income Adequacy in Canada: A 16-Year Follow-Up Study. *Health Reports, 24*(7), 14–22: Tables 2 and 3, pp. 17–18.

Raphael, D. (2016). Social determinants of health: Key issues and themes. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (3rd ed., pp. 3-31). Toronto: Canadian Scholars' Press.

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journal homepage: www.elsevier.com/locate/ssmph

Article

# Towards an understanding of the structural determinants of oral health inequalities: A comparative analysis between Canada and the United States

Julie Farmer [a,*], Logan McLeod [b], Arjumand Siddiqi [c,d], Vahid Ravaghi [e], Carlos Quiñonez [a]

[a] Discipline of Dental Public Health, Faculty of Dentistry, University of Toronto, Ontario, Canada
[b] Department of Economics, Lazaridis School of Business & Economics, Wilfrid Laurier University, Waterloo, Ontario, Canada
[c] Dalla Lana School of Public Health, University of Toronto, Ontario, Canada
[d] Department of Health Behavior, Gillings School of Global Public Health, University of North Carolina – Chapel Hill, Chapel Hill, NC
[e] School of Dentistry, University of Birmingham, Birmingham, UK

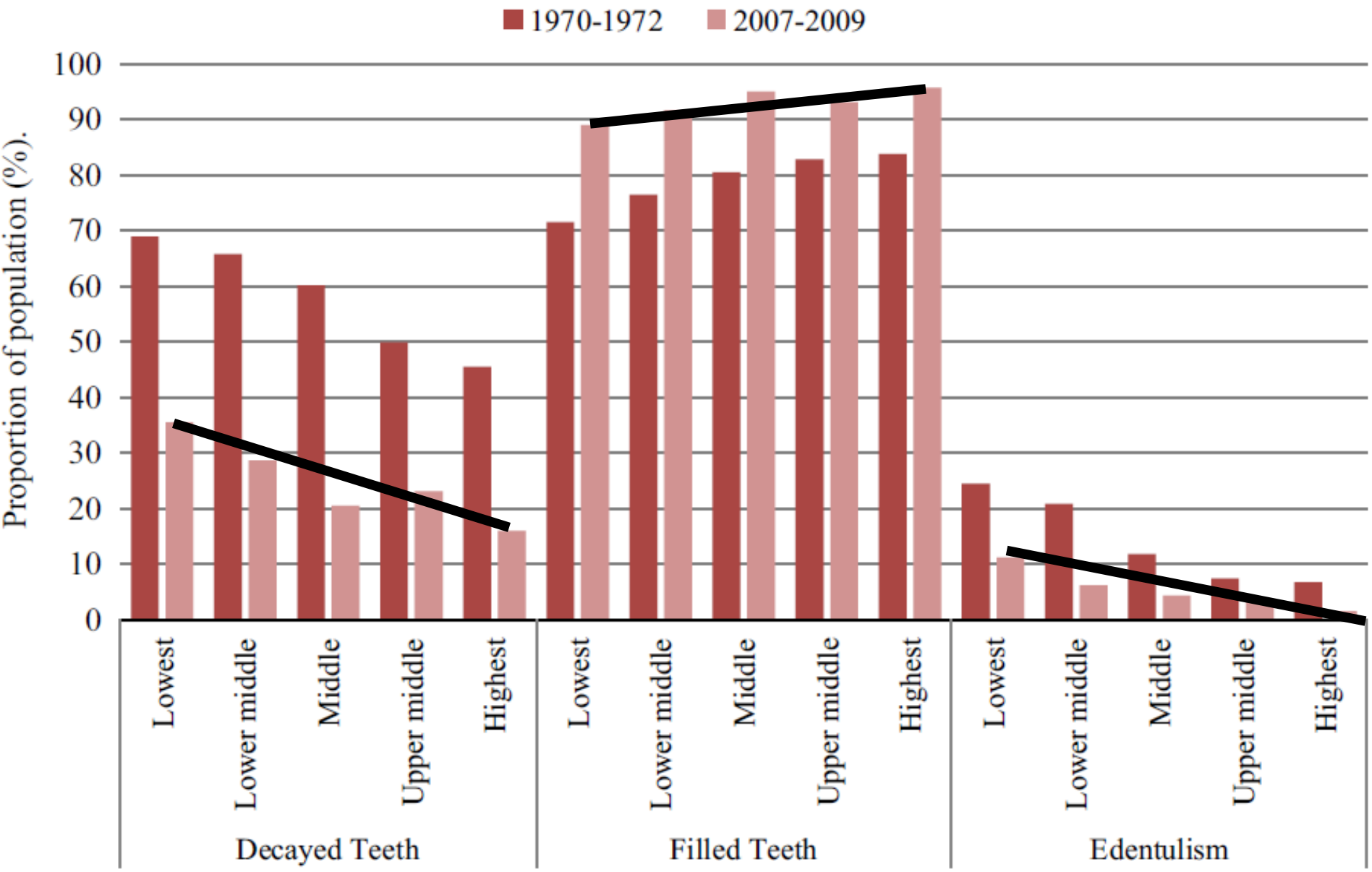



**Fig. 1.** Prevalence of oral health outcomes in Canada, by income quintile.

Ramraj *et al. BMC Oral Health* 2012, **12**:46
http://www.biomedcentral.com/1472-6831/12/46

BMC Oral Health

RESEARCH ARTICLE Open Access

# Dental treatment needs in the Canadian population: analysis of a nationwide cross-sectional survey

Chantel Ramraj[1*], Amir Azarpazhooh[1], Laura Dempster[1], Vahid Ravaghi[2] and Carlos Quiñonez[1]

**Table 4 Percent and unadjusted odds ratios of individuals who have at least one clinically determined treatment need by each independent factor**

| | % | Unadjusted OR (95% CI) | P-value |
|---|---|---|---|
| **Enabling Factors** | | | |
| **Income adequacy** | | | |
| Highest income (Reference) | 26.1 | | |
| Middle income | 35.7 | 1.6 (1.3, 1.9) | 0.001 |
| Lowest income | 43.0 | 2.1 (1.6, 2.9) | 0.001 |
| **Dental insurance** | | | |
| Private coverage (Reference) | 27.2 | | |
| Public coverage | 47.6 | 2.4 (1.6, 3.6) | 0.001 |
| Non-insured | 41.2 | 1.9 (1.5, 2.3) | 0.001 |

*Community Dent Oral Epidemiol 2009; 37: 294–304*


COMMUNITY DENTISTRY AND ORAL EPIDEMIOLOGY

# Oral health disparities and food insecurity in working poor Canadians

**Vanessa Muirhead[1], Carlos Quiñonez[2], Rafael Figueiredo[2] and David Locker[2]**

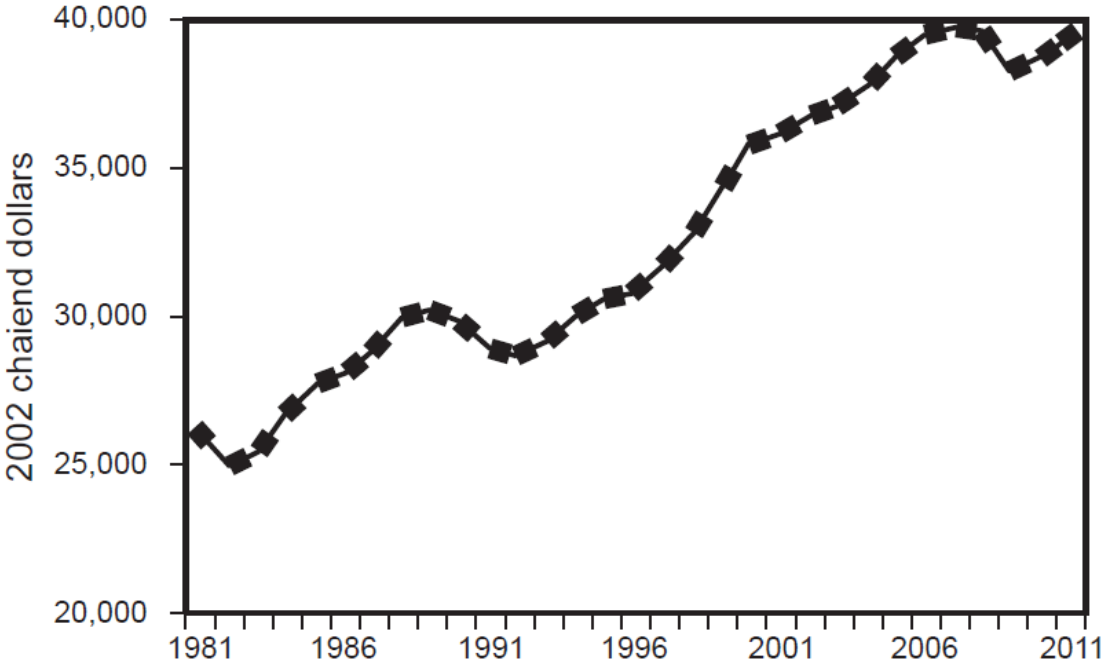
[1]Faculty of Dentistry, McGill University, Montreal, QC, Canada, [2]Community Dental Health Services Research Unit, Faculty of Dentistry, University of Toronto, Toronto, ON, Canada

Muirhead V, Quiñonez C, Figueiredo R, Locker D. Oral health disparities and food insecurity in working poor Canadians. Community Dent Oral Epidemiol 2009; 37: 294–304. © 2009 John Wiley & Sons A/S

Canada has never been wealthier.

How is this wealth being distributed?

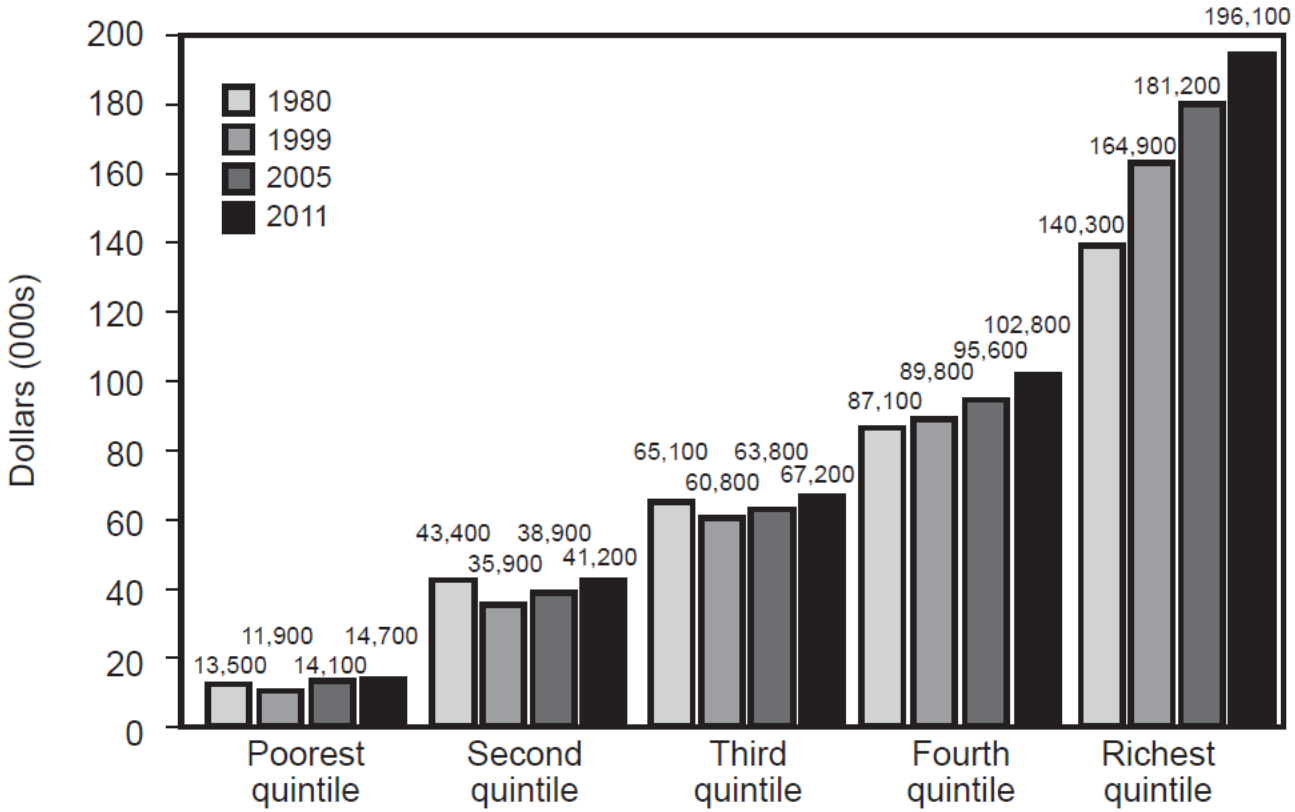
## Figure 20.1: Real GDP per capita, Canada, 1981–2011 (2002 chained dollars)




*Source*: Employment and Social Development Canada. (n.d.). Financial Security—Standard of Living. Online at http://well-being.esdc.gc.ca/misme-iowb/.3ndic.1t.4r@-eng.jsp?iid=26.

Langille, D. (2016). Follow the money: How business and politics define our health. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (3rd ed., pp. 470-490). Toronto: Canadian Scholars' Press.

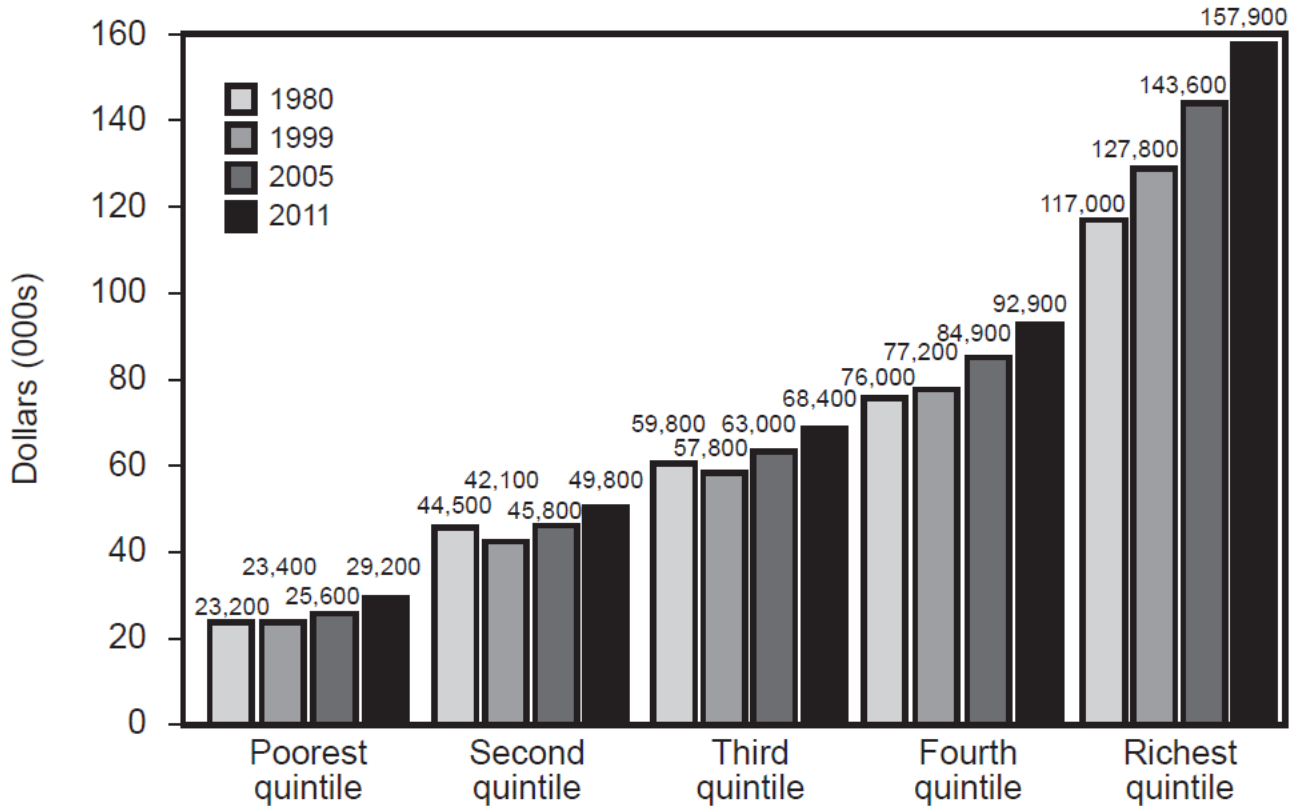
## Figure 3.1: Distribution of market income by quintile, 1980 through 2011




*Source*: Author's analysis of Statistics Canada, CANSIM Table 202-0703.

Curry-Stevens, A. (2016). Precarious changes: A generational exploration of Canadian incomes and wealth. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (3rd ed., pp. 60-89). Toronto: Canadian Scholars' Press.

## Figure 3.8: Governments limit inequality, though fall far short of halting it



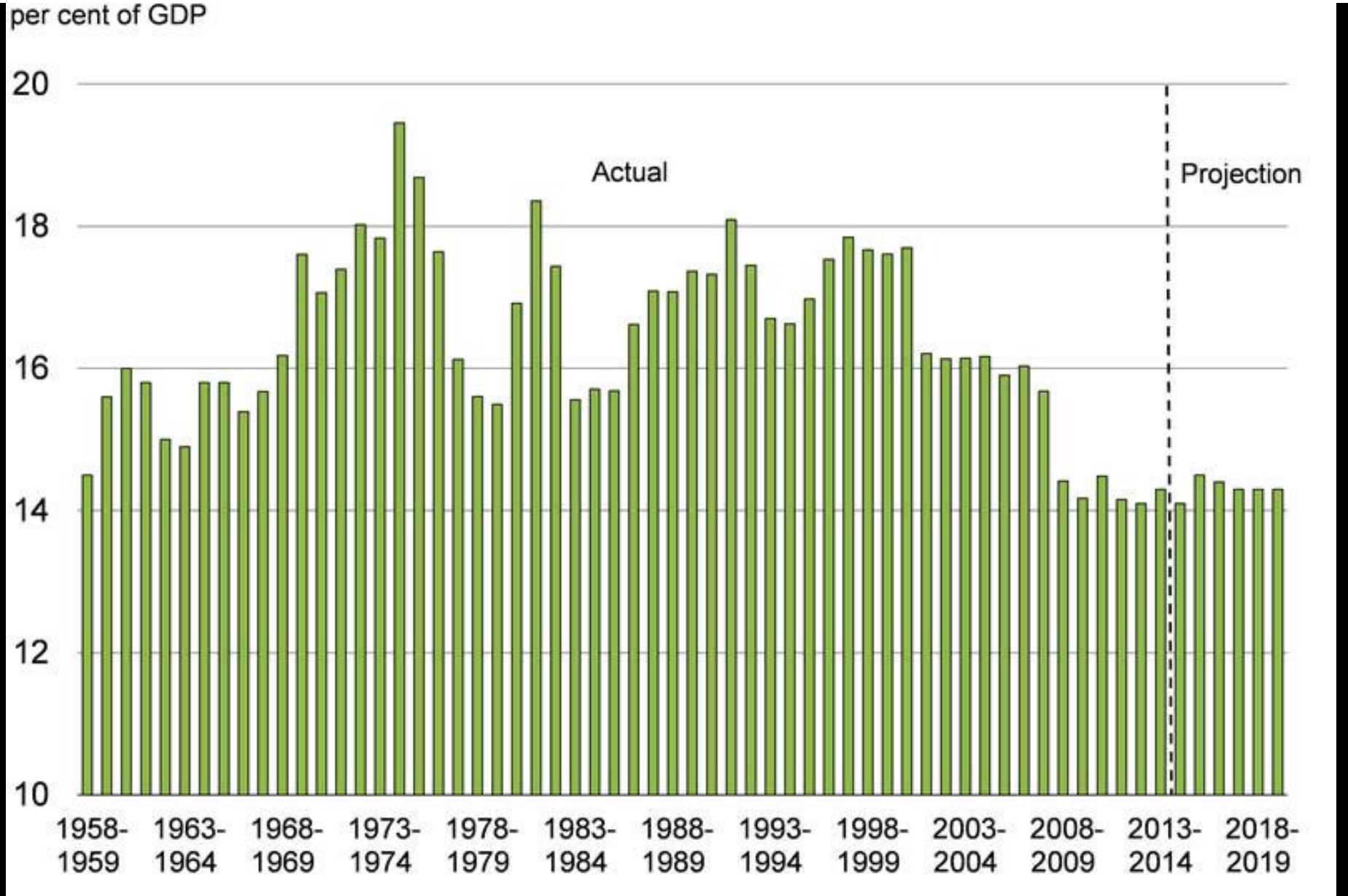

*Source*: Author's analysis of Statistics Canada, CANSIM Table 202-0703.

Curry-Stevens, A. (2016). Precarious changes: A generational exploration of Canadian incomes and wealth. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (3rd ed., pp. 60-89). Toronto: Canadian Scholars' Press.

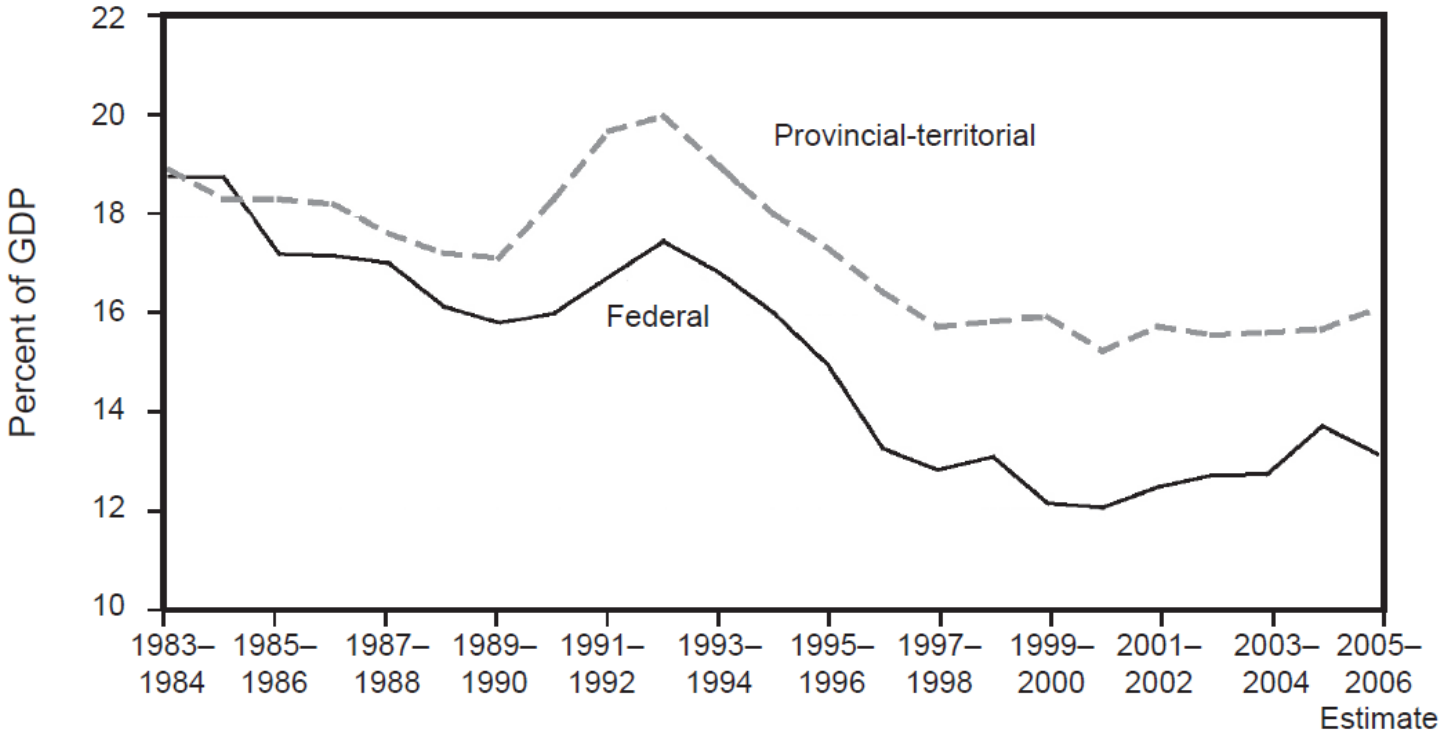
**The federal revenue-to-GDP ratio has fallen since 2006–07 to its lowest level in over 50 years**

**Chart A1.2**

**Revenue-to-GDP Ratio**



## Figure 20.2: Federal and provincial-territorial program expenditures have both declined significantly over the last two decades




*Source*: Department of Finance Canada. (2006). Budget 2006. Ottawa: Author. Online at http://www.fin.gc.ca/budget06/fp/fpa2-eng.asp.

Langille, D. (2016). Follow the money: How business and politics define our health. In D. Raphael (Ed.), Social Determinants of Health: Canadian Perspectives (3rd ed., pp. 470-490). Toronto: Canadian Scholars' Press.

# Overview of Health Equity in the Ontario Context

# Life Expectancy in Ontario by Income Quintile, 2005-2007

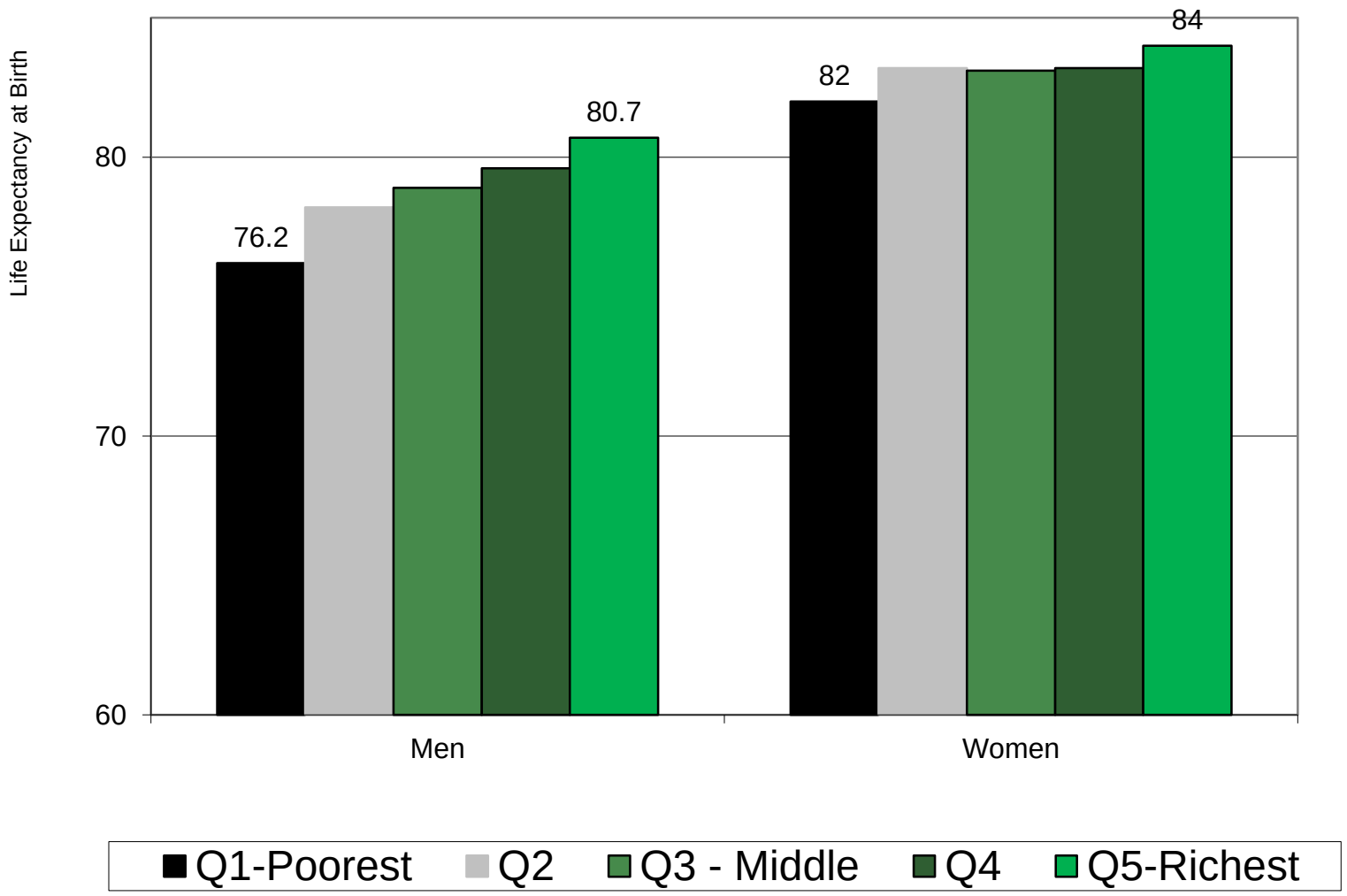
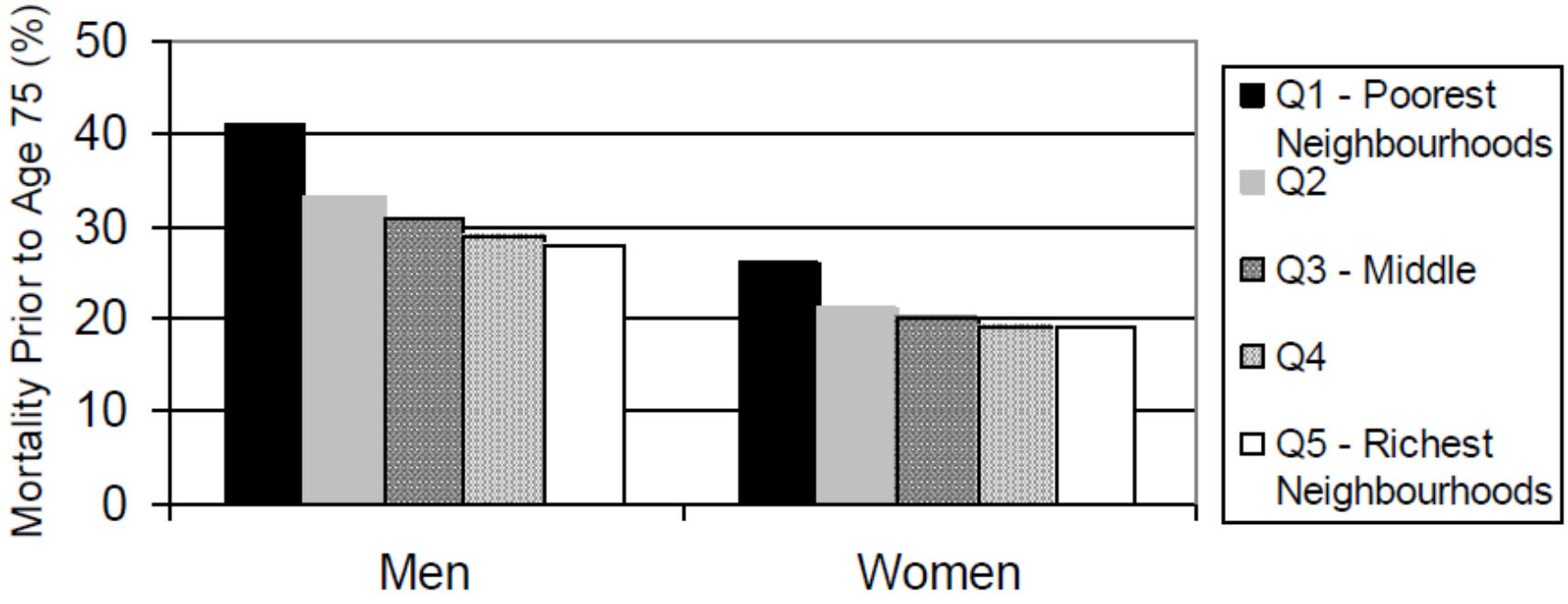


Figure 1. Premature Mortality in Percentage of Men and Women in Ontario, by Neighbourhood Quintile, 2001



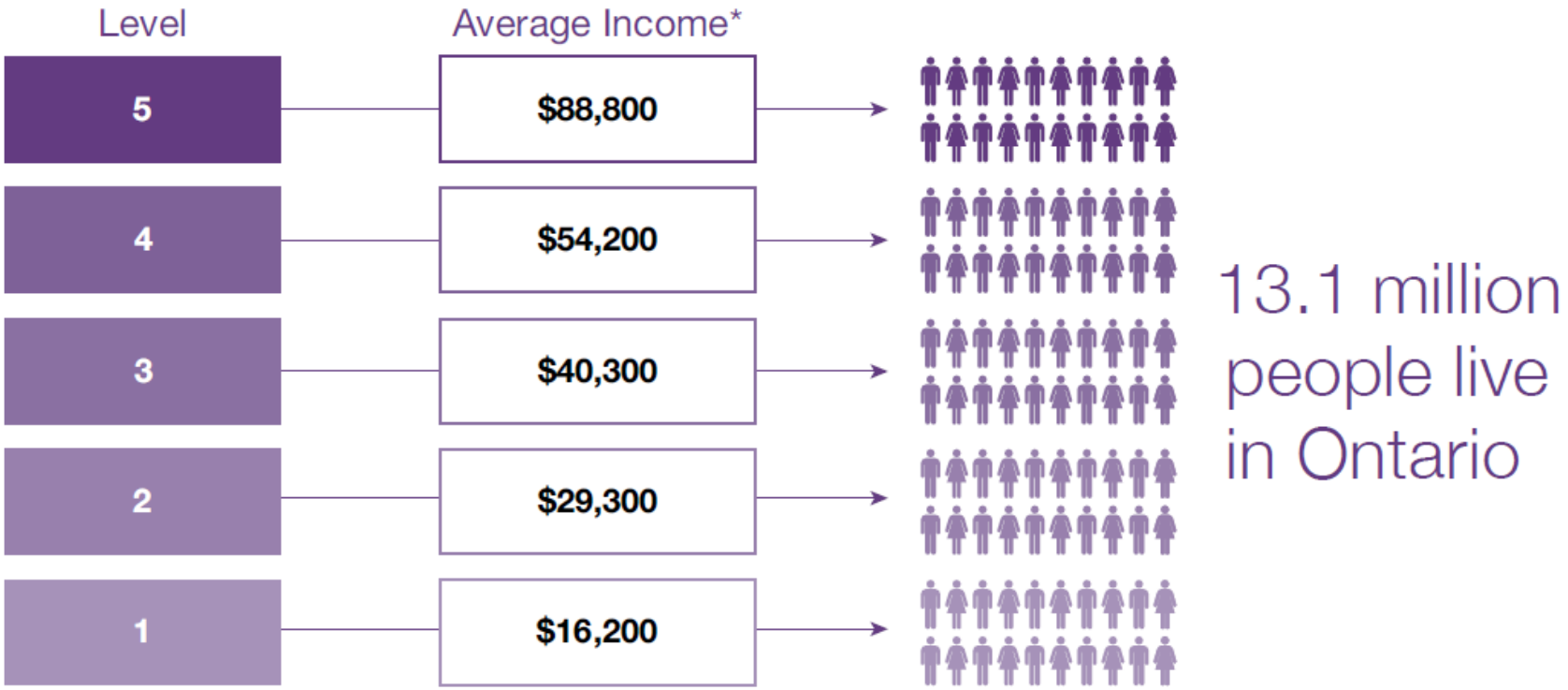

Source: Power Study (2012).

# Income and Health

## Opportunities to achieve health equity in Ontario

*Let's make our health system healthier*

Ontario
Health Quality Ontario




*__Notes:__ Based on average after-tax household income per adult, 2011 constant Canadian dollars. As methods and data sources vary, the values associated with the income levels should be used only as context when reviewing the results presented in this report.

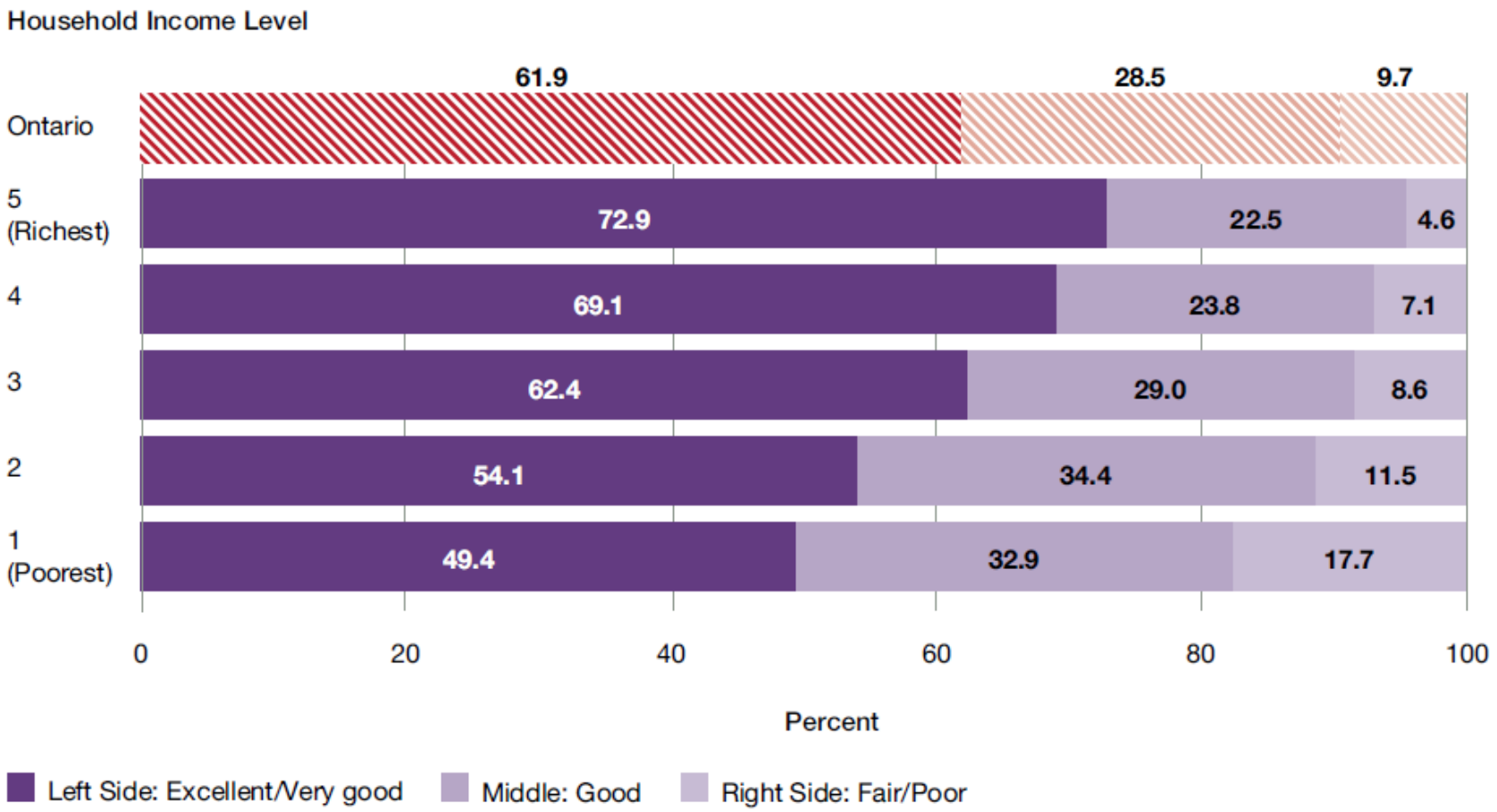
FIGURE 1.1

**Percentage of the population* who report not having access to enough food to meet their basic dietary needs†, in Ontario, by income level, 2013**


**Data source:** Canadian Community Health Survey, 2013 provided by Institute for Clinical Evaluative Sciences. †Age-and-sex adjusted. **Notes:** Based on household income, the value for the 3rd, 4th and 5th levels represent an average of the three proportions; small numbers for income levels 4 and 5 (72 and 15, respectively) and high coefficients of variation (18.9 and 32, respectively). *Population aged 12 and older.

FIGURE 3.1

## Self-reported health status for the population†*, in Ontario, by income level, 2013




**Data source:** Canadian Community Health Survey, provided by Institute for Clinical Evaluative Sciences. †Age adjusted. **Note:** *Aged 12 and older.

Canadian Centre for Policy Alternatives | Ontario
August 2017

# Losing Ground

## Income Inequality in Ontario, 2000–15

Sheila Block

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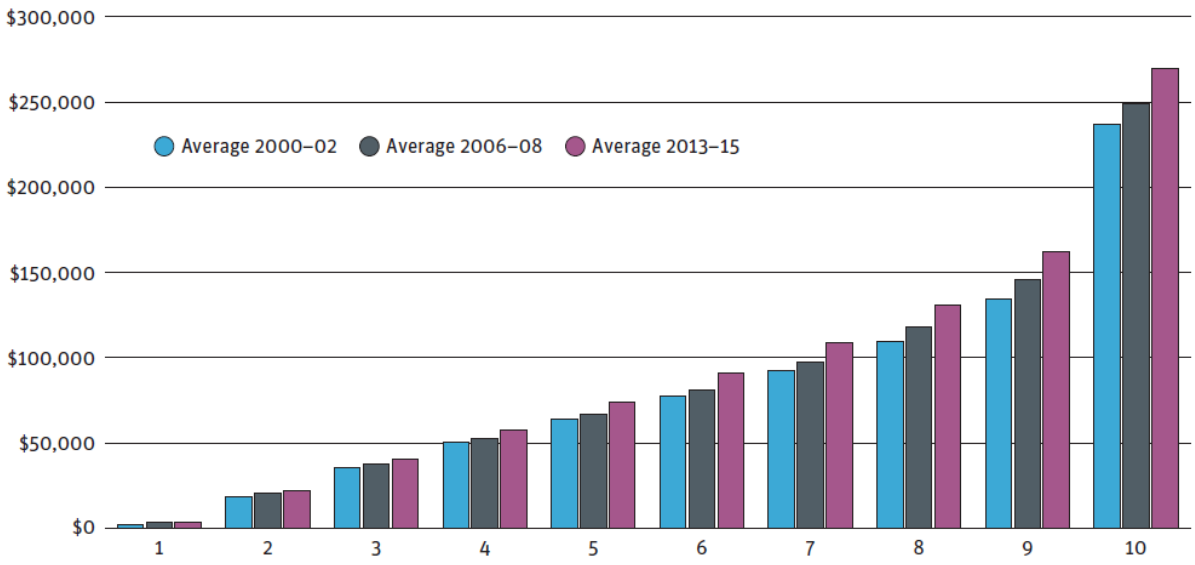
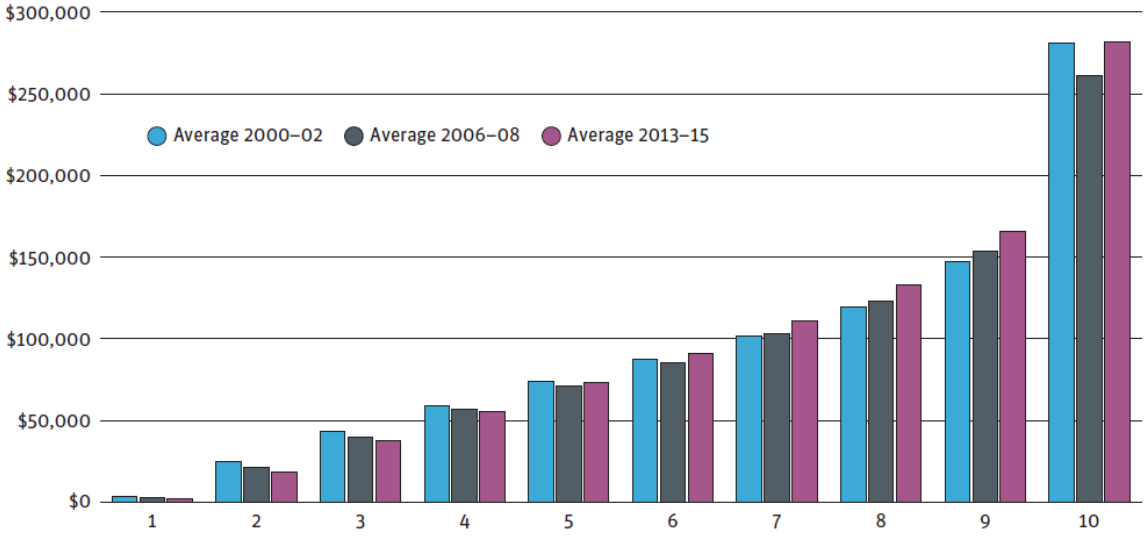
CANADIAN CENTRE for POLICY ALTERNATIVES ONTARIO OFFICE

**FIGURE 2** Real earnings of familes with children, by decile: Canada




**Source** Statistics Canada, special tabulations based on CIS and SLID

**FIGURE 3** Real earnings of families with children by decile: Ontario




**Source** Statistics Canada, special tabulations based on CIS and SLID

Figure Appendix V.4. Percentage Living in Low Income, After-Tax Low Income Measure, By Age Group, Ontario, 1980-2010

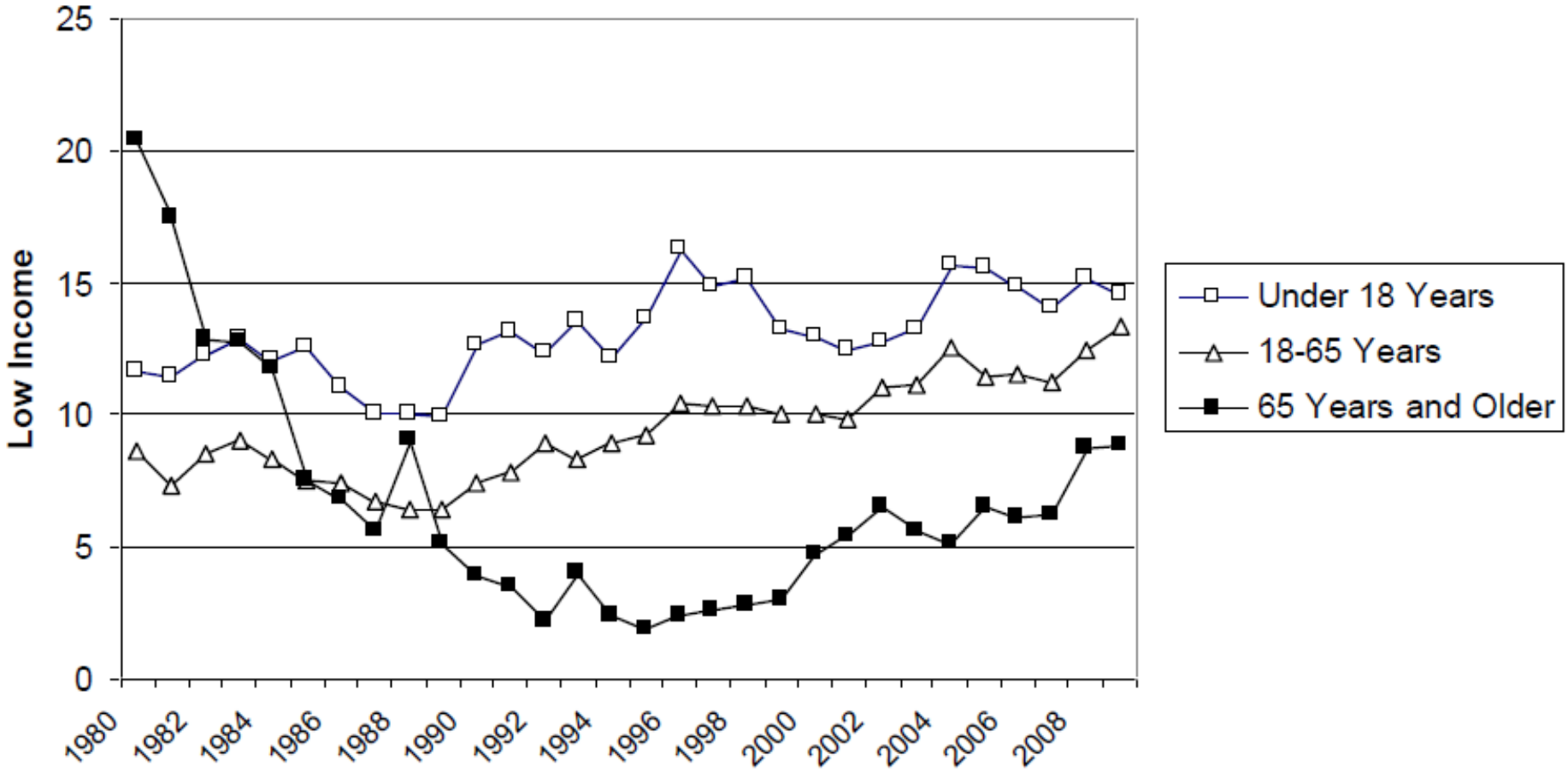


Figure Appendix V.5. Low Income Gap, all Families, using Various Low Income Measures, Ontario, 1980-2010

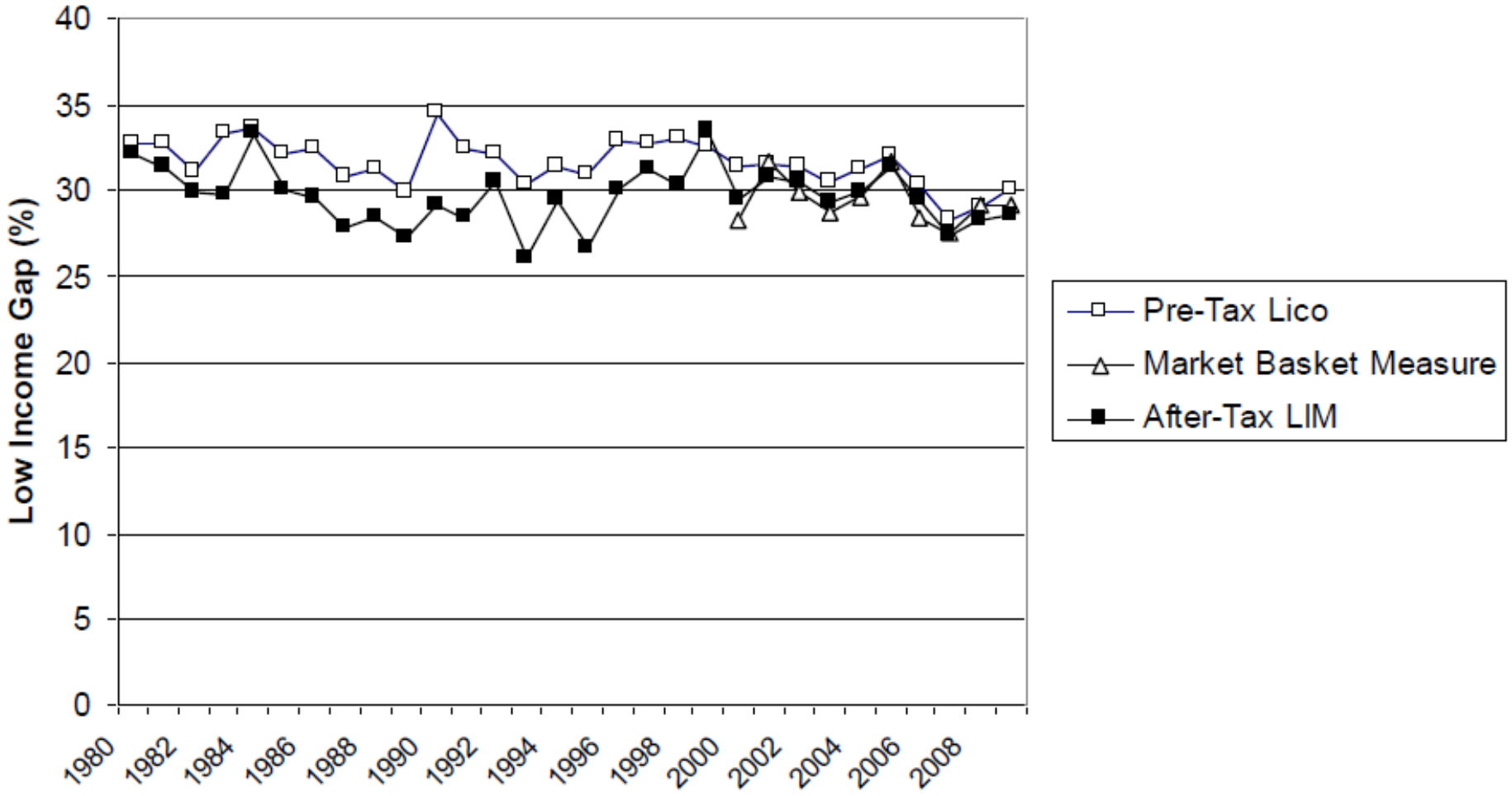
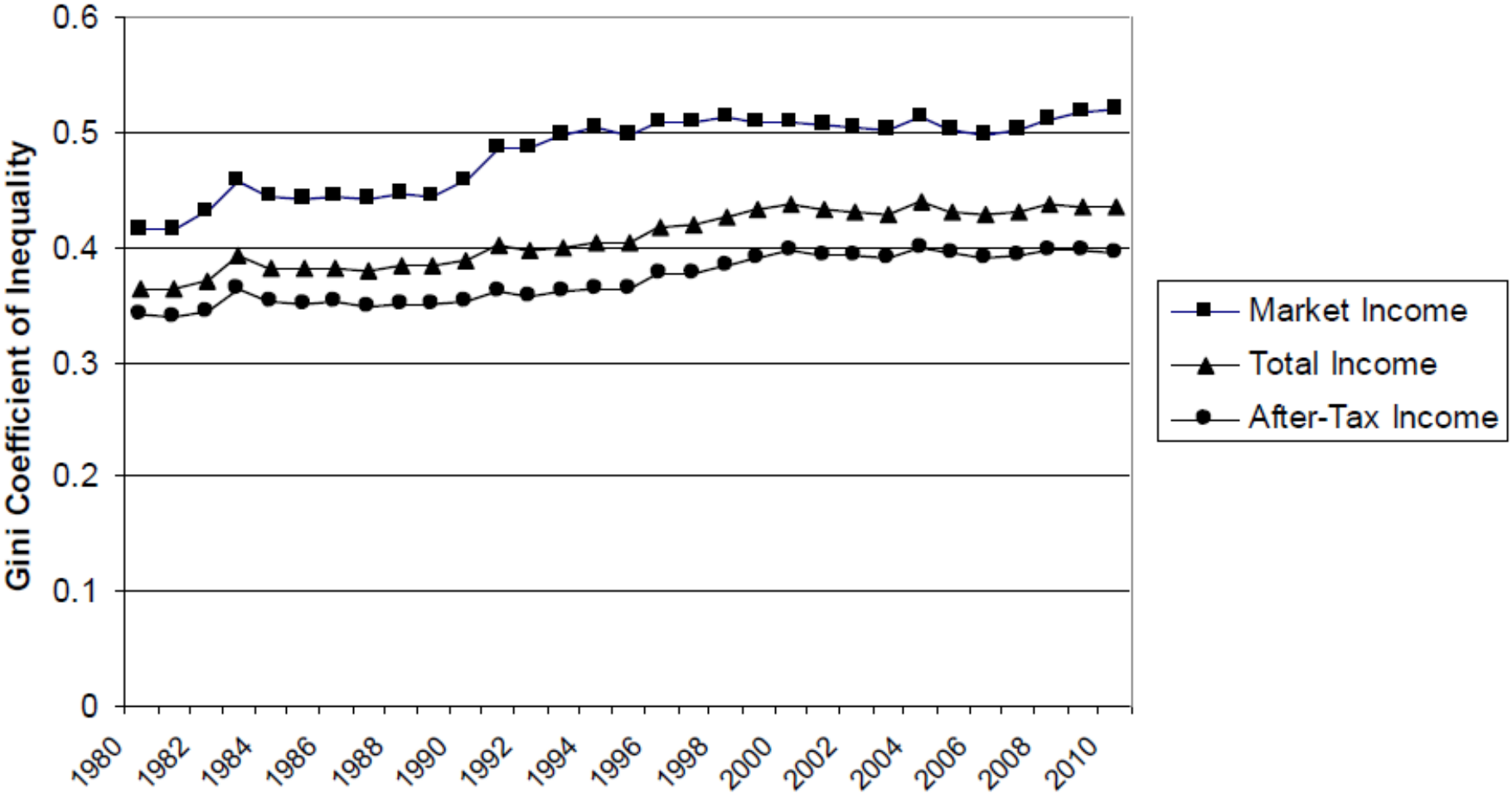


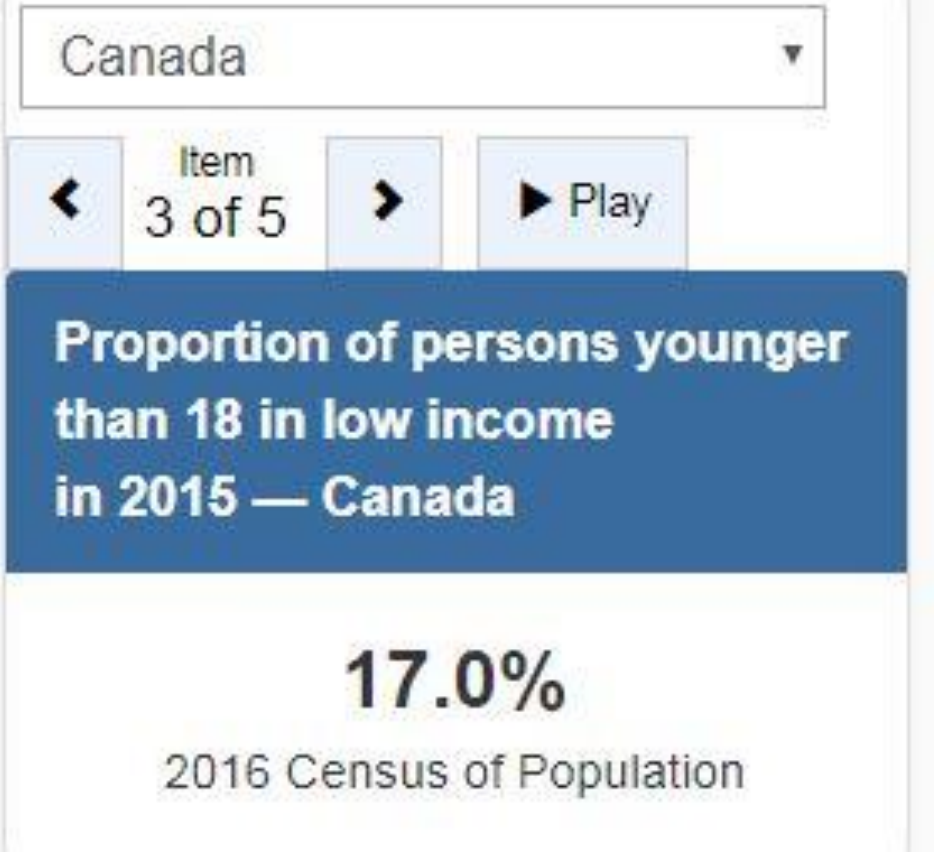
Figure Appendix V.7. Inequality in Income, All Family Units, Ontario, 1980-2010

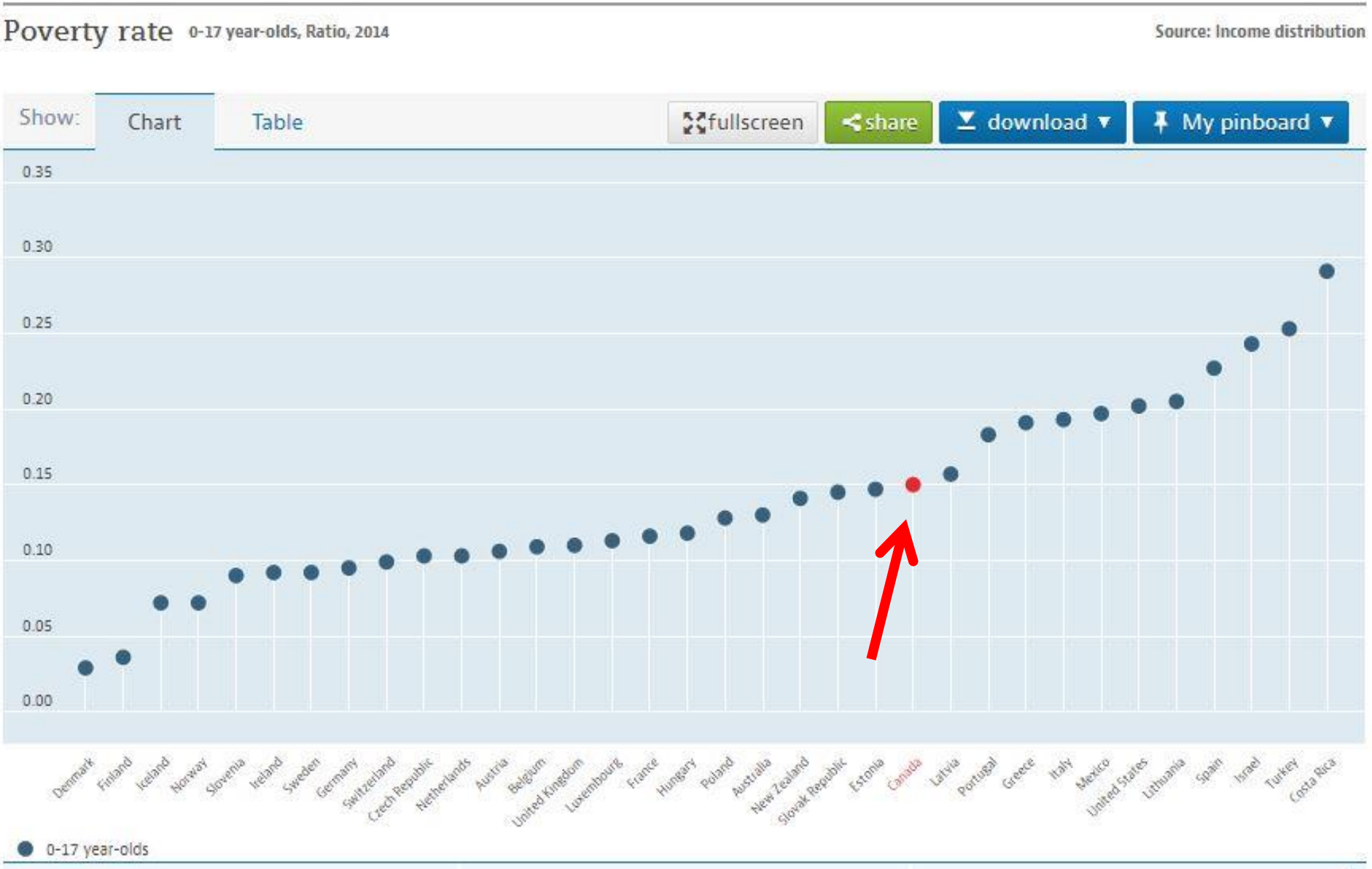



Ontario 14.4%

Source: Household income in Canada: Key results from the 2016 Census. Available at: http://www.statcan.gc.ca/daily-quotidien/170913/dq170913a-eng.htm?CMP=mstatcan

Ontario 18.4%






Source: OECD (2017). Poverty rates. Available at https://data.oecd.org/inequality/poverty-rate.htm

# Health Equity, SDOH, and Related Key Concepts

# What will Make Canada a Healthier Country?

It may not be what you think. We all know we should eat a healthy diet, exercise, and not smoke. These lifestyle choices matter, but research shows that the socio-economic, cultural, and environmental conditions of our lives – called the determinants of health – have just as strong an impact, if not stronger.

This is most starkly evident among those who are struggling in or close to poverty, and who are much more likely than other Canadians to suffer from chronic diseases, to use the health care system more frequently, and to die prematurely.

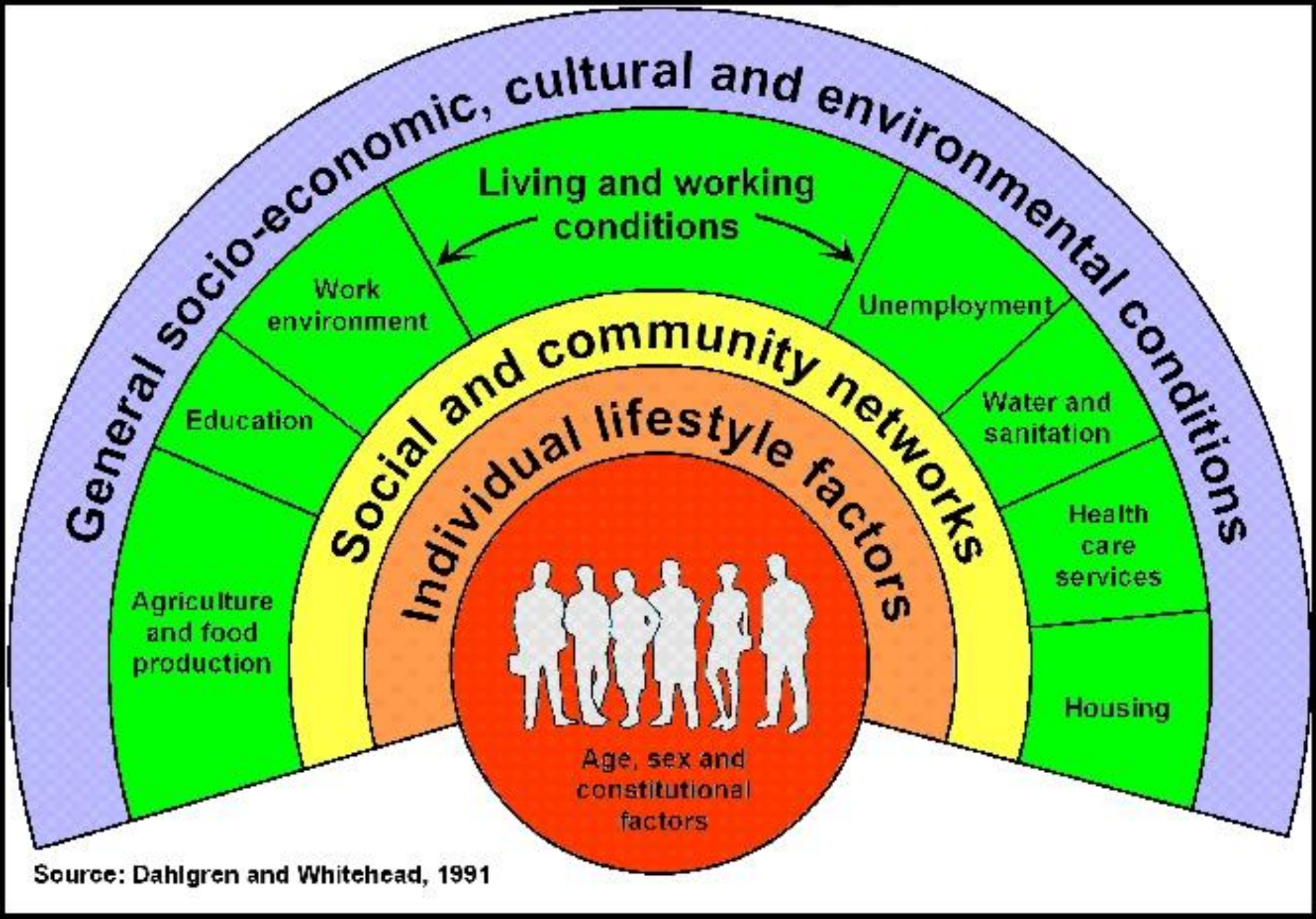
Source: Health Council of Canada (2010). *Stepping It Up: Moving the Focus from Health Care in Canada to a Healthier Canada.*

# Promoting Health Equity

- Health inequities are “systematic, socially produced (and therefore modifiable) and unfair.”
- Inequities result from circumstances stemming from socioeconomic status, living conditions and other social, geographical, and environmental determinants that can be improved upon by human actions.
- In other words, they are neither naturally predetermined nor inevitable.
- Source: Unite for Sight (2015). New Haven CT: http://www.uniteforsight.org/about-us

# What are Social Determinants of Health?

- Social determinants of health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.
- Social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members.




Source: Dahlgren and Whitehead, 1991

# The Canadian Perspective

- Aboriginal status
- disability
- early life
- education
- employment and working conditions
- food security
- health services
- gender
- housing
- income and income distribution
- race
- social exclusion
- social safety net
- unemployment

Source: Mikkonen, J. and Raphael, D. (2010). *Social Determinants of Health:* The *Canadian* Facts. On-line at http://thecanadianfacts.org

# Social Determinants of Health

***SDOH affect health in a number of ways:***

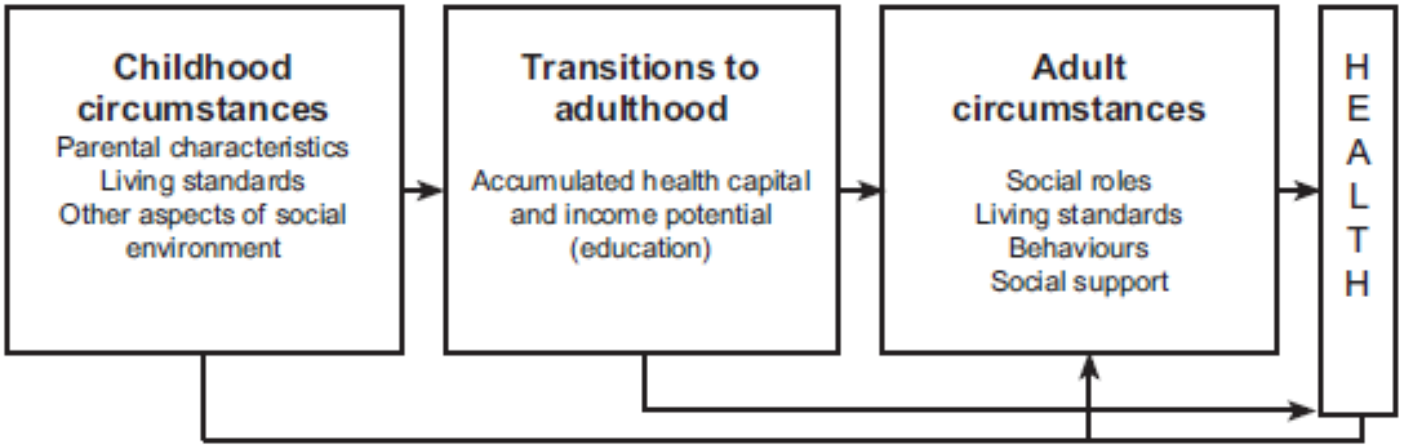
- *Social determinants define the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society;*
- *Social determinants can cause stress and anxiety which can damage people's health;*
- *Social determinants can limit peoples' choices and militates against desirable changes in behaviour.*

Source: Adapted from Benzeval, Judge, & Whitehead, 1995, p.xxi, *Tackling Inequalities in Health: An Agenda for Action.*

# Mechanisms

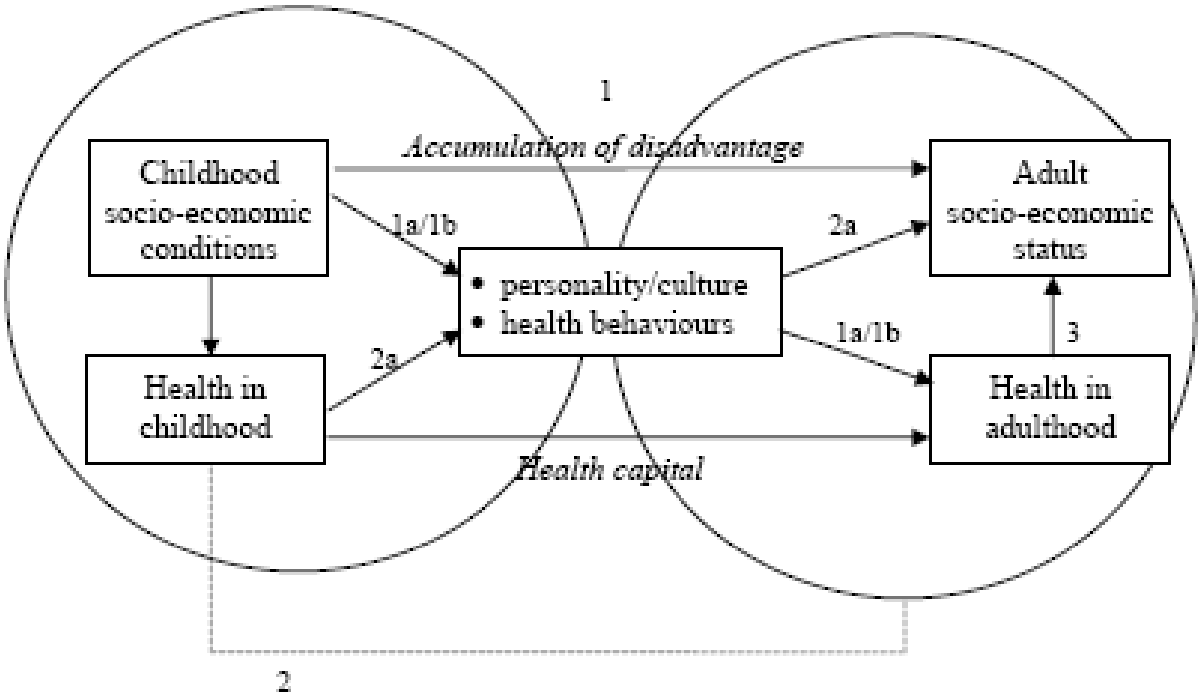
Material Living Conditions

## Figure 2.2: Income and health: A life-course perspective




Source: From "Income and Health Over the Lifecourse: Evidence and Policy Implications," by M. Benzeval, A. Dilnot, K. Judge, and J. Taylor, in *Understanding Health Inequalities* (p. 98), by H. Graham (Ed.), 2001, Buckingham, UK: Open University Press.

Figure 1: Living Conditions, Socio-economic Inequalities and Children's Health




1 contribution of childhood socio-economic conditions to socio-economic health inequalities in adult life
1a independent effect of childhood socio-economic conditions on adult health
1b independent effect of childhood socio-economic conditions on adult health through health behaviours and personality/cultural factors
2 contribution of childhood health to socio-economic health inequalities in adult life
2a contribution of childhood health to socio-economic health inequalities in adult life through selection on health in childhood
3 selection on health in adult life

Source: van de Mheen, H., K. Stronks, and J Mackenbach. 1998. "A lifecourse perspective on socioeconomic inequalities in health, Figure 1, p. 194. In the *Sociology of Health Inequalities*, edited by M. Bartley, D. Blane, and G. Davey Smith. Oxford UK: Blackwell Publishers.

Community Dent Oral Epidemiol 2000; 28: 161–9
Printed in Denmark . All rights reserved



COMMUNITY DENTISTRY AND ORAL EPIDEMIOLOGY
ISSN 0301-5661

Commissioned review

# Deprivation and oral health: a review

**D. Locker**
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Locker D: Deprivation and oral health: a review. Community Dent Oral Epidemiol 2000; 28: 161–9. © Munksgaard, 2000

Abstract – The link between socioeconomic status and health, including oral health, is well established. The conventional measures of socioeconomic status used in these studies, such as social class and household income, have a number of weaknesses so that alternatives, in the form of area-based measures of deprivation, are increasingly being used. This paper reviews epidemiological research linking deprivation and oral health. Four types of study are identified and described: simple descriptive, comparative, analytic and explanatory. These studies confirm that deprivation indices are sensitive to variations in oral health and oral health behaviours and can be used to identify small areas with high levels of need for dental treatment and oral health promotion services. As such, they are likely to provide a useful administrative tool. In terms of research, the studies demonstrate that these measures provide a ready way of controlling for socioeconomic status in studies examining the association between oral health and other variables. However, this research, in largely replicating previous studies using social class, does not address fundamental issues concerning the mechanisms which link social inequality and health. Deprivation measures have a major role to play in research that examines features of people and places, and how they promote and/or damage both oral and general health.

Key words: deprivation; oral health; socioeconomic status

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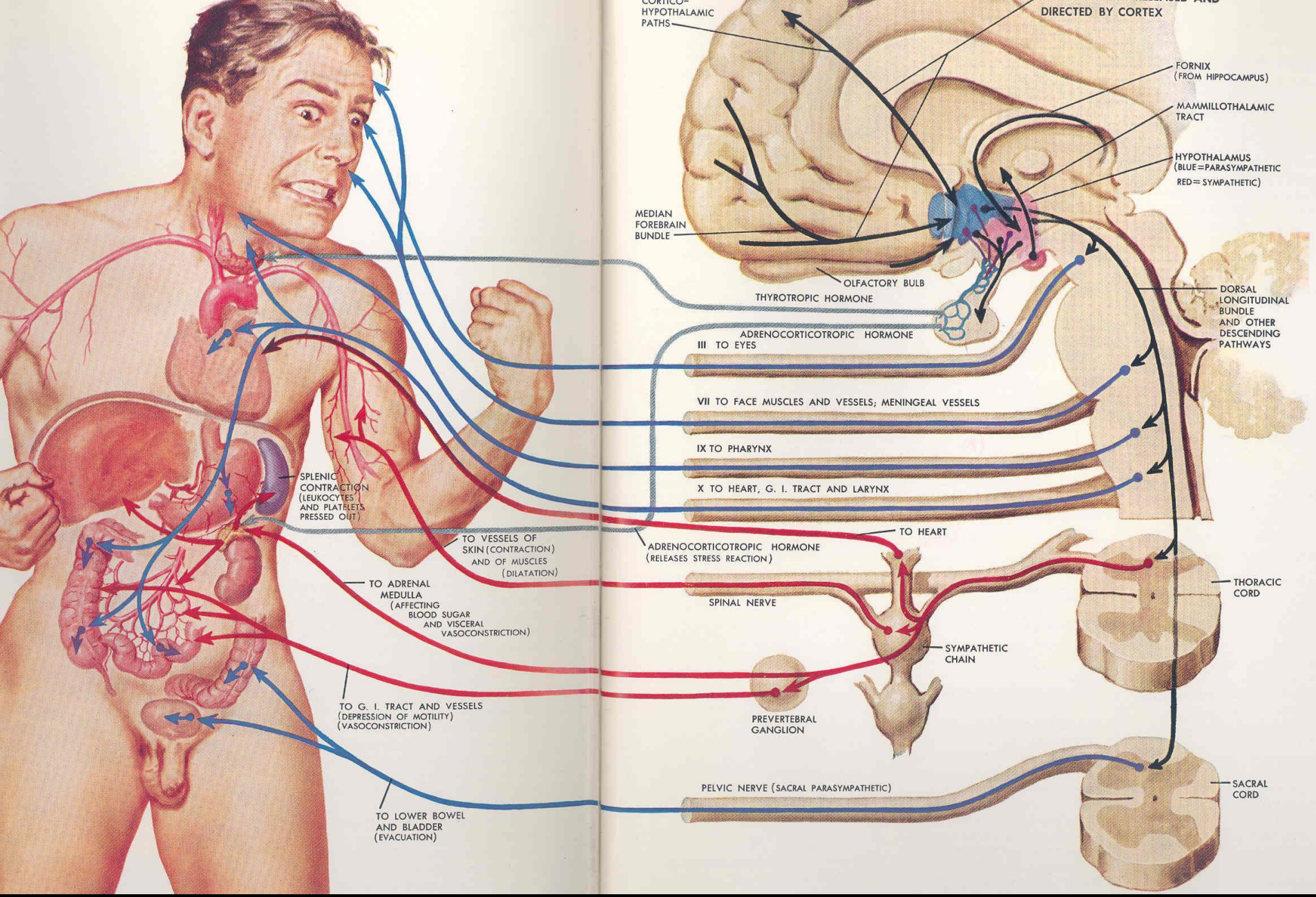
Accepted without peer review 14 February 1999

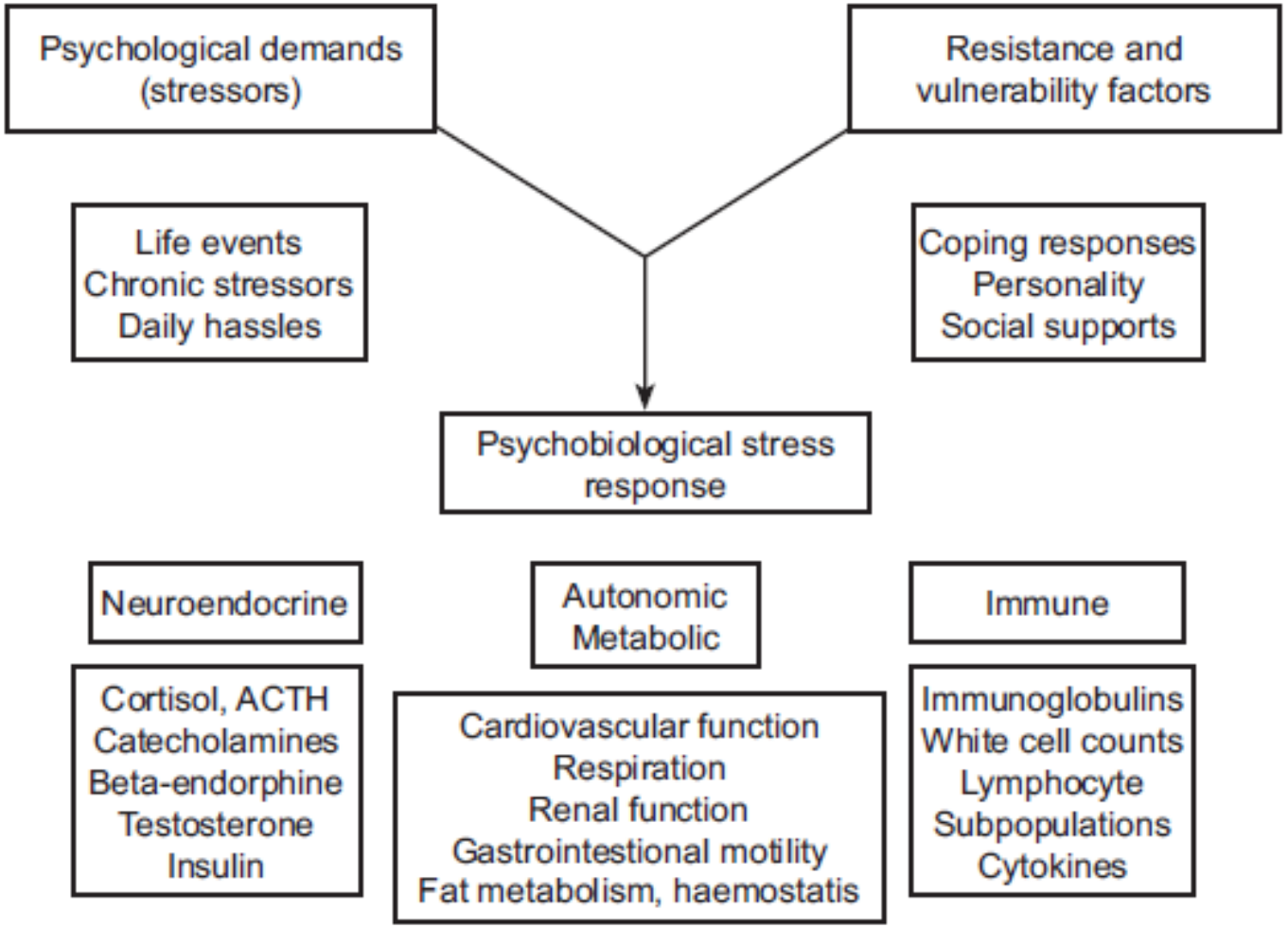
# Mechanisms

Stress




Source: Netter, F. (1964). *The Ciba Collection of Medical Illustrations, Vol. 1: Nervous System.*

## Figure 2.3: The psychobiological stress response




Source: A. Steptoe, "Psychophysiological Bases of Disease," in *Comprehensive Clinical Psychology*, vol. 8, *Health Psychology*, ed. D.W. Johnston and M. Johnston (1969): 39–78.

Vasiliou *et al. BMC Oral Health* (2016) 16:88
DOI 10.1186/s12903-016-0284-y

BMC Oral Health

RESEARCH ARTICLE Open Access

# Current stress and poor oral health

A. Vasiliou[1], K. Shankardass[2,3,4*], R. Nisenbaum[3,4] and C. Quiñonez[1,4]

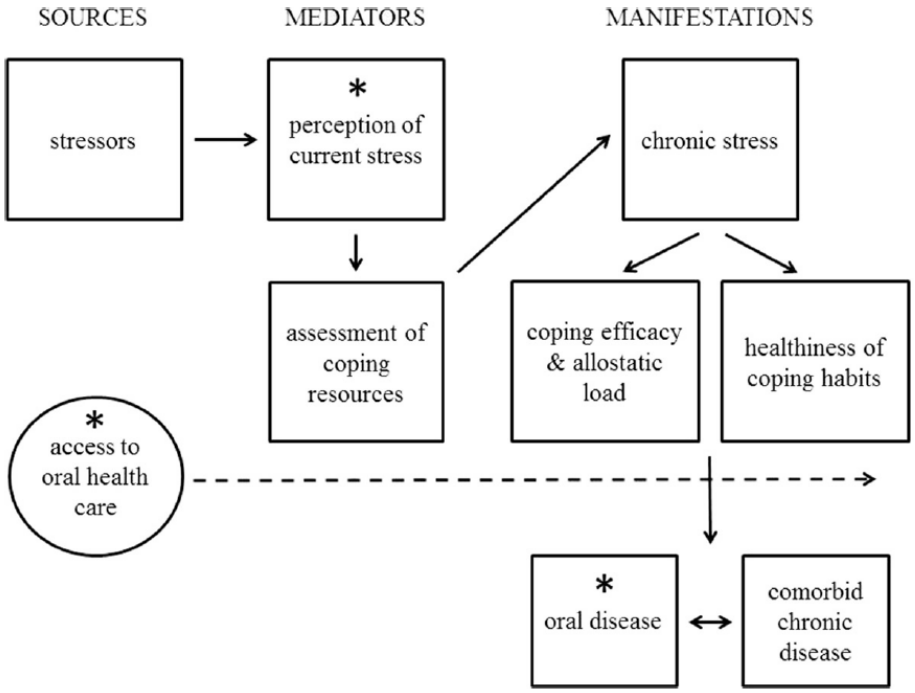



**Fig. 1** Conceptual framework of causal and moderating pathways linking the stress process to oral health practices and outcomes. Boxes indicate factors involved in the stress process (i.e., sources, mediators and manifestations). Straight lines indicate main causal relationships of interest. Circle with dashed line indicates a moderating effect of oral health practices

# Mechanisms

Effects upon Health Behaviours


THE WORKING POOR

# Mechanisms

Public Policy

**TABLE 2** ***Social Determinants of Health and their Public Policy Antecedents***

| Determinants | Public policy antecedent |
|---|---|
| Aboriginal status | Culturally appropriate education, social and health care services; control over local community institutions |
| Early life | Adequate income either inside or outside the working force, availability of good childcare and early education, support services |
| Education | Support for literacy initiatives, greater public spending, tuition policy |
| Employment and working conditions | Training and retraining programs (active labour policy), support for collective bargaining, increasing worker input into workplaces |
| Food security | Developing adequate income and poverty-reduction policies, promoting health food policy, providing affordable housing |
| Gender | Pay equity legislation, access to employment benefits, affordable and good childcare |
| Health services | Managing resources effectively, providing comprehensive accessible, responsive and timely care |
| Housing | Providing adequate income and affordable housing, reasonable rental controls and housing supplements, providing social housing for those in need |
| Income and income distribution | Fair taxation policy, adequate minimum wages, and social assistance levels that support health |
| Social exclusion | Developing and enforcing anti-discrimination laws, providing ESL and job training, approving foreign credentials, supporting a variety of other health determinants |
| Social safety net | Providing supports comparable to those provided in other developed nations |
| Unemployment and employment security | Active labour policy, providing adequate replacement benefits, enforcing labour legislation and workplace regulations |

Raphael, D. (2009). Restructuring society in the service of mental health promotion: Are we willing to address the social determinants of mental health*? International Journal of Mental Health Promotion, 11,* 18-31.

Health Policy 97 (2010) 250–258

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# How much of the income inequality effect can be explained by public policy? Evidence from oral health in Brazil

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*Objectives:* To evaluate the association between income inequality, a public policy scale and to oral health.

*Conclusions:* Income inequality effect was explained mainly by public policies, which had an independent effect that was greater among the better-off.

Quiñonez and Grootendorst *International Journal for Equity in Health* 2011, **10**:14
http://www.equityhealthj.com/content/10/1/14

INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH

RESEARCH Open Access

# Equity in dental care among Canadian households

Carlos Quiñonez[1*] and Paul Grootendorst[2]

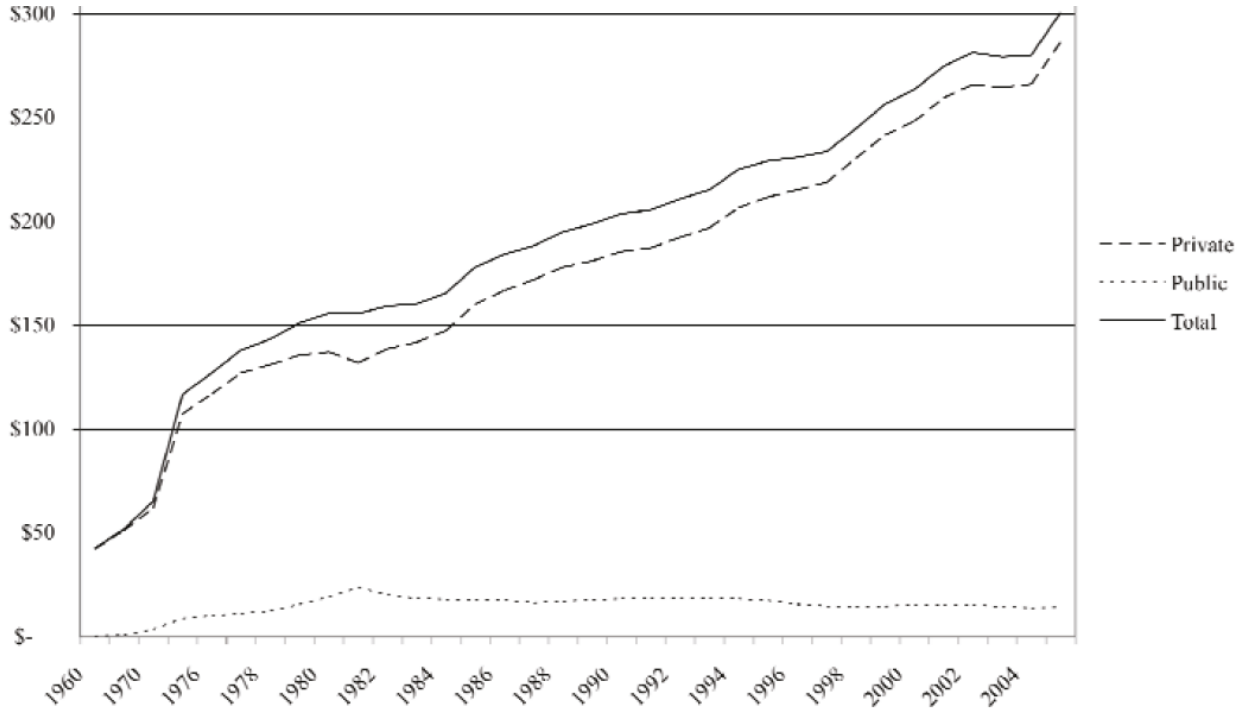



**Figure 2 Total, private, and public per capita dental care expenditures, Canada, 1960-2005 (constant dollars)**. Source: Historical Statistics

# Situation in NBPSDHU region as it relates to SDOH and HE

# Average Family Income

***Definitions:***

**Economic family** refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law, adoption, or a foster relationship. A couple may be of opposite or same sex.

**Family income** refers to the total combined income of all members of a family. Families can be couple-only families, couple-with-children families, and lone-parent families

**After-tax income of family** refers to total income from all sources minus federal provincial and territorial income taxes paid for 2010.

**Average income of economic families** refers to the weighted mean total income of families in 2010, which is calculated by dividing the aggregate income of specific group of families by the number of families in that group.

***Data source:***

Statistics Canada, 2011 National Household Survey (NHS). Date Extracted October 2015.

- Economic families in the North Bay Parry Sound District Health Unit (NBPSDHU) region have a lower average after-tax income ($70,759) compared to Ontario ($83,322; Table 1).
- Lone-parent economic families earn less compared to couple-only families and couple-with-children families in the NBPSDHU region, North East Local Health Integration Network (NELHIN) region, and Ontario (Table 1).
- The proportion of couple-with children economic families (36.8%) was lower than couple-only economic families (46.5%) in NBPSDHU area, with the reverse seen in Ontario (47.9%, and 33.9%, respectively).

**Table 1. Average economic family income and proportion of total population, by health region, 2010**

| Economic Family | NBPSDHU | | NELHIN | | Ontario | |
|---|---|---|---|---|---|---|
| | **Before tax** | **After tax** | **Before tax** | **After tax** | **Before tax** | **After tax** |
| Couple-only ($) | 74,489 | 63,966 | 75,510 | 64,704 | 89,678 | 74,551 |
| *% of total* | *46.5* | | *44.2* | | *33.9* | |
| Couple-with-children ($) | 103,111 | 88,106 | 108,530 | 91,376 | 121,285 | 99,843 |
| *% of total* | *36.8* | | *38.8* | | *47.9* | |
| Lone-parent ($) | 50,857 | 45,430 | 50,349 | 45,301 | 58,622 | 51,624 |
| *% of total* | *13.4* | | *14.2* | | *14.8* | |

# EDUCATION

***Definitions:***

**Post-secondary graduates** include individuals who reported their highest completed education included trades, college, or university qualifications.. This includes apprenticeship or trades certificates or diplomas, college, CEGEP or other non-university certificates or diplomas, and university certificates, diplomas and degrees.

***Data source:***

Statistics Canada, 2011 National Household Survey (NHS). Table 109-0400- National Household Survey indicator profile, Canada, provinces, territories, health regions (2014 boundaries) and peer groups every 5 years (number unless otherwise noted). Date Extracted: October 2015.

- In 2011, 87.2% of the population aged 25 to 29 in North Bay Parry Sound District Health Unit (NBPSDHU) region had completed high school, compared to 87.3% in the North East Health Integration Network (NELHIN) region and 90.8% in Ontario (Table 1).
- Of the population aged 25 to 54 years in NBPSDHU, 62.5% reported they had completed post-secondary education, lower than Ontario (67.2%; Table 1).

**Table 1. Number and percent of reported education status, by age group and health region, 2011**

| Highest Education | NBPSDHU | NELHIN | Ontario |
|---|---|---|---|
| Population aged 25 to 29 years | 6,345 | 28,990 | 808,445 |
| High school graduates aged 25 to 29 | 5,535 | 25,300 | 734,305 |
| *% of population aged 25 to 29 years* | *87.2* | *87.3* | *90.8* |
| Population aged 25 to 54 | 47,220 | 214,990 | 5,405,490 |
| Post-secondary graduates aged 25 to 54 | 29,490 | 135,200 | 3,631,685 |
| *% of population aged 25 to 54 years* | *62.5* | *62.9* | *67.2* |

# CHILDREN LIVING IN LOW INCOME AFTER-TAX HOUSEHOLDS

***Low income after-tax (LIM-AT) households:***
Households with household incomes that are 50% of the Canadian after-tax median income adjusted for family size and age of children. For a more detailed explanation of the method for deriving the LIMs-AT, see: http://www12.statcan.gc.ca/nhs-enm/2011/ref/dict/fam021-eng.cfm

***Couple family household:***
Refers to a married or common-law couple, either with or without children. A couple may be of same or opposite sex, or an intact or stepfamily.

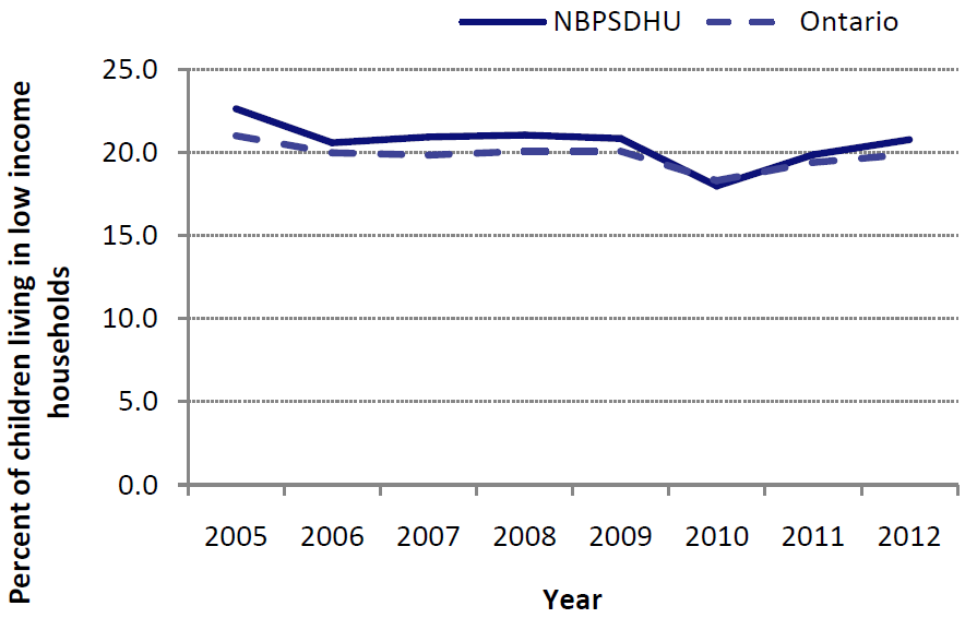
***Lone-parent family household:***
Refers to a lone parent of any marital status, with at least one child.

***Data sources:***
*LIM-AT* – Statistics Canada, Income Statistics Division & Small Area and Administrative Data Division, Table 18: Family data – After-tax low income, 2005-2012

## Children Living in Low Income After-tax Households

In 2012, 20.8% of children aged 17 years and younger in the North Bay Parry Sound District Health Unit (NBSPDHU) region lived in low income after-tax households (LIM-AT), compared to 19.9% in Ontario (see Figure 1). In the NBPSDHU region, the percentage of children living in low income after-tax households decreased from 22.6% in 2005 to 20.8% in 2012.

**Figure 1. Percentage of Children Aged 17 Years and Younger Living in LIM-AT Households, by Health Region and Year.**



# EMPLOYMENT

***Definitions:***

**Labour force** refers to persons who, during the week of Sunday, May 1 to Saturday, May 7, 2011, were either employed or unemployed.

**Employed** refers to the number of persons employed in the week of Sunday, May 1 to Saturday, May 7, 2011, expressed as a percentage of the total population.

**Unemployed** refers to persons who, during the week of Sunday, May 1 to Saturday, May 7, 2011, were without paid work or without self-employment work and were available for work and either:

- Had actively looks for paid work in the past four weeks; or
- Were on temporary lay-off and expected to return to their job; or
- Had definite arrangements to start a new job in four weeks or less.

The **long term unemployed** includes unemployed individuals who last worked in or before 2010.

The **unemployment rate** is the number of unemployed persons expressed as a percentage of the labour force.

The **employment rate** is the number of employed persons expressed as a percentage of the total population.

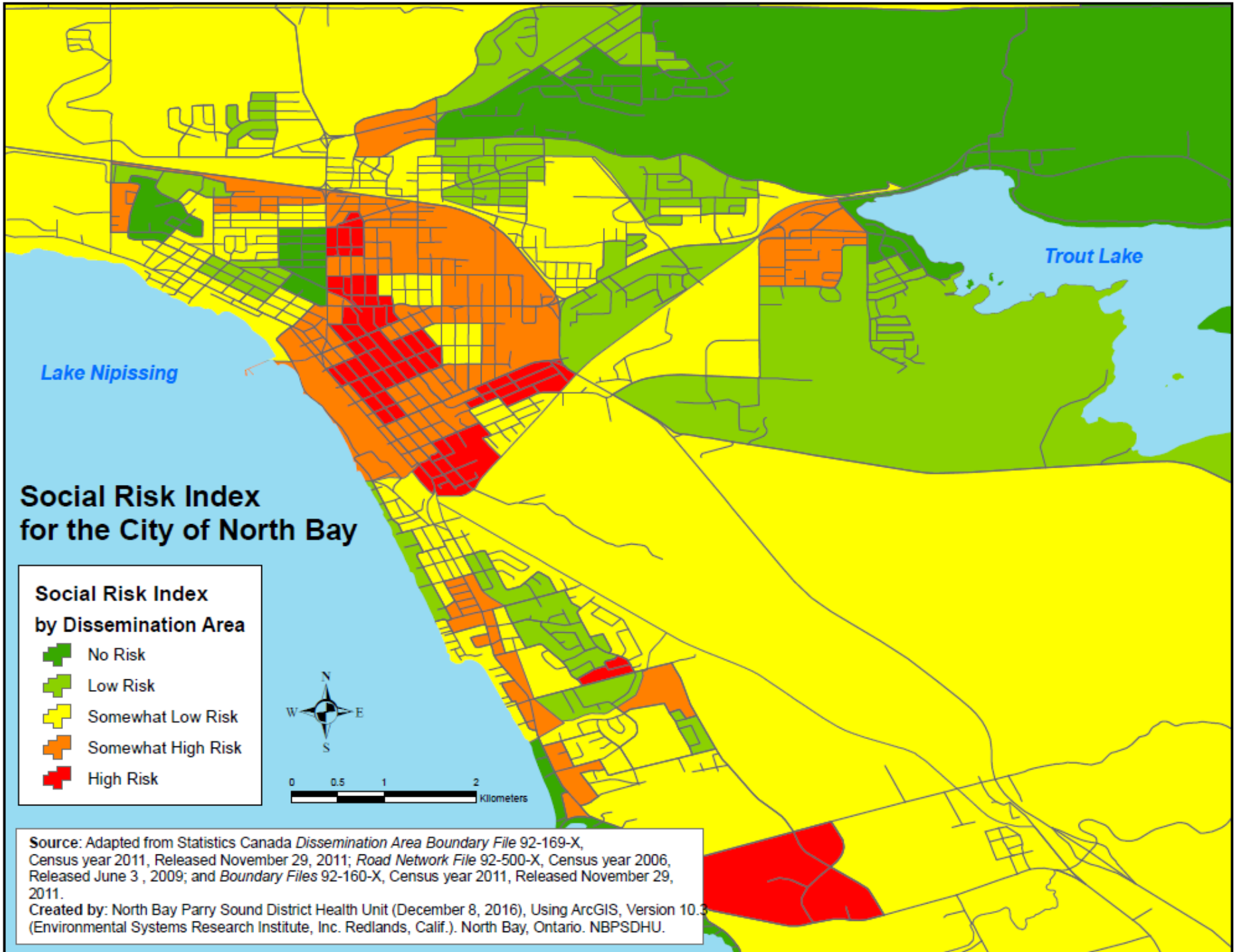
## Employment Status

The unemployment rate of the labour force aged 15 years and older in the North Bay Parry Sound District Health Unit (NBPSDHU) region was 10.0%, compared to 9.5% for the North East Health Integration Network (NELHIN) region and 8.3% for Ontario (Table 1).

Approximately three-quarters (77.3%) of the population aged 25 to 54 years in the NBPSDHU region were employed, compared to 77.8% in the NELHIN region and 79.9% in Ontario (Table 1).

**Table 1. Employment status, by age and health region, 2011**

| Employment Status | NBPSDHU | NELHIN | Ontario |
|---|---|---|---|
| Labour force aged 15 years and older | 61,780 | 274,215 | 686,4985 |
| *Unemployment rate 15+ years (%)* | *10.0* | *9.5* | *8.3* |
| Long-term unemployed | 3,685 | 14,525 | 330,545 |
| *Long-term unemployment rate labour force 15+ years (%)* | *6.0* | *5.3* | *4.8* |
| Employed persons aged 25 to 54 years | 36,500 | 167,170 | 431,8600 |
| *Employment rate 25-54 years (%)* | *77.3* | *77.8* | *79.9* |




**Source**: Adapted from Statistics Canada *Dissemination Area Boundary File* 92-169-X, Census year 2011, Released November 29, 2011; *Road Network File* 92-500-X, Census year 2006, Released June 3 , 2009; and *Boundary Files* 92-160-X, Census year 2011, Released November 29, 2011.

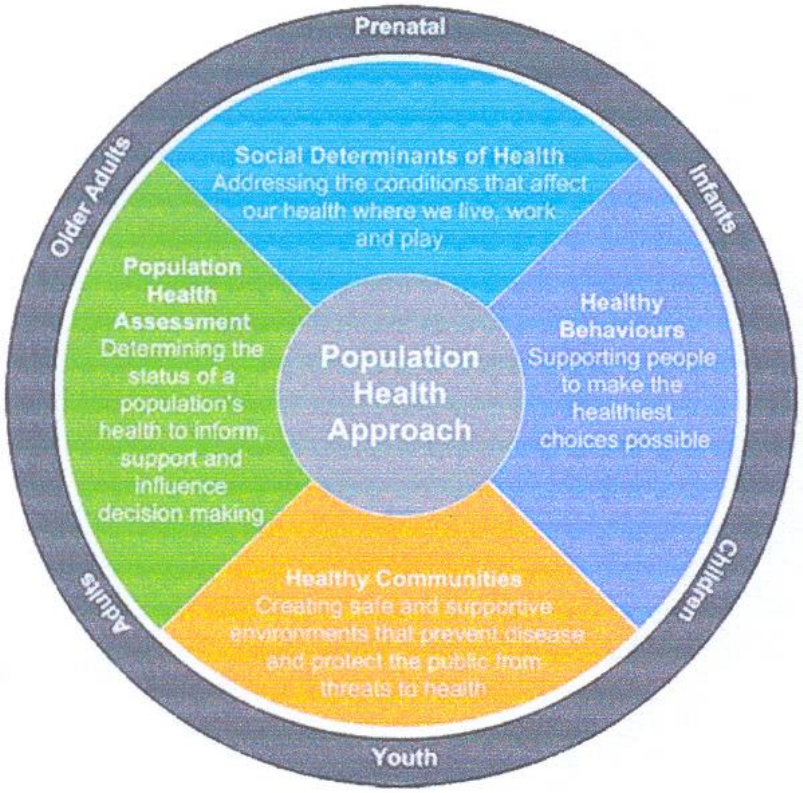
**Created by**: North Bay Parry Sound District Health Unit (December 8, 2016), Using ArcGIS, Version 10.3 (Environmental Systems Research Institute, Inc. Redlands, Calif.). North Bay, Ontario. NBPSDHU.

Ontario landscape with perspective on (e.g., Public Health Standards, linking of LHINs, Patients First, BIG)

# New Public Health Standards

The Good, Bad and the Ugly
(with apologies to Clint Eastwood)

## Figure 1: What is Public Health?




Public health work is grounded in a population health approach – focused on upstream efforts to promote health and prevent diseases to improve the health of populations and the differences in health among and between groups. Health risks and priorities change as people grow and age and public health works to address health across the life course.

3

## Figure 2: Policy Framework for Public Health Programs and Services

| | | | | | |
|---|---|---|---|---|---|
| **GOAL** | To improve and protect the health and well-being of the population of Ontario and reduce health inequities | | | | |
| **POPULATION HEALTH OUTCOMES** | • Improved health and quality of life<br>• Reduced morbidity and mortality<br>• Reduced health inequity among population groups | | | | |
| **DOMAINS** | **Social Determinants of Health** | **Healthy Behaviours** | **Healthy Communities** | **Population Health Assessment** | |
| **OBJECTIVES** | To reduce the negative impact of social determinants that contribute to health inequities | To increase knowledge and opportunities that lead to healthy behaviours | To increase policies and practices that create safe, supportive and healthy environments | To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system | |
| **ENABLERS** | Legislation | Funding | Evidence | Agencies & Associations | Municipal & Federal Governments | Partner Organizations |
| **PROGRAMS AND SERVICES** | **GOALS**<br>• To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system<br>• To reduce health inequities with equity focused public health practice<br>• To increase the use of current and emerging evidence to support effective public health practice<br>• To improve behaviours, communities and policies that promote health and well-being<br>• To improve growth and development for infants, children and adolescents<br>• To reduce disease and death related to infectious and communicable diseases of public health importance<br>• To reduce disease and death related to vaccine preventable diseases<br>• To reduce disease and death related to food, water and other environmental hazards<br>• To reduce the impact of emergencies on health | | | | |
| **PARTNERS** | Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations | | | | |

# Lifestyle drift

"The tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors".

## Goal

**Public health practice aims to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.**

## Program Outcomes

- Multi-sectoral collaboration informs development of local strategies to decrease health inequities.
- Community partners and the public are aware of local health inequities and their causes.
- There is an increased awareness on the part of the LHIN(s) and other community partners of the impact of social determinants of health on health outcomes and increased support for actions to decrease health inequities.
- Priority populations are meaningfully engaged in the planning of public health interventions.
- Indigenous communities are engaged in a way that is meaningful for them.

## Requirements

1. The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.
2. The board of health shall modify and orient public health interventions to decrease health inequities by:
   a) Engaging priority populations in considering their unique needs, histories, cultures, and capacities; and
   b) Aiming to improve the health of the entire population while leveling up the health of priority populations.
3. The board of health shall engage in community and multi-sectoral collaboration with LHIN(s) and other relevant stakeholders in decreasing health inequities. Engagement with Indigenous organizations and communities shall include, but not be limited to, fostering the creation of meaningful relationships with them, starting with engagement through to collaborative partnership.
4. The board of health shall lead, support, and participate with other stakeholders in policy development, health equity analysis, and promoting decreases in health inequities.

But what exactly is the public health unit supposed to do?

# Program Standards

## Chronic Diseases and Injury Prevention, Wellness and Substance Misuse

### Goal

**To reduce the burden of chronic diseases of public health importance, preventable injuries, and substance misuse.**[8]

### Program Outcomes

- There is a reduction in population health inequities related to chronic diseases, injuries, and substance misuse.
- Population health inequities and priority populations have been identified and relevant data have been communicated to community partners.
- Public health chronic diseases, injury prevention, and substance misuse programs and services are implemented taking into account all relevant programs and services available in the health unit.
- Community partners, including policy-makers, and the public are meaningfully engaged in the planning, implementation, development and evaluation of chronic diseases, injury prevention, and substance misuse programs and services of relevance to the community.
- There is increased public awareness of the risk factors and healthy behaviours associated with chronic diseases, substance misuse, and injuries.
- There is an increased adoption of healthy living behaviours among populations targeted through chronic diseases, injury prevention, and substance misuse program interventions.
- Youth have reduced access to tobacco products, e-cigarettes and tanning beds.
- Tobacco vendors are in compliance with the *Smoke-Free Ontario Act*.

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[8] Chronic diseases of public health importance include, but are not limited to, cardiovascular diseases, respiratory disease, cancer, diabetes, and mental illness (including problematic use of alcohol and other substances, suicide, suicide attempts, and suicide ideation). Injury, both intentional and unintentional, prevention includes, but is not limited to, falls across the lifespan, road and off-road safety, and other injuries of public health importance.

# Public Health within an Integrated Health System

Report of the Minister's Expert Panel on Public Health

# Goals of Patients First

- Effective integration of services and greater equity
- Timely access to, and better integration of, primary care
- More consistent and accessible home & community care
- Stronger links to population and public health
- Inclusion of Indigenous voices in health care planning

**Strong relationships outside the health system to protect and promote health.**

Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

**More focus on the social determinants of health and greater health equity.**

Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

**More comprehensive targeted health interventions.**

Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

**Better care pathways and health outcomes.**

A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.


ACCESS
CONNECT
INFORM
PROTECT
Patients First:
Action Plan
for Health Care
February 2015

# Patients First: Action Plan for Health Care

The ***Patients First: Action Plan for Health Care*** strengthens our commitment to put people and patients first by improving the health care experience.

This next phase builds on the progress of our 2012 *Action Plan for Health Care*.

Ontarians will have better and faster access to quality health services. They will have better information so they can make decisions that will help them live healthy and stay healthy. And their health care services will be protected for generations to come.

## *Putting patients first*

- **Support Ontarians to make healthier choices and help prevent disease and illness.**
- **Engage Ontarians on health care, so we fully understand their needs and concerns.**
- **Focus on people, not just their illness.**
- **Provide care that is coordinated and integrated, so a patient can get the right care from the right providers.**
- **Help patients understand how the system works, so they can find the care they need when and where they need it.**
- **Make decisions that are informed by patients, so they play a major role in affecting system change.**
- **Be more transparent in health care, so Ontarians can make informed choices.**

# Inform

***Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.***

For Ontarians, health is about more than just visiting a doctor. It is about learning how to stay healthy and how to manage illness when it happens. Creating a culture of health and wellness will support Ontarians in making educated, informed decisions about their care.

**Supporting Ontarians in Taking Charge of their Health**
To help Ontarians make informed decisions about healthy food choices, proposed legislation would require calories to be posted on menus in chain restaurants and other places that sell ready-to-eat food. This would also encourage the industry to offer healthier choices to their customers.

A new online screening tool, My CancerIQ, will also help inform Ontarians about their risk of developing certain types of cancer. It provides personalized recommendations to help people be more proactive about their health and take action to lessen their risk of getting cancer. This is one example of how we will provide more information and tools to increase health literacy, helping Ontarians to live healthy lives and manage illness.

**Working Towards a Smoke-Free Ontario**
To help us achieve the lowest smoking rates in Canada, we will continue to help inform young Ontarians about the health risks of smoking. We are proposing a ban on the sale of flavoured tobacco, a product that often appeals to youth, and can lead to smoking at a younger age. We have also prohibited smoking on bar and restaurant patios, playgrounds and public sports fields, and the sale of tobacco on university and college campuses. Ontario will continue to limit smoking behaviour by our proposal to ban the use of e-cigarettes in any place where smoking tobacco is not permitted, and to prohibit the sale of e-cigarettes to those under the age of 19.

**We will further promote healthy behaviours by:**

- Encouraging physical activity and healthy eating, through the Healthy Kids Strategy.
- Expanding proven programs in schools and workplaces to promote mental well-being and prevent addictions, to help people deal with challenges and recognize when they need help.
- Making it easier for children in low-income families to get dental care through a single integrated program.
- Strengthening the effectiveness of Ontario's immunization system, including better informing parents about their school-aged child's immunization status.

BASIC INCOME GUARANTEE

SERIES | JUNE 2017

# IMPLICATIONS OF A BASIC INCOME GUARANTEE FOR HOUSEHOLD FOOD INSECURITY

By Dr. Valerie Tarasuk

# Basic income an 'absolute necessity' to deal with deep poverty: Dennis Raphael

Posted by **Roderick Benns (/leaderslegacies)** 192sc on September 25, 2016

By Roderick Benns

A basic income guarantee is not a magic bullet for all forms of economic deprivation in our society, according to a York University professor – but it's absolutely necessary for the most severe instances of poverty.

Dr. Dennis Raphael, a professor of Health Policy and Management at York University in Toronto, says the people in poverty within the bottom 10-15 percent "suffer profoundly."

"A basic income is a chance to remove the most egregious forms of poverty," he says.

"A basic income is an absolute necessity, but it is only one small part. If the basic income could eliminate food banks, and if it can be in tandem with child care and Pharmacare, then there's no doubt this would be a profound achievement," says Raphael.

But by addressing a re-balancing of power between business and labour, such as the examples provided by Scandinavian and continental European countries, much more progress could be made, he points out.

"There are basic needs, and then there are the needs for a flourishing society."

Canadian Centre for Policy Alternatives | Ontario
October 2016

# Basic Income:

## Rethinking Social Policy

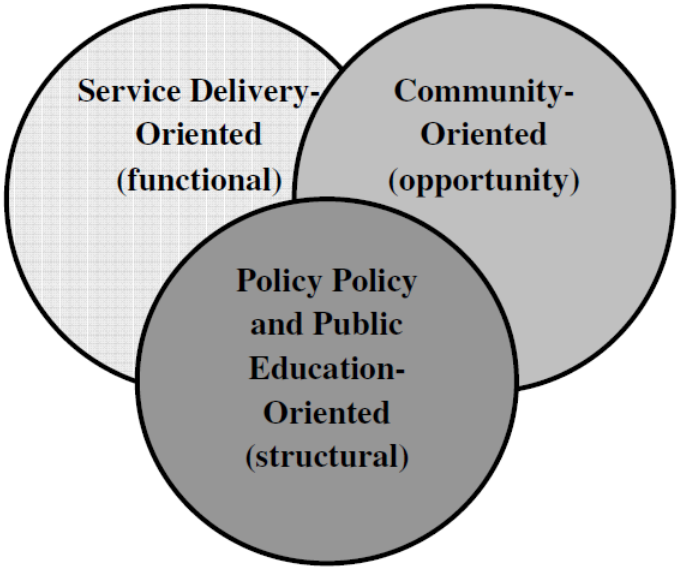
Alex Himelfarb and Trish Hennessy, editors

www.policyalternatives.ca RESEARCH ANALYSIS SOLUTIONS

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
ONTARIO OFFICE

# What is PHU & community role in advancing health equity?

A brief introduction




| Service-Delivery | Community-Oriented | Advocacy/Education |
|---|---|---|
| SDH seen primarily as risk factors shaping health outcomes | SDH seen as risk factors shaped by public policy that limits opportunities | SDH are risks caused by public policy that creates social inequities |
| SDH identify groups to whom services need to be provided | SDH identify groups with limited opportunities | SDH identify groups experiencing marginalization |
| Focus is on evidence-based health-related outcomes | Focus is on evidence-based and community-related outcomes | Focus is on evidence-based community, and structural outcomes |
| Unit organization for addressing SDH tends to be undeveloped | Unit organization for addressing SDH tends to be devolved to sections | Unit organization for addressing SDH tends to be centralized |
| SDH issues are de-politicized | SDH issues implicitly seen as political | SDH issues explicitly seen as political |

# Part 2: 11:-12:15

- Overview of Health Equity and the role of Public Health
- Discuss modernized OPHS
- How can PHU's decrease health inequities
- Emphasis on PHUs (clinical, corporate and community services). Provide examples of programs less often acknowledged (e.g., clinical & corporate services)
- Possible action at the individual at work /program/ organizational level
- Possible action at the Municipal/Provincial/Federal level
- Examples of successes and challenges in other PHUs
- Discuss current "leaders" in public health on health equity (Huron; Leeds, Grenville and Lanark; Peterborough; Sudbury; and Waterloo)

# Lifestyle Drift and Other Traps

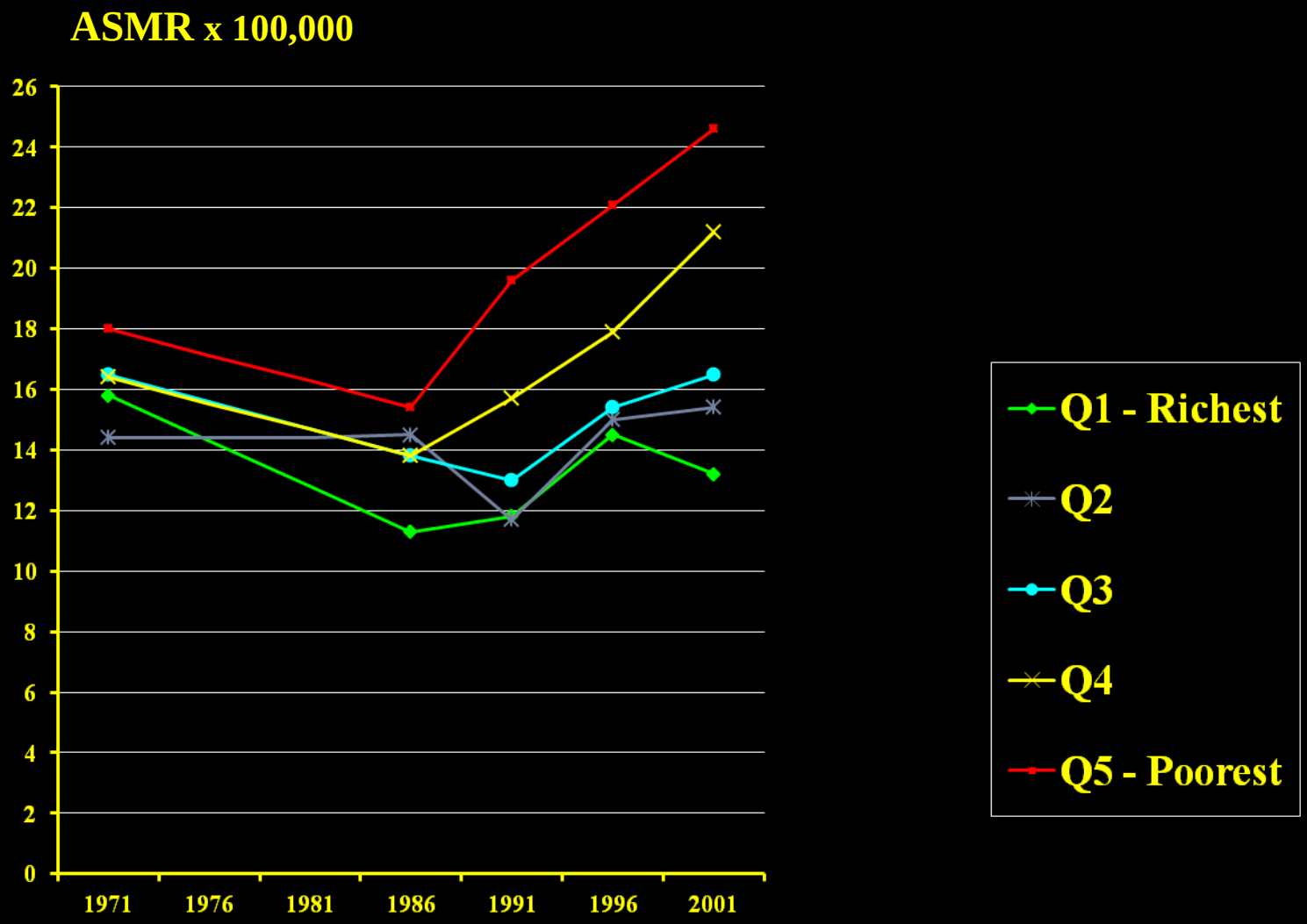
# Universal Policies drift towards interventions in individuals

Re: Lifestyle drift…

Whether or not a social problem remains in the social sphere (and is therefore seen as an area for government intervention)
or an individual problem (subject to individual responsibility) is dependent on the power dynamics between the people experiencing the problem and the broader social order…

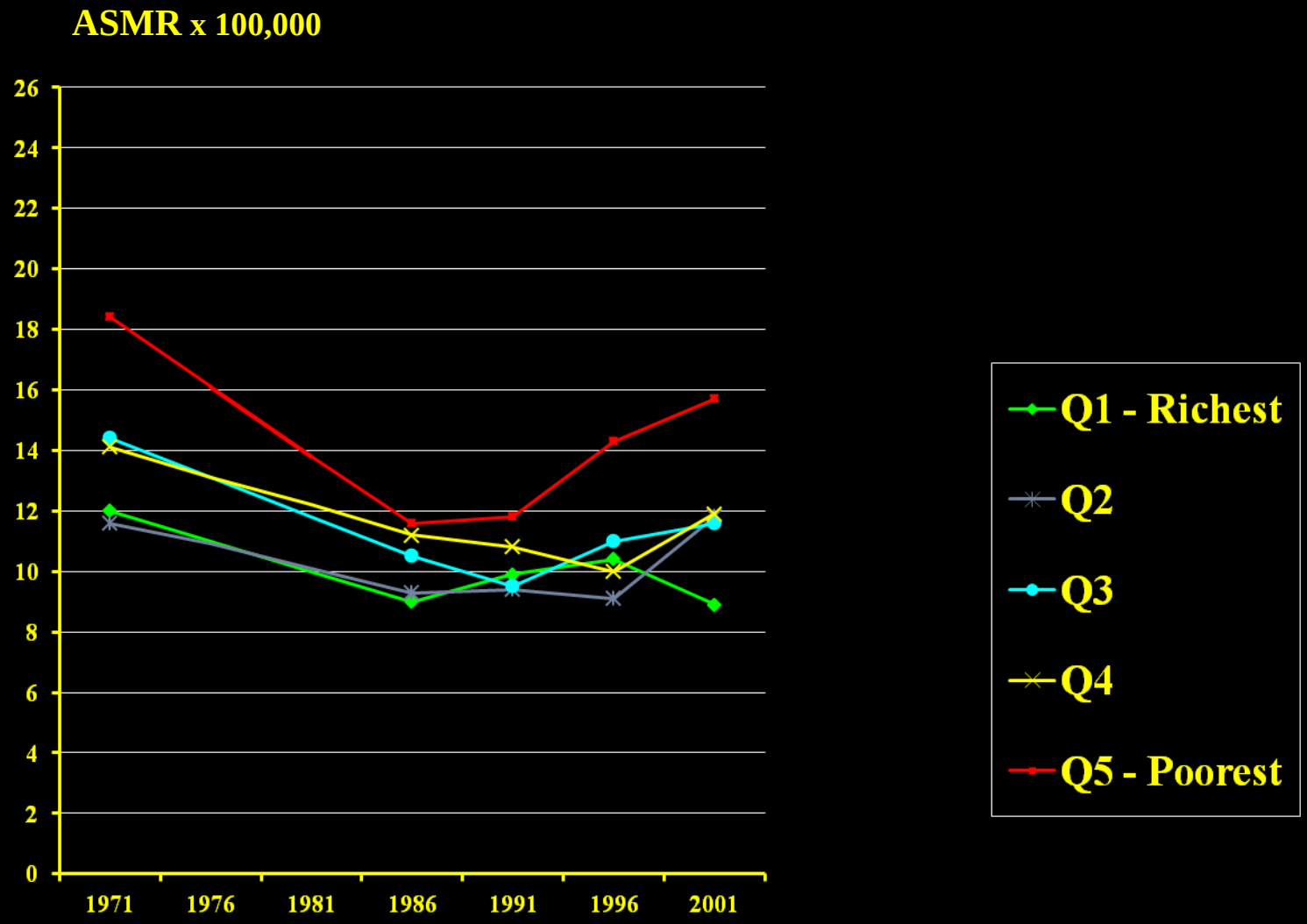
Malbon, E, Pescud, M, Baker, P. Crammond,B. Carey,G. "Whose problem is it anyway? Transforming the public health narrative to stem the tide of "lifestyle drift". Croakey. March 7,2016.

# Diabetes mortality, males, Canada



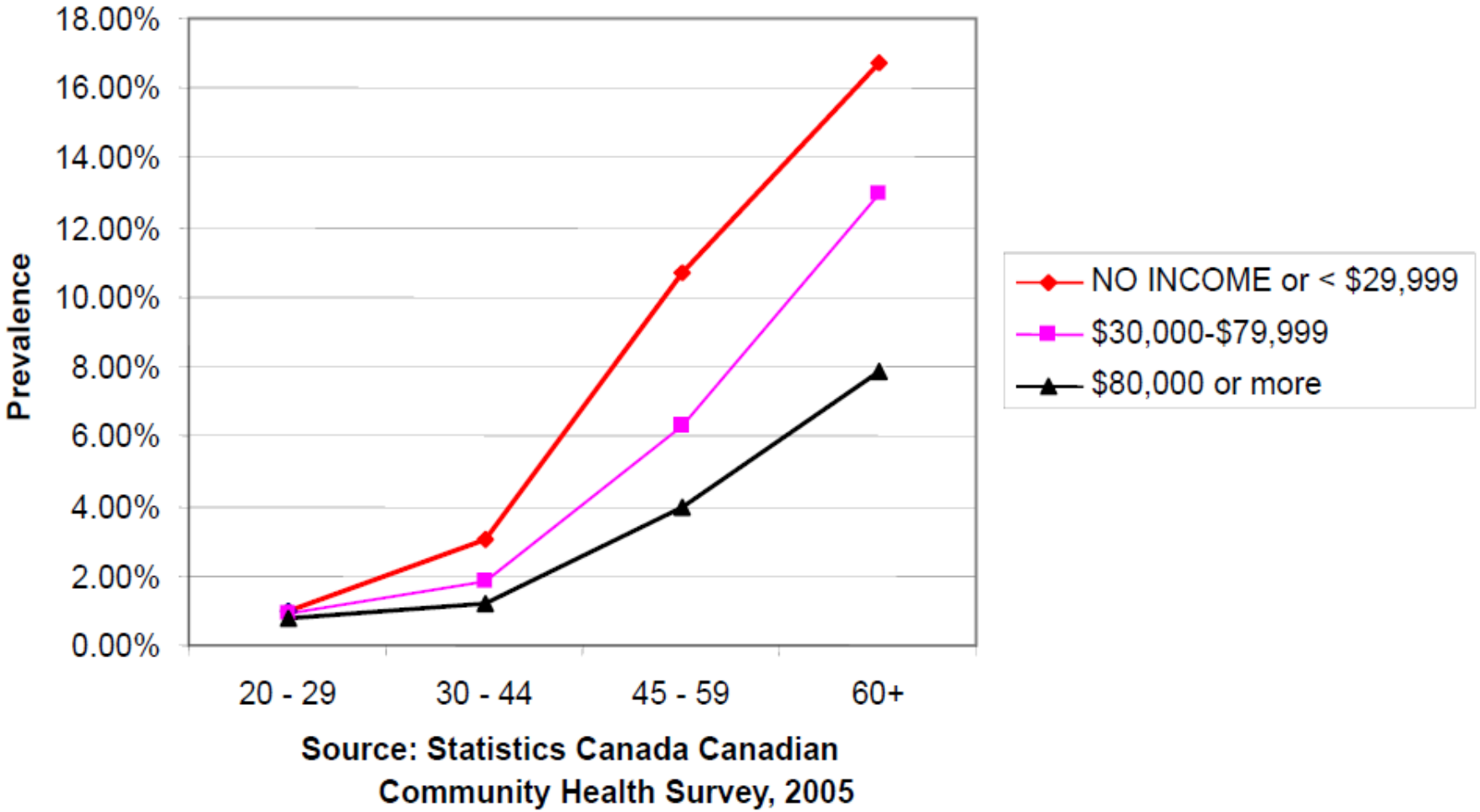

Source: Wilkins et al., 2002, *Health Reports*

# Diabetes mortality, females, Canada




Source: Wilkins et al., 2002, *Health Reports*

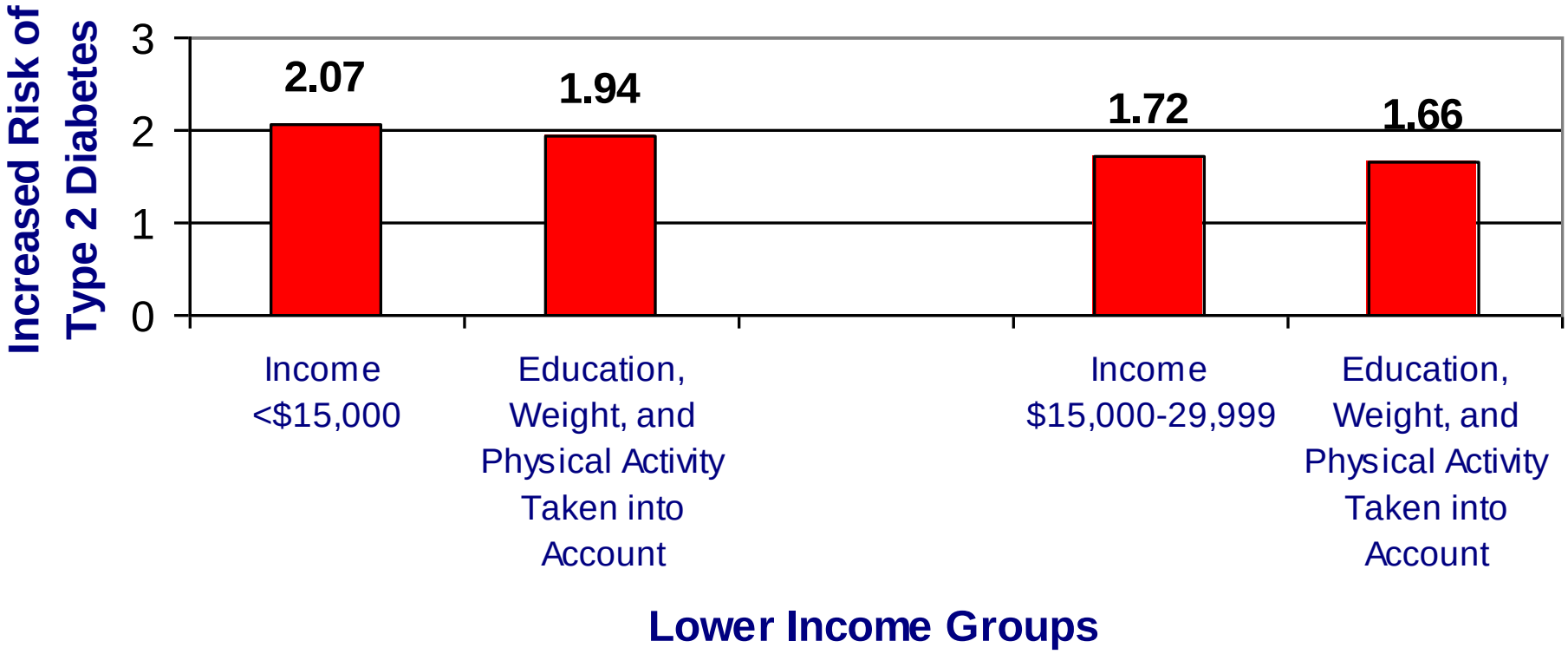
## Diabetes prevalence by age and income




**Source: Statistics Canada Canadian Community Health Survey, 2005**

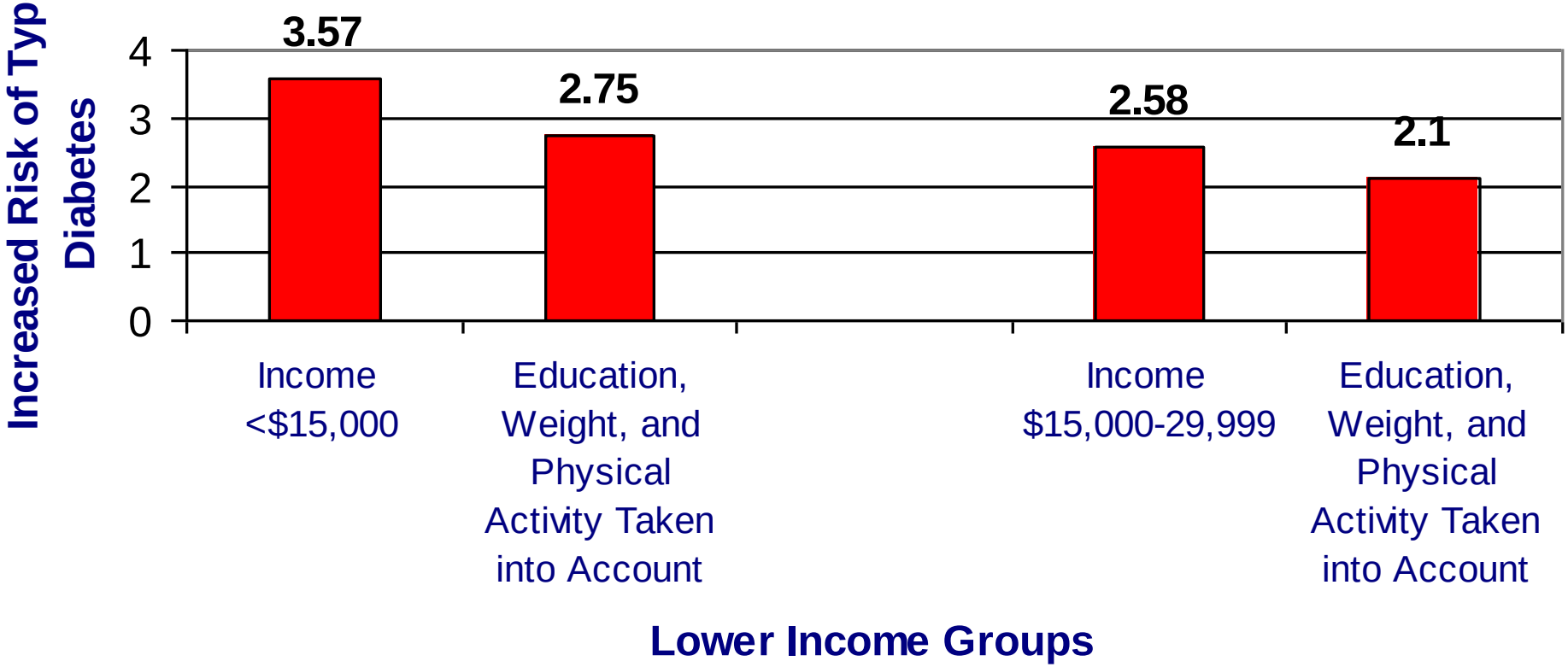
**Source: Dinca-Panaitescua, S., Dinca-Panaitescu, M., Bryant, T., Daiski, I., Pilkington, B., & Raphael, D. (2011). Diabetes prevalence and income: Results of the Canadian Community Health Survey. Health Policy, 99, 116-123.**

## Figure 4. Increased Risk of Type 2 Diabetes for Lower Income Men not Affected by Weight or Physical Activity



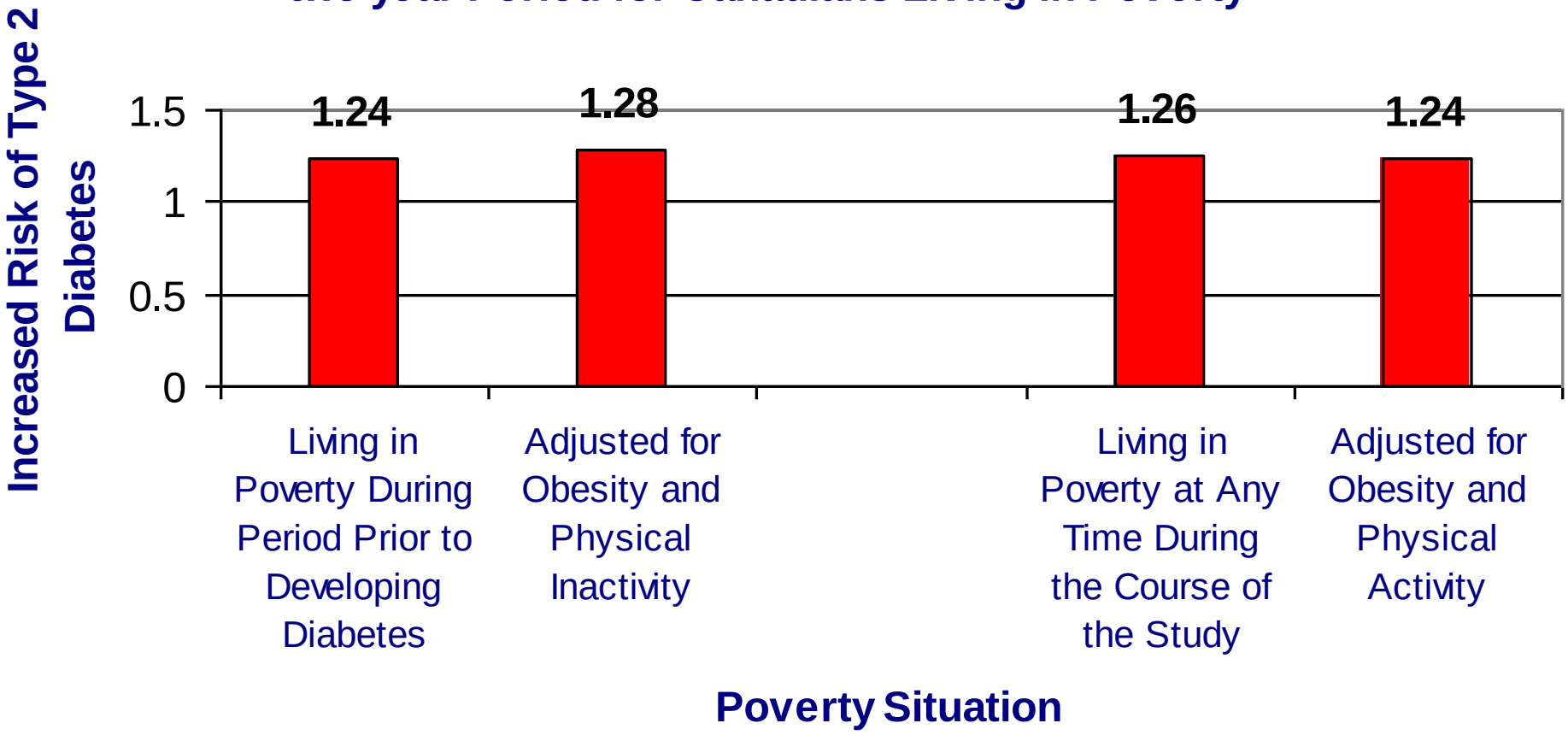

Source: Adapted from Dinca-Panaitescu, S., Dinca-Panaitescu, M., Bryant, T., Daiski, I. Pilkington, B. and Raphael, D. (2011). Diabetes prevalence and income: Results of the Canadian Community Health Survey. *Health Policy,* 99, 116–123

## Figure 5. Increased Risk of Type 2 Diabetes for Lower Income Women Slightly Affected by Weight and Physical Activity




Source: Adapted from Dinca-Panaitescu, S., Dinca-Panaitescu, M., Bryant, T., Daiski, I. Pilkington, B. and Raphael, D. (2011). Diabetes prevalence and income: Results of the Canadian Community Health Survey. *Health Policy,* 99, 116–123

## Figure 6. Increased Risk of Developing Type 2 Diabetes over a two year Period for Canadians Living in Poverty




Dinca-Panaitescua, S., Dinca-Panaitescu, M., Bryant, T., Daiski, I. Pilkington, B. and Raphael, D. (2011). Dinca-Panaitescua, M., Dinca-Panaitescu, S., Raphael, D., Bryant, T., Daiski, I. and Pilkington, B. (2012). The dynamics of the relationship between diabetes incidence and low income: Longitudinal results from Canada's National Population Health Survey. Maturitas, 72, (3), 229-235

# What We Know about Major Chronic Diseases

- **Material deprivation and adversity** during childhood and adulthood make independent contributions to the incidence – and management -- of heart disease and adult-onset diabetes.
- Three pathways mediate this relationship: **material effects**, **psychosocial responses**, and health threatening **coping behaviours.**
- The effects of **living and working conditions** **swamp** the effects of behavioural risk factors.
- **Poverty**, **unemployment,** and adverse **working conditions** are key contributors to incidence and management of these diseases.

ICOHIRP
international centre for oral health inequalities research & policy
a global network committed to promoting oral health equity

# Social inequalities in oral health: from evidence to action

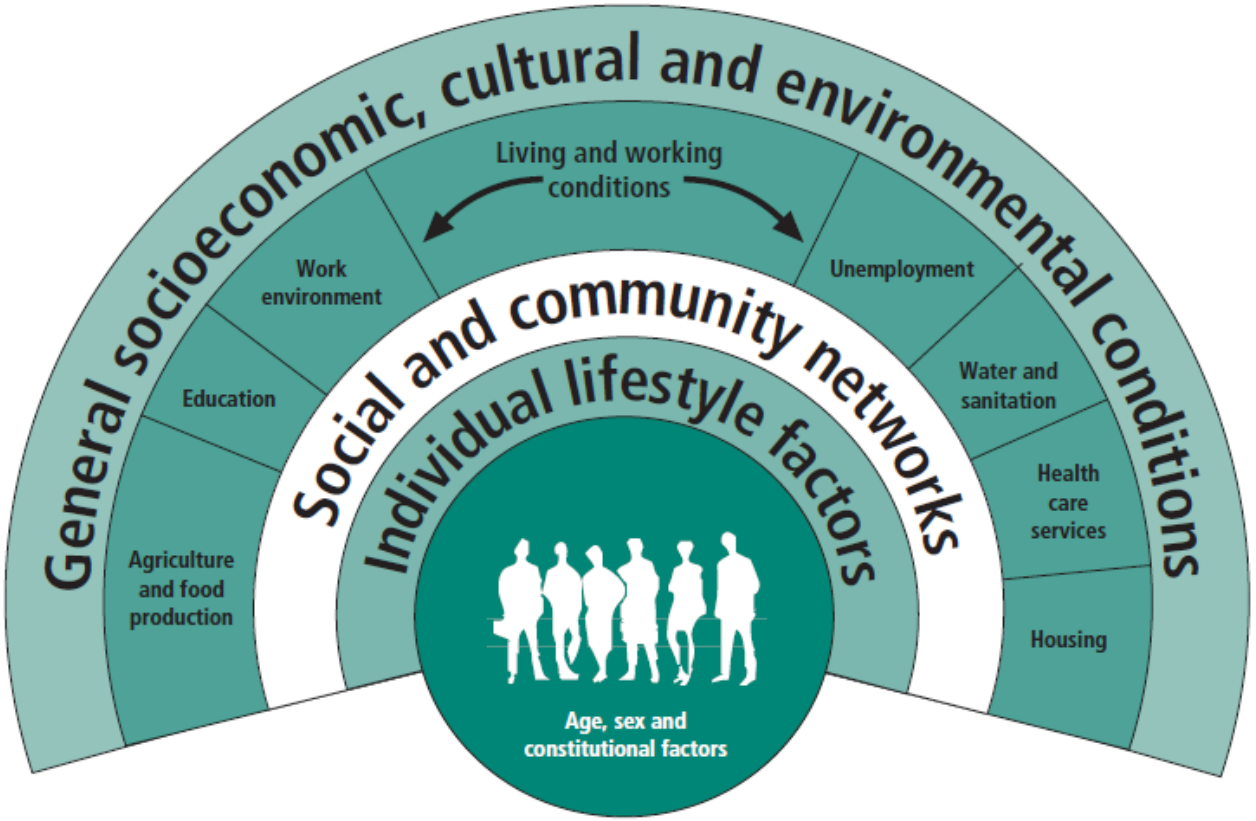
Edited by Richard G Watt, Stefan Listl, Marco Peres and Anja Heilmann

Public Health Reviews

# Strategies and approaches in oral disease prevention and health promotion

Richard G. Watt[1]

Fig. 1. **Social determinants of health**



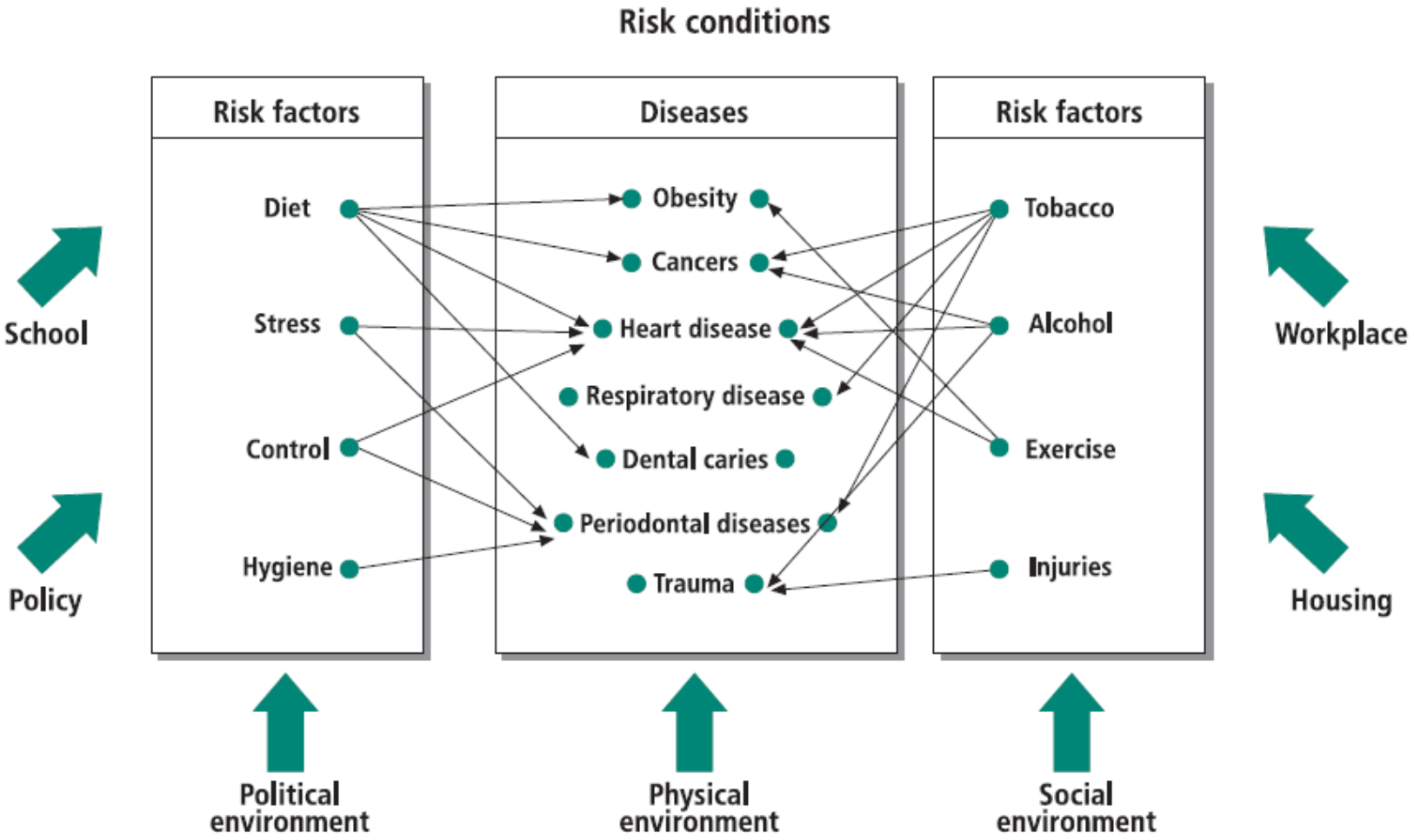

Source: Dahlgren G, Whitehead M. Tackling inequalities in health: what can we learn from what has been tried? Background paper for "*The King's Fund International Seminar on Tackling Health Inequalities*". Ditchely Park, Oxford: King's Fund; 1993. Reproduced with permission of the authors.

*WHO 05.111*

# Beware: Lifestyle Drift!



Fig. 2. **Common risk approach.** Modified from Sheiham & Watt, 2000



# Ontario Public Health Standards 2009

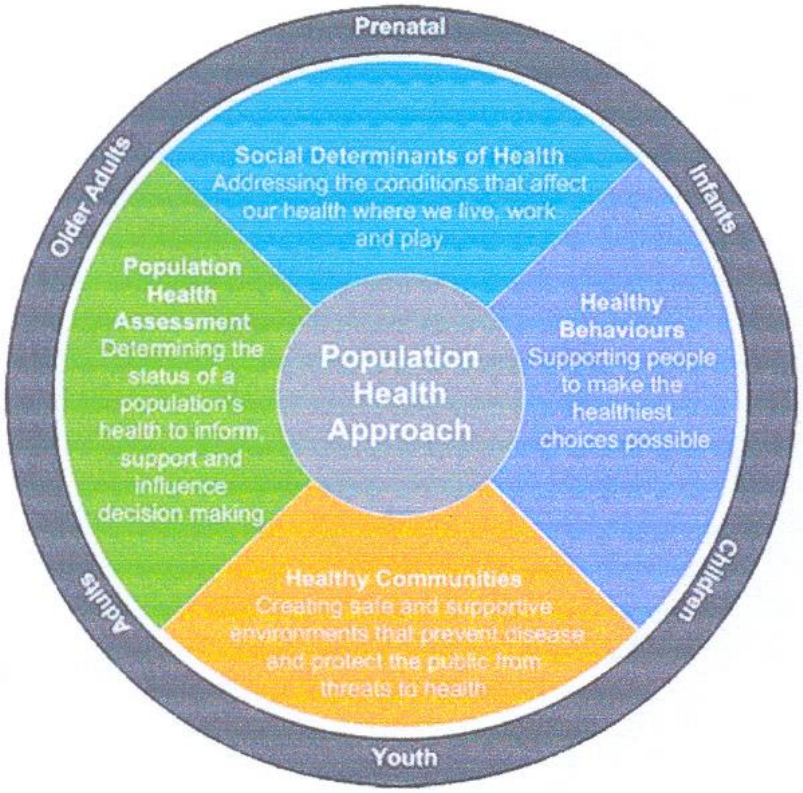
- Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario.
- Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes.

# Ontario Public Health Standards 2009

- The ability to influence broader societal changes is the responsibility of many parties.
- As a sector, public health not only acknowledges the impact of the determinants of health but also strives to influence broader societal changes that reduce health disparities and inequities by coordinating and aligning its programs and services with those of other partners.
- Public health has a leading role in fostering relationships to support broader health goals to achieve the best possible outcomes for all Ontarians.

# New Public Health Standards

## Figure 1: What is Public Health?




Public health work is grounded in a population health approach – focused on upstream efforts to promote health and prevent diseases to improve the health of populations and the differences in health among and between groups. Health risks and priorities change as people grow and age and public health works to address health across the life course.

3

## Figure 2: Policy Framework for Public Health Programs and Services

| | | | | | |
|---|---|---|---|---|---|
| **GOAL** | To improve and protect the health and well-being of the population of Ontario and reduce health inequities | | | | |
| **POPULATION HEALTH OUTCOMES** | • Improved health and quality of life<br>• Reduced morbidity and mortality<br>• Reduced health inequity among population groups | | | | |
| **DOMAINS** | **Social Determinants of Health** | **Healthy Behaviours** | **Healthy Communities** | **Population Health Assessment** | |
| **OBJECTIVES** | To reduce the negative impact of social determinants that contribute to health inequities | To increase knowledge and opportunities that lead to healthy behaviours | To increase policies and practices that create safe, supportive and healthy environments | To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system | |
| **ENABLERS** | Legislation | Funding | Evidence | Agencies & Associations | Municipal & Federal Governments | Partner Organizations |
| **PROGRAMS AND SERVICES** | **GOALS**<br>• To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system<br>• To reduce health inequities with equity focused public health practice<br>• To increase the use of current and emerging evidence to support effective public health practice<br>• To improve behaviours, communities and policies that promote health and well-being<br>• To improve growth and development for infants, children and adolescents<br>• To reduce disease and death related to infectious and communicable diseases of public health importance<br>• To reduce disease and death related to vaccine preventable diseases<br>• To reduce disease and death related to food, water and other environmental hazards<br>• To reduce the impact of emergencies on health | | | | |
| **PARTNERS** | Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations | | | | |

# Challenges

- Public health authorities have struggled with applying the social determinants of health concept.
- Range of differences in activity in addressing the social determinants of health among public health units.
- Little understanding of what underlie these differences among public health units.

# Activities to Address the Social Determinants of Health in Ontario Local Public Health Units

**Summary Report**

Prepared by:
Joint OPHA/alPHa Working Group on Social Determinants of Health

December 2010

# Activities to Address the Social Determinants of Health in Ontario Local Public Health Units

- Twenty-three (of 36) (64%) Ontario PHUs responded and actions on the social determinants of health were evident in the work of the majority of health units across the province.
- Virtually all strongly agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy are appropriate domains of public health unit activity on the SDOH.

- Source: Joint OPHA/ALPHA Working Group on the Social Determinants of Health. (2010). *Activities to Address the Social Determinants of Health in Ontario Local Public Health Units*. Toronto: Author.

# PHU Activities (Selection)

- Health status reports/epidemiology reports (11)
- Community education and awareness campaigns (2)
- Report cards on SDOH and topics (1)
- Participation in Local Poverty Reduction teams (5)
- Participation in community groups/committees - community gardens/kitchens/food boxes (9), oral health coalition (3), positive school coalition, youth development, Healthy Communities Partnership.
- Support advocacy: Access to food/food security (7); Active transportation/transportation access (4); Built environment (bike trails, bicycle racks on public transportation) (4); Fair wages and employment/employability (4); Access to recreation (3)
- Regional Official Plan / Planning department (3).

# Do you believe there are additional important roles for PHUs in taking action on the SDOH?

- *Increase awareness of SDOH (5)*
- *Advocate for policy change on SDOH (2)*
- *Use equity health impact assessments or social equity lens in policy and program development (2)*

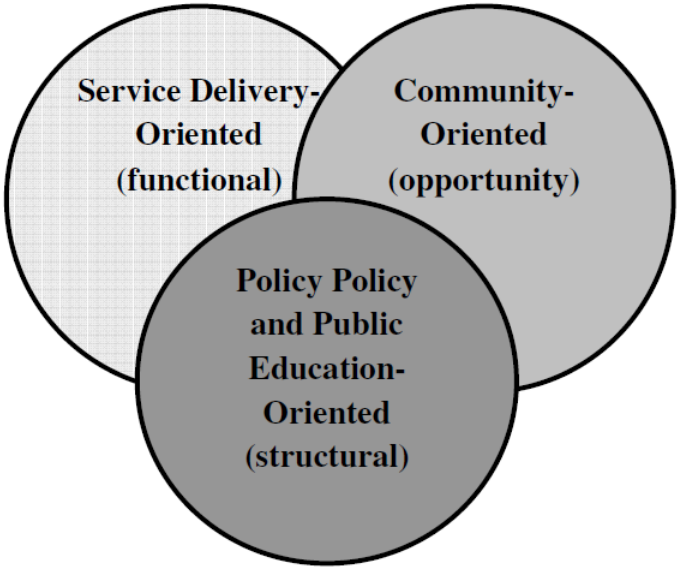
# World Views

*Sources:*

Brassolotto, J., Raphael, D. and Baldeo, N. (2014). Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada. *Critical Public Health, 24,* 3, 321-336.

Raphael, D., Brassolotto, J. and Baldeo, N. (2015). Ideological and organizational components of differing public health strategies for addressing the social determinants of health. *Health Promotion International*, *30*: 855-867.

Raphael, D. and Brassolotto, J. (2015). Understanding action on the social determinants of health: A critical realist analysis of in-depth interviews with staff of nine Ontario public health units. BMC Research Notes, 8, 105.




| Service-Delivery | Community-Oriented | Advocacy/Education |
|---|---|---|
| SDH seen primarily as risk factors shaping health outcomes | SDH seen as risk factors shaped by public policy that limits opportunities | SDH are risks caused by public policy that creates social inequities |
| SDH identify groups to whom services need to be provided | SDH identify groups with limited opportunities | SDH identify groups experiencing marginalization |
| Focus is on evidence-based health-related outcomes | Focus is on evidence-based and community-related outcomes | Focus is on evidence-based community, and structural outcomes |
| Unit organization for addressing SDH tends to be undeveloped | Unit organization for addressing SDH tends to be devolved to sections | Unit organization for addressing SDH tends to be centralized |
| SDH issues are de-politicized | SDH issues implicitly seen as political | SDH issues explicitly seen as political |

# Constructing the SDOH

- In less-active units, SDOH were seen as risk factors

"*And as the term implies it includes such factors as income, employment, housing, etc., the social environment, if you will, with respect to individuals and populations that influence their health.*"

- In active units, SDOH were seen as indicators of structural inequalities in society

"*I think about social determinants in terms of all of those factors beyond life style, genetics, physiology that we know influences health so those range from specific kind of material influences like access to food or housing, etc., beyond to community structures, to power differentials within communities, to issues of class, race, and then all of the policy pieces that govern each of those things.*"

# Structural versus Functional Approach towards Social Determinants

- Units that most actively addressed SDOH had a **structural** approach.

- *"These are societal issues and the policy solutions are societal and all levels of government have a role to play. But as their partner and their influencer is public health, because we can work with all three levels of government… We also have the ability to identify which of the issues really belong in the federal ball court and we can challenge and advocate there."*

# Structural versus Functional Approach towards Social Determinants

- Units that were less active in addressing the SDOH tended to take a **functional** approach.
- *"So the social determinants of health is an underlying principle that underlines the standards and it is, if you will, a concept, a way of thinking about health that should be kept in mind as you're implementing programs."*

# Forms of Evidence

- Units that were less active saw evidence as outcomes as opposed to process (intermediary) indicators.

- *“So we’ve implemented a program called "Nurse-Family Partnership” which is within the mandate of Healthy Babies, Healthy Children but much more evidence based, much more resource intensive and randomized control level evidence showing its effectiveness in improving outcomes for mothers and children, both health outcomes and economic and social outcomes.”*

# Forms of Evidence

- Active units saw evidence as process (intermediary) indicators.

- *"We've had definite success in terms of developing new partnerships. The local poverty reduction network would be a big one that we've supported at the Steering Committee level, the Planning Committee level and many of the Work Groups. I think internally, the health unit has shifted a bit in terms of its comfort in using social determinants as a lens for analysis. We definitely have Board support now, and we have developed a health equity checklist for the planning of our programs."*

# Forms of Outcomes

- Differing ideas about *evidence* revealed different conceptions of *outcomes*.

- **Concrete** vs. structural indicators of change

- "*We want to look at and see outcomes and mostly those are defined in terms of behaviours. So how many people are smoking? How many people are eating their fruits and vegetables? So if we look at how health is even defined within public health it is defined as in terms of behaviour and absence of disease.*"

# Forms of Outcomes

- Concrete vs. *structural* indicators of change

- *"In the community there's been an increase in services, programs and resources for previously underserved populations.  Some examples would include a new nurse practitioner clinic that we helped bring community agencies together to support, a Homelessness Partnership Strategy that we participate in, and an initiative in the community that we have supported to move people from Ontario Works to ODSP."*

# Role of Public Health in Addressing SDOH

- Active units saw PHUs as having a role in: researching, reporting, disseminating information to the public and to politicians, advocacy, engaging in community partnerships and capacity building, and assessing the health impacts of various policies and decisions.

- *"I think that we can and should bring the health equities knowledge that we have, and the voice and credibility that we have, back to other tables. So, be it education or municipal councilors or whomever, to help them to think through the decisions they make and the impact that it has on health and health equity."*

# Role of Public Health in Addressing SDOH

- Less-active units saw the role of PHUs as primarily: applying knowledge of SDOH to existing programming and using determinant-specific approaches to priority populations, refraining from 'health imperialism', and strategic partnerships.
- *"We frankly do not see public health as in a position…to fundamentally change every aspect of our society, particularly our economic structure… It may be emotionally satisfying to think that we can go out and restructure Canadian society. It's self-indulgent, in my opinion, and it's not the business we're in."*

*"It's a means to an end and so you look at your basket of programs and you say to yourself 'how can I influence this basket of programs by applying SDOH thinking?'… I think you need to be realistic."*

# Conclusions I

- All units involved see SDOH as important and worthy of addressing.
- Epistemological barriers and different worldviews create more of a barrier to action on SDOH than limited funds/time/staff
- Action is too dependent on leadership, passions/interests of senior management. Needs to be institutionalized.
- Lack of clarity about how to apply SDOH and role of PHUs in doing so.

# Conclusions II

- Health equity is often applied as a lens to existing programming, rather than treated as an objective in itself or as grounds for new initiatives.
- There is little to no internal or external accountability for units' success/failure in addressing their SDOH strategic goal(s).
- There is tension around the political nature of SDOH. How to remain non-partisan while addressing inherently political issues? Health impact assessment and similar approaches may be helpful.

# Structures and Activities

# Organizational Structures

- Central Organization

  "*The social determinants of health committee has certainly been vital. And then we now operate the social determinants program under the foundational standards so we have a foundational standards team that has come together."*

- Decentralized Organization

*" It is decentralized in the sense we haven't put together a unit."*

*"There is no social determinants working group. We've just started and hopefully this might morph into something."*

# Unit Activities

- Staff education
- Planning services
- Research
- Influencing governance
- Entering coalitions – intersectoral activity
- Public policy advocacy
- Health impact assessment
- Public education

# Staff Education

- *“We’ve done staff education and so last year we launched a staff education initiative to talk about social determinants of health and what they are and examples of how they can be used. So it was to get some conversations starting. We also have websites for staff internally that talk about social determinants of health, share research, share examples, kind of testimonials from staff. So that’s to build kind of our internal understanding.”*

# Planning Services

- *“So, we’ve tried to put out money where our mouth is particularly focusing on the children and of course in addition to those two funded programs, the province recently provided us with funding to enhance oral health care for children through Healthy Smiles Ontario. So strategic planning tools, advocacy and, if you will, using the social determinants of health for planning and implementation purposes.”*

# Influencing Governance

- *“This is one of the advantages of being part of a regional government and that is the strong links with our social community service department and the other departments that are around the table such as planning and the finance department and public works. By being the head of the health department I get to sit on the senior management committee team for* the *Region.*
- *So it was the head of public works who oversees the transportation master plan, myself as the medical officer of health, and my boss, the CAO, the three of us in a room to confirm that the health department – with me as the medical officer of health -- is happy with what is written in that transportation master plan especially with regard to the active transportation component.”*

# Entering Coalitions – Intersectoral Activity

- *“We’re just very, very active on our own and also in collaboration with other social justice groups and community groups in the community so we’re very integrated now into the local poverty reduction network and to a lot of the work groups of the poverty reduction network and we just work very closely with our community partners on all of these issues.”*

# Public Policy Advocacy

- *“I think we’re serving a very diverse population many of whose opportunities for health are strongly affected by social determinants. So we need to build that in to how we serve them on the service side and we also have a role in terms of speaking out for healthy public policy and a more direct approach to social determinants which is not the lever that we have at the local lever as a service delivery organization but we may be able to influence.”*

# Health Impact Assessment

- *“That is actually on our list of things to tackle this year. It should be outlined in our terms of reference. We’ve called it a staff resource tool kit but it really means we need to figure out what health impact assessment tools out there would be best suited for our programs to use. Because we do operational planning every year so how do we take those lenses and apply them to our operational plan?”*

# Public Education

- *“I think we have a role. Right now we haven’t defined it. Whether it’s something like a social marketing campaign the way that some other units have gone or if it’s working more on the ground with community organizations to give that information in a more face-to-face kind of way I think that’s going to evolve and emerge over the next couple of years. We sort of haven’t wrapped our head around that piece yet. I think we see ourselves as having a role. I just think we haven’t defined it.”*

# Public Education

- *“So I think that we have in terms of again our responsibilities and I think that comes with the knowledge and the resources of the public health system. I think that we have a huge role to play in helping to change the headlines, helping the public to be more aware of the factors that impact and influence on health so kind of purposeful reporting.*
-

# Need for Local Action

- Unlike cities in Europe which are able to address SDoH issues that may be neglected by higher levels of governments, cities in Canada have very limited powers under the Canadian Constitution.
- “Few countries in the world have senior levels of government that have been so resistant to loosen restraint and regulation as has been in the case in Canada” (Smith & Spicer, 2017, p.1).

- Source: Raphael, D. and Sayani, A. (2017). Assuming Policy Responsibility for Health Equity: Local Public Health Action in Ontario, Canada. *Health Promotion International*, forthcoming.

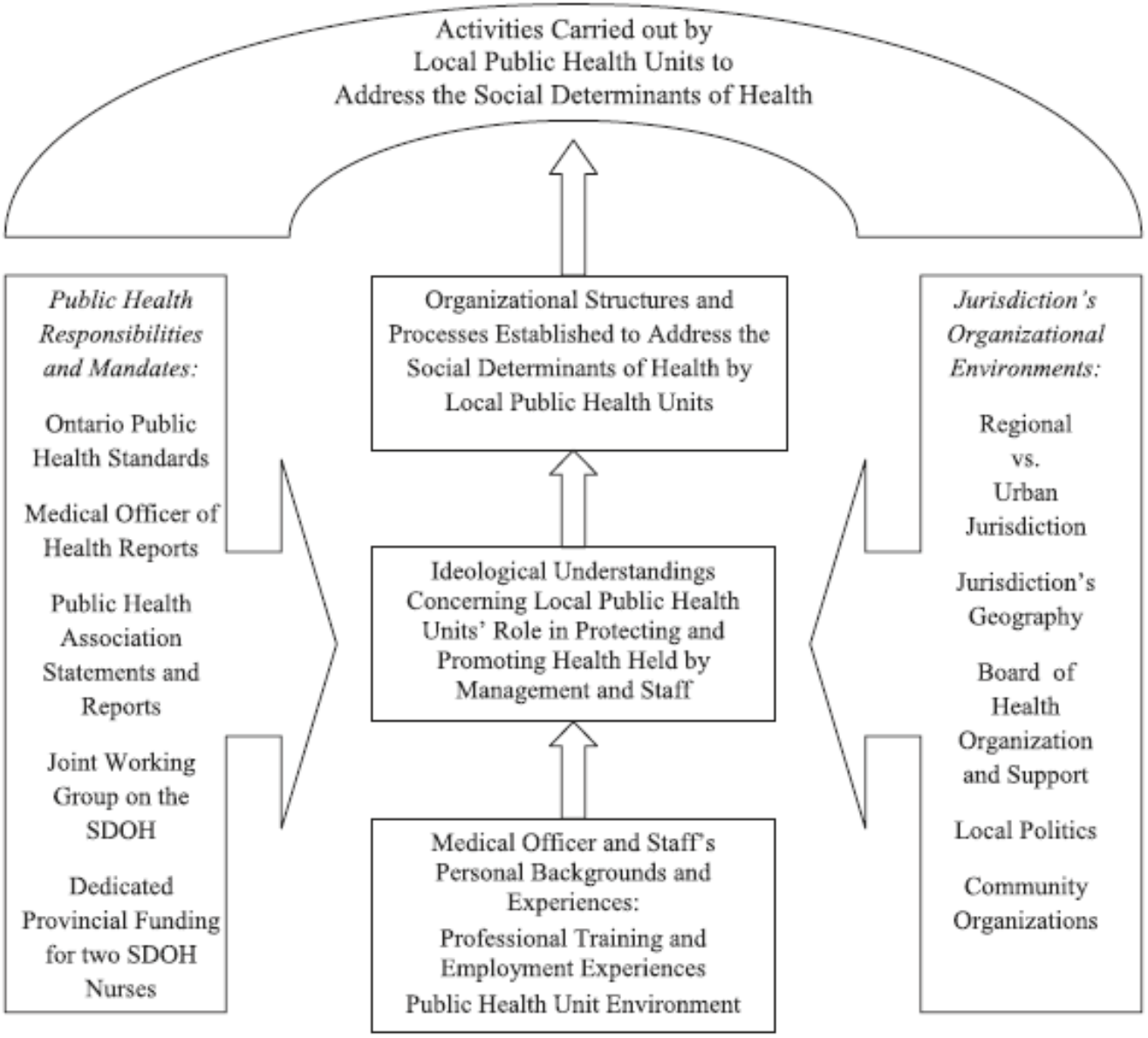



**Figure 2 Potential structures and processes (*the real*) as well as influences (*the actual*) upon local public health units approaches (*the empirical*) to addressing the social determinants of health.**

Sudbury & District Health Unit
Service de santé publique

# Let's Start a Conversation About *Health* . . .

## and Not Talk About *Health Care* at All

## USER GUIDE

# A Majority Of Units!

1. Chatham-Kent
2. Elgin
3. Grey Bruce
4. Haldimand and Norfolk
5. Halton
6. Huron
7. Lambton
8. Leeds Grenville
9. Middlesex-London
10. Niagara
11. Northwestern
12. Peterborough
13. Simcoe-Muskoka
14. Sudbury
15. Thunder Bay
16. Timiskaming
17. Wellington-Dufferin-Guelph
18. Windsor-Essex
19. York Region
20. Oxford
21. Eastern Ontario

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# Assuming Policy Responsibility for Health Equity: Local Public Health Action in Ontario, Canada

Box 2. Key Messages from Let's Start a Conversation . . .

1. Health improves at every rung up the income and social ladder. Yes, our health is influenced by genetics and behaviours such as smoking, diet and physical activity. However, the greatest predictor of how healthy we are is our social and economic status.
2. Everyone has different opportunities for health, largely influenced by their social and economic conditions.
3. Social and economic conditions are the result of the actions that all of us can take. Individually and collectively, we CAN make decisions and choices that are good for our communities and good for our health.
4. Health care alone cannot fix our health problems. An effective health care system is essential for treating us when we are ill…Health, of course, is about much more than illness care. Individual and community health, well-being and prosperity are created when all sectors invest in health-supporting actions.
5. Health inequities are differences in health status experienced by different groups of people that are systematic, socially produced, and unfair and unjust. In other words: The avoidable differences in health between groups that are caused by our living conditions (jobs, schools, housing, neighbourhoods, etc.).

Abstracted from: Sudbury and District Health Unit (2016). *Health Equity Resources*. Sudbury: Author. Available at https://www.sdhu.com/health-topics-programs/health-equity/health-equity-resources.

| Table 1. Number of PHUs Intending to use the Adapted Video for Each Activity | | | |
|---|---|---|---|
| Enhance Service Delivery | Promote Community Collaboration | Public Policy Advocacy | Public Education |
| 17 | 17 | 15 | 14 |
| | | | |
| All four activities: | | 14 | |
| Service Delivery, Community Collaboration, and Advocacy: | | 1 | |
| Service Delivery and Community Collaboration: | | 2 | |

# Building Organizational Capacity – Beginning the Conversation

- *When the adaptation was complete and video final, the SDoH PHNs had the opportunity to show it to staff through team meetings (spanning several months in 2013). The objective of the team presentations was to start conversations (literally!) about the SDoH. The SDoH PHNs gathered baseline data on staff understanding & value of SDoH, as well as examples in current practice, challenges, and opportunities. This baseline data helped inform the SDoH PHNs to develop the first SDoH work plan, which lead to the creation of an internal SDoH committee.* (Unit 2)

# Social Mobilization – Extending the Conversation

- *Raise awareness, help spark the discussion and help reorient key community decision makers & health care workers cultural competence so they are enabled to incorporate a health equity lens into practice and program planning.* (Unit 12)
- *The main goal was to use the video as a teaching and awareness raising tool, and to stimulate conversation amongst staff and external partners about the root causes of poor health and how communities can address the SDoH.* (Unit 11)

# Public Education and Public Policy Advocacy – Consolidating the Conversation

- *The video is one component of a multi-faceted approach to community education about health equity and the social determinants of health. Other components include presentations to Council and the Board of Health, main stream media coverage, social media initiatives, public advocacy, and community events. It complements a previous multi-media campaign we had developed around the message of "Some things a doctor can't prescribe", such as adequate income, housing and nutritious food.* (Unit 11)

Table 2. Examples of the Audiences for the Video Adaptation

| PHU 17 | PHU 15 |
|---|---|
| *Internal Audiences* | *Internal Audiences* |
| • All internal staff (ongoing as it is part of new staff and student orientation) | • Staff of the Health Unit (at Director's Forum where staff discuss emerging issues in the PHU) |
| *Community Partners* | *Community Partners* |
| • Local Immigration Partnership<br>• Community Circles - our local poverty reduction group<br>• Registered Nurses Association of Ontario - local chapter<br>• Our local Community Homelessness Initiative Network<br>• Our local Poverty Reduction Network<br>• Catholic District School Board<br>• District School Board<br>• Economic Partnership | • 250 participants who attended the Healthy Communities Conference<br>• Staff of Children's Aid Society, mental health counselling centres, County Housing staff.<br>• Staff who work for Ontario Works and Ontario Disability Pension<br>• Natural Resources and Conservation Authority<br>• United Way<br>• Mental health groups<br>• Alcohol and drug addiction staff<br>• Interagency groups<br>• Poverty Task Force committee members (approx 50)<br>• School Boards and teachers<br>• YMCA staff<br>• The Fall Prevention for Older Adults Program: Practical Nursing and Personal Support Worker Students (approximately 200 students)<br>• Fall prevention training to County paramedics (over 100) |
| *Public and Policymakers* | *Public and Policymakers* |
| • College Nursing Students<br>• County's Board of Health<br>• University Community Health Promotion Course (2nd degree BScN students)<br>• University Master of Public Health Program<br>• Community members at large - Facebook, twitter and YouTube | • Ministerial Associations for attention of church members<br>• Rotary clubs<br>• Municipality leaders and councilors<br>• Board of Health<br>• Decision makers of organizations such as children's programming, recreation depts., housing authorities, family health teams, women's shelters<br>• Rogers Cable TV – ½ hour live interviews with hosts<br>• Advocacy groups and grass roots groups<br>• Media |

# Conclusions

- The public health sector has an important role to play in reducing inequities in health.
- All 17 PHUs intend to move towards building local action to help crack the nut of health equity by building bottom-up pressures for public policy action on the SDoH (Baum, 2007).
- Local PHU action can compensate for an absence of State support for promoting health equity through action on the SDoH.
- Evaluation work by the SDHU on its own use of the video provides evidence of positive effects at all levels of practice (Sudbury and District Health Unit, 2012b, 2013). It has been well received by staff, community partners, decision makers and members of the public.

# Supports and Barriers

# 10 PROMISING PRACTICES
# TO GUIDE LOCAL PUBLIC HEALTH PRACTICE TO REDUCE SOCIAL INEQUITIES IN HEALTH

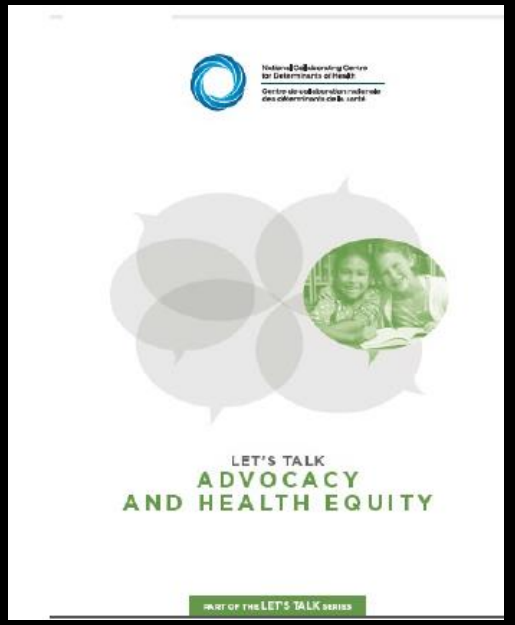
*TECHNICAL BRIEFING*

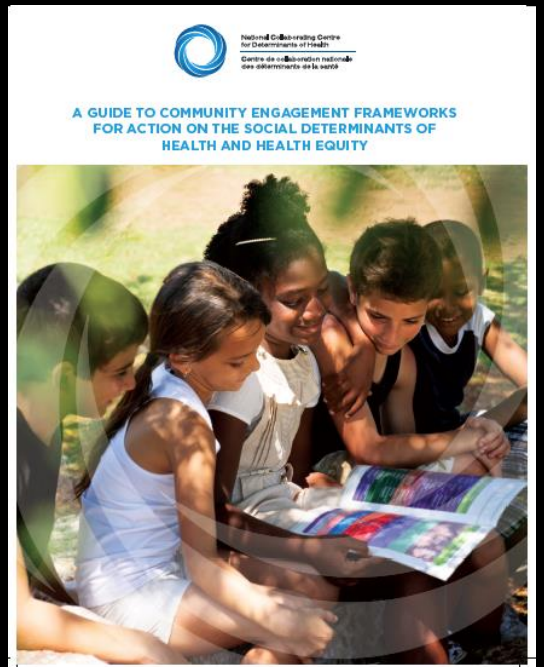
Sudbury & District
Health Unit
Service de santé publique

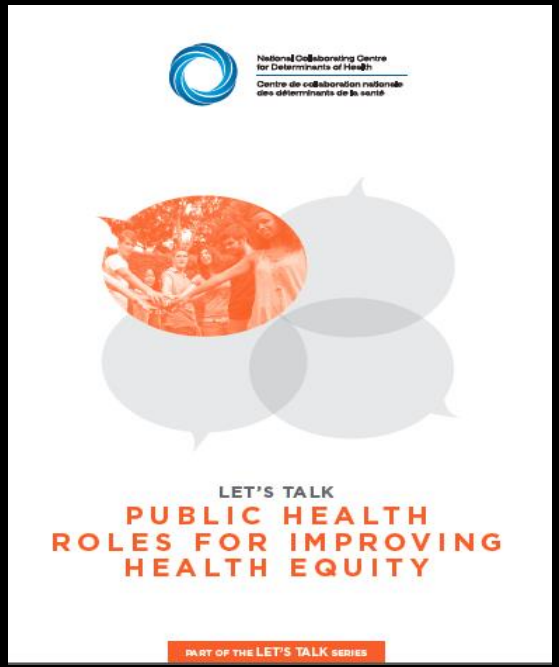
## 10 promising practices to guide local public health practice to reduce social inequities in health 1

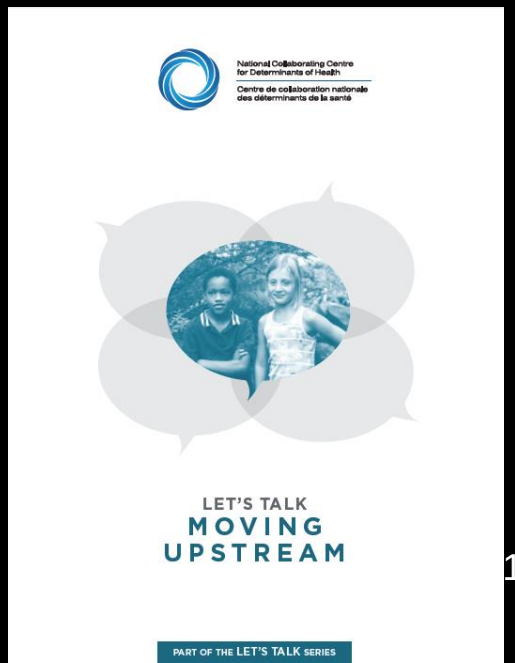
# National Collaborating Centre on Determinants of Health





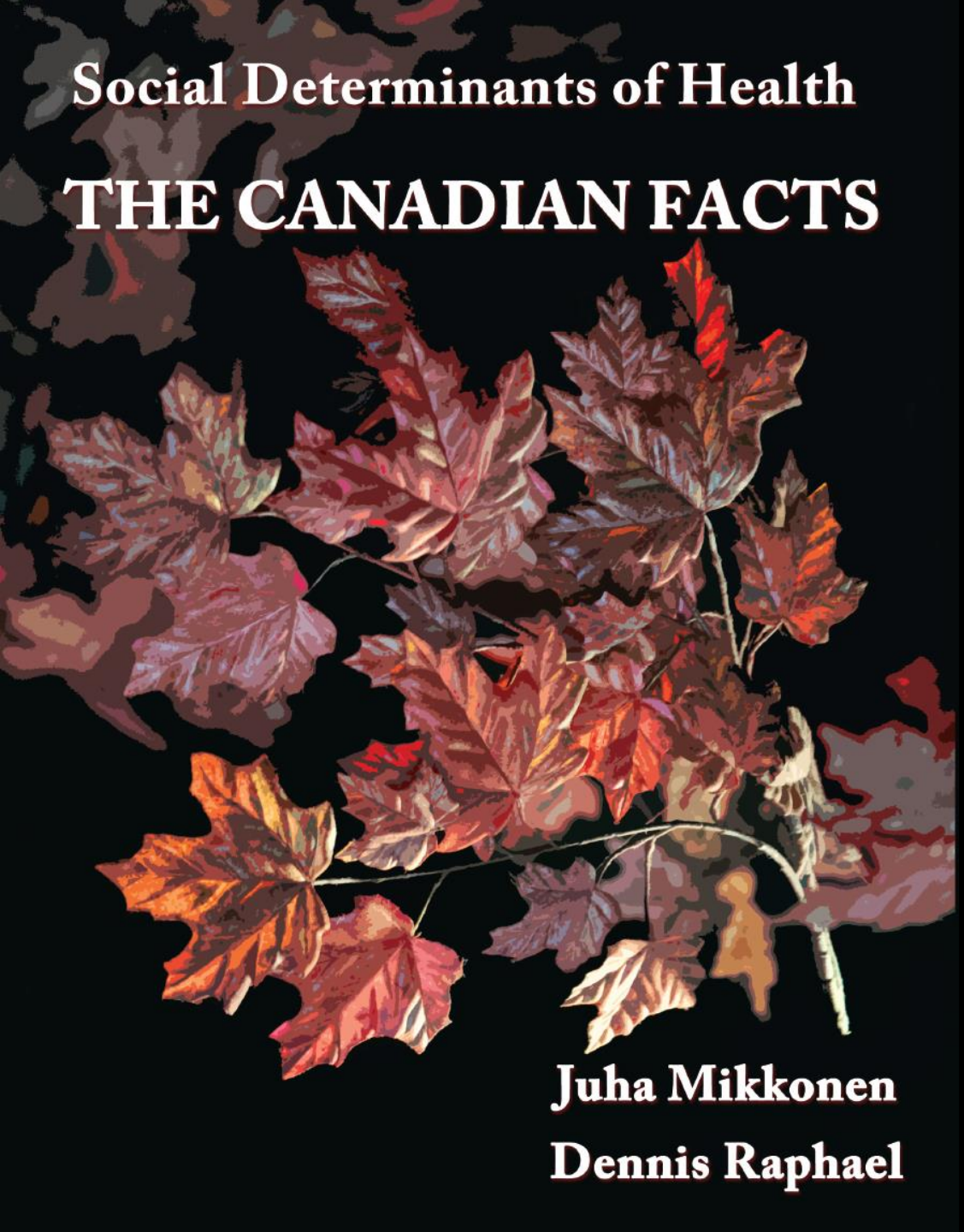
# Barriers

- *“I think one of the biggest barriers is it’s a huge problem. I mean even tackling any single one of the social determinants of health is a huge problem. Public health, you know, does not have a lot of control over many of the determinants and how they’re approached so we really have to rely on partnerships and on collaboration. We also have to take a really long-term view. We are not going to see significant changes in many of these, even if they are being addressed, for many years. And I think that that is a challenge to be able to maintain interest and momentum in a health unit to keep at it when you don’t get any of those quick wins.”*

# Implications

- Important to be explicit as to what is intended by SDOH activity
- Activity needs to be informed by disciplines beyond traditional public health approaches
- Staff education is essential to moving forward
- Areas that need to be critically explored include:
  - Various paradigms of knowledge and action
  - Role of public education
  - Potential value of health impact assessment
- Network of SDOH Public health units can play a key role in these activities
- Discussion of role of Ministry of Health and Long-term Care and Public Health Ontario

# Learn more…

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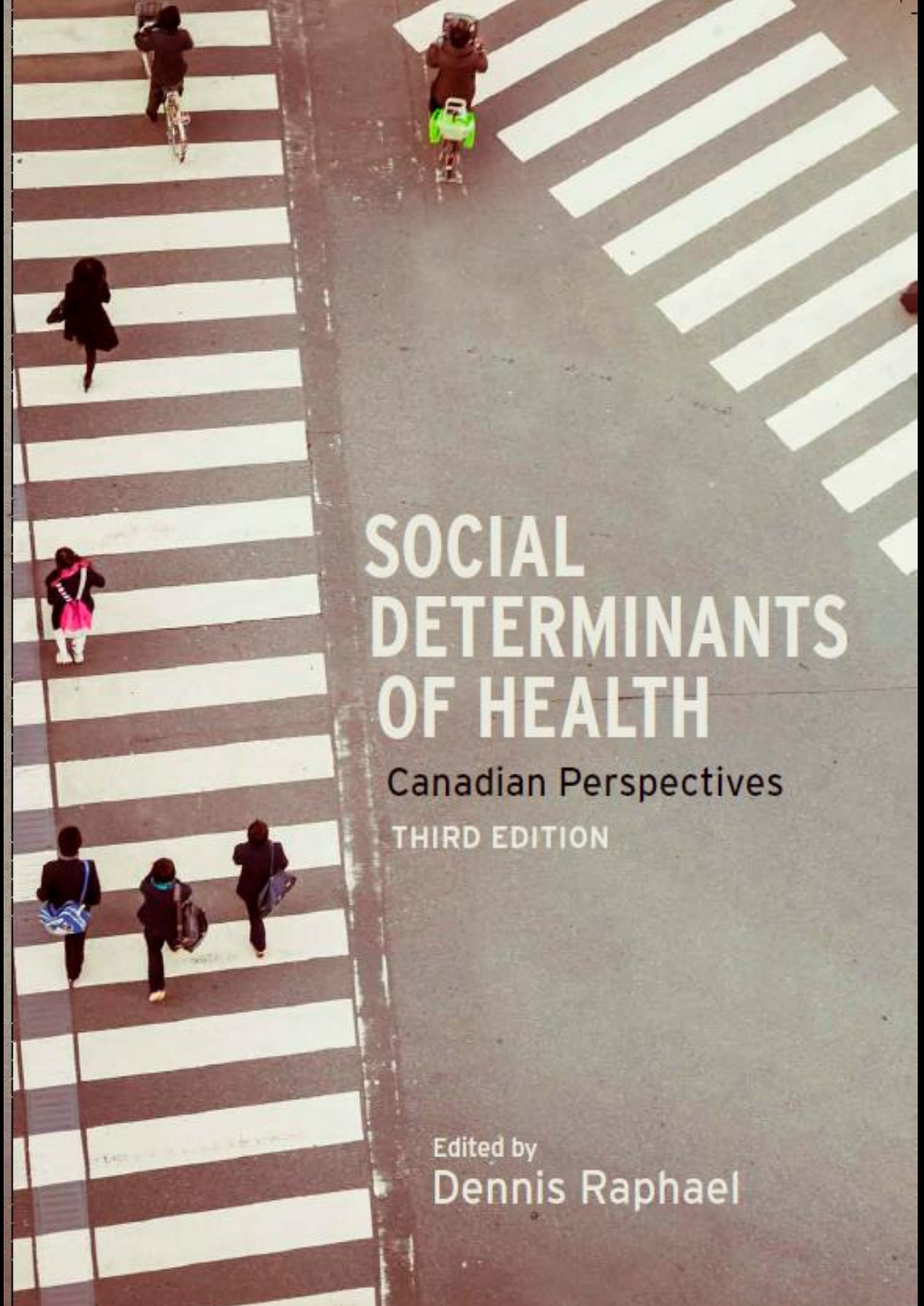
ABOUT CANADA

# HEALTH AND ILLNESS

2ND EDITION

Dennis Raphael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OF HEALTH
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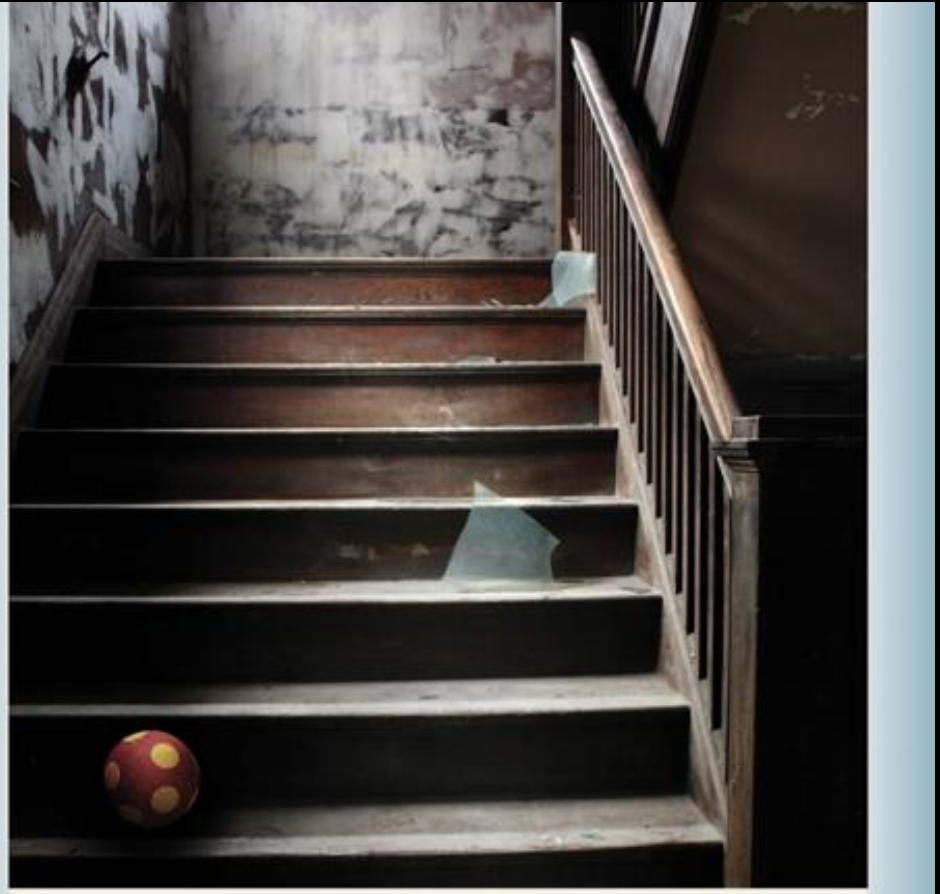
THIRD EDITION
Edited by
Dennis Raphael



# POVERTY IN CANADA

SECOND EDITION

IMPLICATIONS FOR HEALTH AND QUALITY OF LIFE

DENNIS RAPHAEL

FOREWORD BY ROB RAINER

# Part 3: 1:30-3:00

- INSPIRE!!
- Focus on health equity specific to NBPSDHU and HEAC
- Advise our health equity champions
- What is a health equity champion?
- Who can be a health equity champion?
- Why do we need health equity champions?
- Next steps
- What do we need to have in place (e.g. structures, policies, etc.)?

# Exploring Practical Implications of SDOH

- Ways of Thinking about SDOH
- Implications for Public Health Practice
- Implications for Local Action
- Supports and Barriers
- Ways Forward
- And…

**Table 24.1: Social determinants of health discourses**

| SDOH discourse | Key concept | Dominant research and practice paradigms | Practical implications of the discourse |
|---|---|---|---|
| 1. *SDOH as identifying those in need of health and social services.* | Health and social services should be responsive to peoples' material living circumstances. | Develop and evaluate services for those experiencing adverse living conditions. | Focus limited to service provision with assumption that this will improve health. |
| 2. *SDOH as identifying those with modifiable medical and behavioural risk factors.* | Health behaviours (e.g., alcohol and tobacco use, physical activity, and diet) are shaped by living circumstances. | Develop and evaluate lifestyle programming that targets individuals experiencing adverse living conditions. | Focus limited to health behaviours with assumption that targeting for behaviour change will improve health. |
| 3. *SDOH as indicating the material living conditions that shape health.* | Material living conditions operating through various pathways—including biological—shape health. | Identify the processes by which adverse living conditions come to determine health. | Identifying SDOH pathways and processes reinforce concept and strengthen evidence base. |
| 4. *SDOH as indicating material living circumstances that differ as a function of group membership.* | Material living conditions systematically differ among those in various social locations such as class, disability status, gender, and race. | Carry out class-, race-, and gender-based analysis of differing living conditions and their health-related effects. | Providing evidence of systematic differences in life experiences among citizen groups forms the basis for further anti-discrimination efforts. |
| 5. *SDOH and their distribution as results of public policy decisions made by governments and other societal institutions.* | Public policy analysis and examination of the role of politics should form the basis of SDOH analysis and advocacy efforts. | Carry out analyses of how public policy decisions are made and how these decisions impact health (i.e., health impact analysis). | Attention is directed toward governmental policy making as the source of social and health inequalities and the role of politics. |
| 6. *SDOH and their distribution result from economic and political structures and justifying ideologies.* | Public policy that shapes the SDOH reflects the operation of jurisdictional economic and political systems. | Identify how the political economy of a nation fosters particular approaches to addressing the SDOH. | Political and economic structures that need to be modified in support of the SDOH are identified. |
| 7. *SDOH and their distribution result from the power and influence of those who create and benefit from health and social inequalities.* | Specific classes and interests both create and benefit from the existence of social and health inequalities. | Research and advocacy efforts should identify how imbalances in power and influence can be confronted and defeated. | Identifying the classes and interests who benefit from social and health inequalities mobilizes efforts towards change. |

Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health, 21*, 221-226.

# SDH as identifying those in need of health and social services

- Health and social services should be responsive to peoples' material living circumstances.
- Develop and evaluate services for those experiencing adverse living conditions.

# SDH as identifying those with modifiable medical and behavioural risk factors

- Health behaviours (e.g., alcohol and tobacco use, physical activity, and diet) are shaped by living circumstances.
- Develop and evaluate lifestyle programming that targets individuals experiencing adverse living conditions.

# SDH as indicating the material living conditions that shape health

- Material living conditions operating through various pathways – including biological -- shape health.
- Identify the processes by which adverse living conditions come to determine health.

# SDH as indicating material living circumstances that differ as a function of group membership

- Material living conditions systematically differ among those in various social locations such as class, disability status, gender, and race.
- Carry out class-, race-, and gender-based analysis of differing living conditions and their health-related effects.

# SDH and their distribution as results of public policy decisions made by governments and other societal institutions

- Public policy analysis and examination of the role of politics should form the basis of SDH analysis and advocacy efforts.
- Carry out analyses of how public policy decisions are made and how these decisions impact health (i.e., health impact analysis).

Social Determinants of Health and their Public Policy Antecedents

| | |
|---|---|
| Early life | Wages that provide adequate income inside the workforce, or assistance that does so for those unable to work, affordable quality childcare and early education, affordable housing options, and responsive social and health services |
| Education | Support for adult literacy initiatives, adequate public education spending, tuition policy that improves access to postsecondary education |
| Employment and working conditions | Training and retraining programs (active labour policy), support for collective bargaining, enforcing labour legislation and workplace regulations, increasing worker input into workplace environments |
| Food security | Developing adequate income and poverty-reduction policies, promoting healthy food policy, providing affordable housing and affordable child care |
| Health services | Managing resources more effectively, providing integrated, comprehensive, accessible, responsive and timely care |

| | |
|---|---|
| Housing | Providing adequate income and affordable housing, reasonable rental controls and housing supplements, providing social housing for those in need |
| Income and its distribution | Fair taxation policy, adequate minimum wages, and social assistance levels that support health, facilitating collective bargaining |
| Social exclusion | Developing and enforcing antidiscrimination laws, providing ESL and job training, approving foreign credentials, supporting a variety of other health determinants for newcomers to Canada |
| Social safety net | Providing economic and program supports to families and citizens comparable with those provided in other wealthy developed nations |
| Unemployment and job insecurity | Strengthening active labour policy, providing adequate replacement benefits, provisions for part-time benefits and advancement into secure employment |

SDH and their distribution result from economic and political structures and justifying ideologies

- Public policy that shapes the SDH reflects the operation of jurisdictional economic and political systems.
- Identify how the political economy of a nation fosters particular approaches to addressing the SDH.

# Esping-Anderson Typology and its Variants

- *Three Worlds of Welfare Capitalism* identified Social Democratic, Conservative, and Liberal welfare state regimes (Esping-Andersen, 1990, 1999, 2009).

- Central features of welfare regimes are extent of stratification, decommodification, and role of the State, Market, and Family in providing security.

- Model produced by Saint-Arnaud and Bernard (2003) has been especially useful (at least for me)

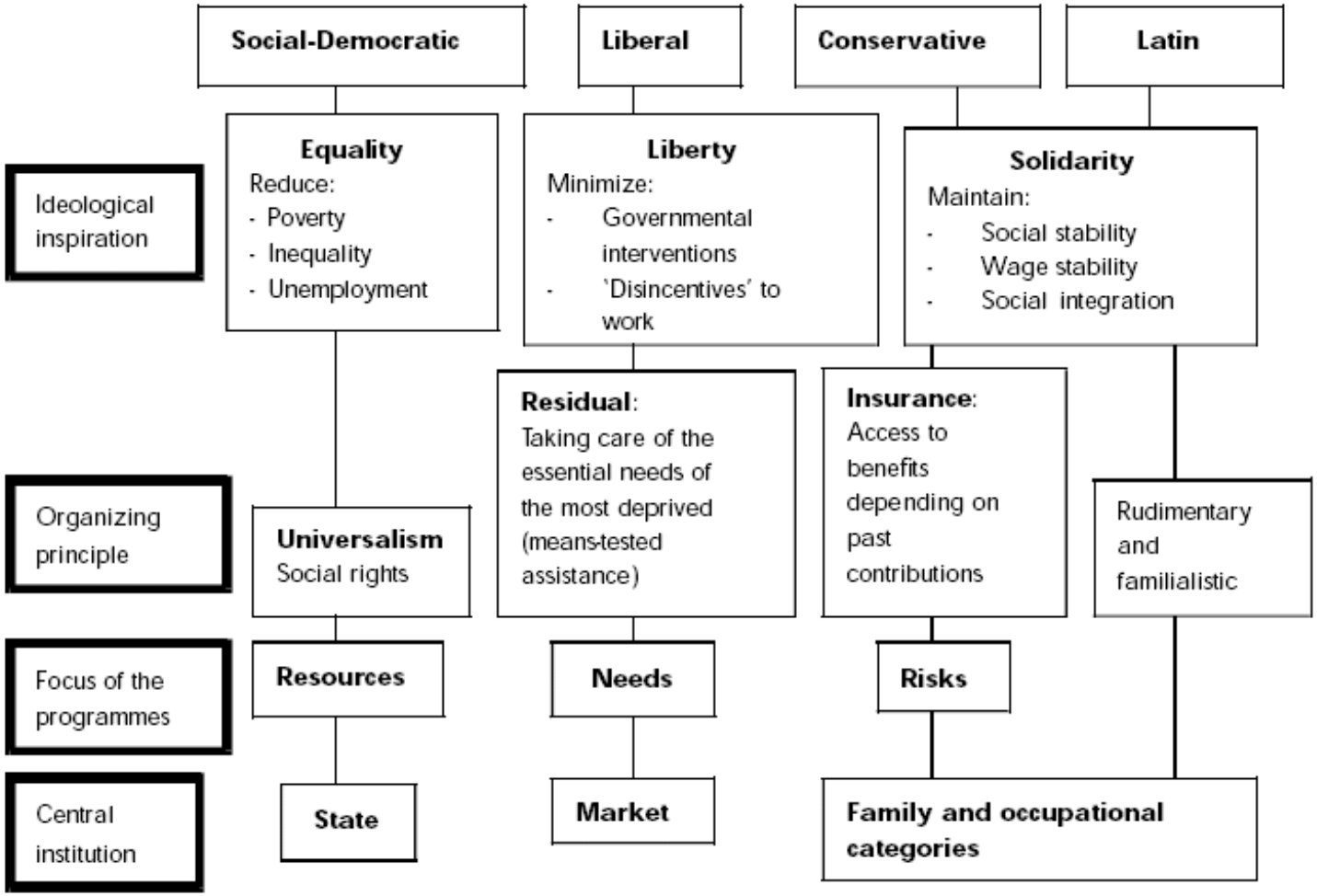



**Figure 2** The Characteristics of Welfare Regimes

Source: Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchial cluster analysis of the welfare regimes in advanced countries. Current Sociology, 51(5), 499-527.

SDH and their distribution result from the power and influence of those who create and benefit from health and social inequalities

- Specific classes and interests both create and benefit from the existence of social and health inequalities.
- Research and advocacy efforts should identify how imbalances in power and influence can be confronted and defeated.

# Options…


# Upstream

@UpstreamAction FOLLOWS YOU

By using the best evidence to invest in what really determines health, we can identify what we want and what we need. And we can make it happen.

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Politics
Who Gets What, When, How

# CHANGE THE SYSTEM

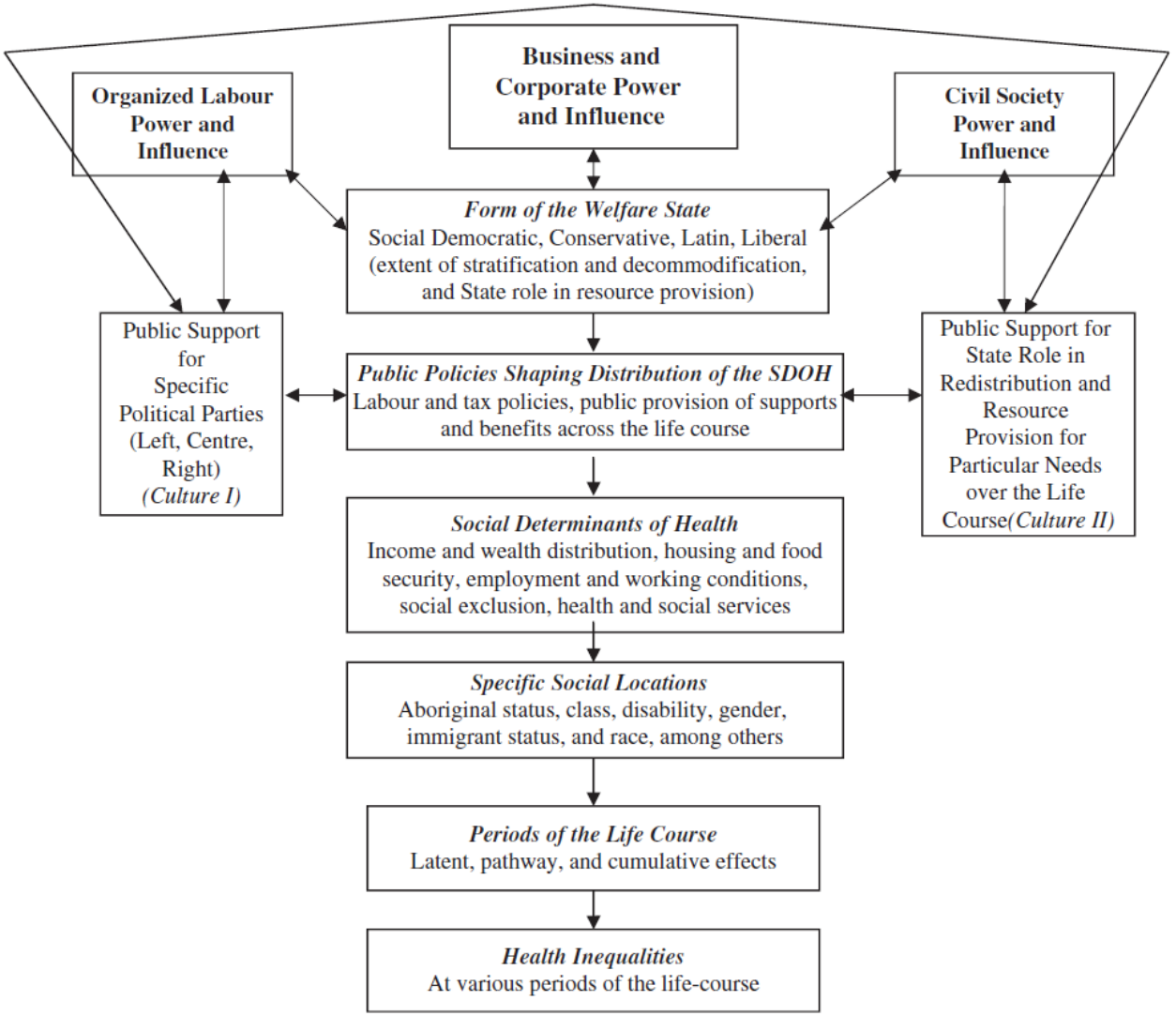
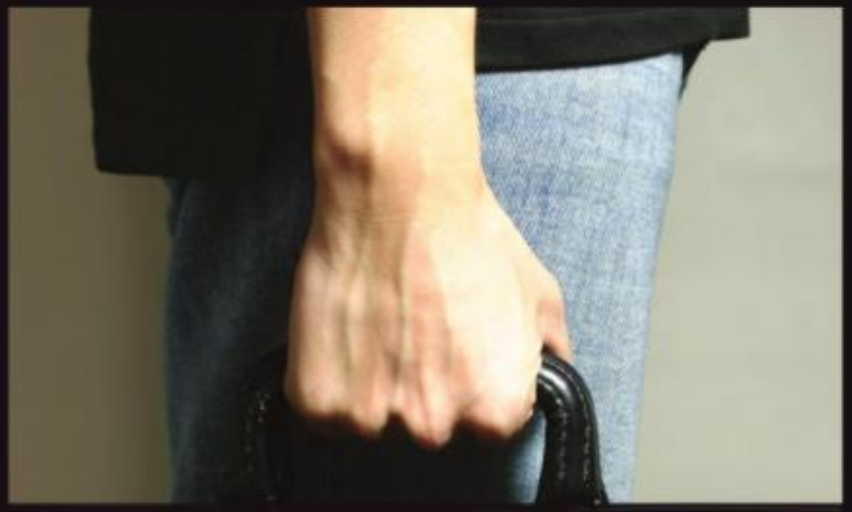



**Figure 1:** Depiction of pathways by which the relative strengths of the business, labour and civil society sectors act in concert with form of the welfare state and voter political activity and public support for a state role in distributing resources to produce public policy that shapes the quality and distribution of the SDH across the life course.

Raphael, D. and Bryant, T. (2015). Power, intersectionality and the lifecourse: Identifying the political and economic structures of welfare states that support or threaten health. *Social Theory and Health,* 13, 245-266.



# WORK & LABOUR IN CANADA

## CRITICAL ISSUES

SECOND EDITION

ANDREW JACKSON

foreword by Wallace Clement

Table 9.5: Benefits Coverage: Union vs. Non-union

| | Medical plan | Dental plan | Life/Disability insurance | Pension plan |
|---|---|---|---|---|
| **All employees** | 57.4% | 53.1% | 52.5% | 43.3% |
| **Unionized** | 83.7% | 76.3% | 78.2% | 79.9% |
| **Non-unionized** | 45.4% | 42.6% | 40.8% | 26.6% |

Source: Akyeampong, Ernest. "Unionization and Fringe Benefits," *Perspectives* (August 2002: 3–9).

**Table 9.2: The Union Average Hourly Wage Advantage, 2007**

| | Union | Non-union | Union advantage | Union advantage as % of non-union |
|---|---|---|---|---|
| **All** | $23.58 | $18.98 | $4.59 | 24.2% |
| **Men** | $24.38 | $21.20 | $3.18 | 15.0% |
| **Women** | $22.79 | $16.71 | $6.08 | 36.4% |
| **Age 15–24** | $14.45 | $11.63 | $2.82 | 24.2% |
| **By occupation:** | | | | |
| Professionals in business, finance | $30.03 | $28.94 | $1.09 | 3.8% |
| Secretary, administration | $22.00 | $19.05 | $2.95 | 15.5% |
| Clerical, supervisors | $20.12 | $15.92 | $4.20 | 26.4% |
| Natural sciences | $29.61 | $28.32 | $1.29 | 4.6% |
| Health, nursing | $29.96 | $29.22 | $0.74 | 2.5% |
| Assist health occupation | $21.05 | $18.94 | $2.11 | 11.1% |
| Social sciences | $26.13 | $21.64 | $4.50 | 20.8% |
| Teacher, professor | $30.45 | $23.44 | $7.01 | 29.9% |
| Art, culture, recreation | $24.42 | $19.33 | $5.09 | 26.3% |
| **Mainly low-wage private services:** | | | | |
| Retail, sales, cashier | $13.02 | $11.40 | $1.62 | 14.2% |
| Chefs, cooks | $15.22 | $11.42 | $3.80 | 33.2% |
| Protective services | $23.68 | $16.81 | $6.87 | 40.9% |
| Child care | $17.88 | $11.56 | $6.32 | 54.7% |
| Sales, service, travel | $15.18 | $11.26 | $3.92 | 34.8% |
| **Blue-collar:** | | | | |
| Construction trades | $24.76 | $18.50 | $6.26 | 33.8% |
| Other trades | $25.76 | $19.60 | $6.16 | 31.4% |
| Transport equipment | $21.62 | $17.00 | $4.62 | 27.2% |
| Trades helpers | $21.01 | $14.41 | $6.60 | 45.8% |
| Primary industry | $22.29 | $16.69 | $5.60 | 33.5% |
| Machine operators | $20.75 | $17.10 | $3.65 | 21.3% |
| Process, manufacturing | $17.38 | $13.07 | $4.31 | 32.9% |

Source: Statistics Canada. *Labour Force Survey*, 2007. Calculated from microdata files.


# Reject unions and prosper

## *Enacting a worker-choice law would give a province a competitive advantage*

by **Niels Veldhuis and Amela Karabegović**

Over the past two decades, Canadian politicians, bureaucrats, and others have become increasingly aware of the importance of business investment to the overall health of our economy. Business investment in plants, machinery, and equipment drives economic growth, creates jobs, and increases productivity. When workers have more capital (machines, equipment, and technology) at their disposal, they can produce more and/or higher-valued goods and services per hour and they can, therefore, demand higher wages.

***Given a choice, workers choose unions less often***

To attract business investment many provinces have focused on implementing policies to improve their investment climates. These have included more prudent management of government finances (pre-recession, of course), lower personal and corporate income taxes, the elimination of corporate capital taxes, invest-

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The End!

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