Take a Sad Song and Make it Better: Promoting Health Equity through Political Engagement and Policy Change

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Key Health Promotion Concepts

- Prerequisites of Health/SDOH
  - peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity.
- Citizen Empowerment
  - People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health.
- Important Role for Public Policy
  - Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change.

Source: Ottawa Charter for Health Promotion, 1986

Health Promotion Rhetoric

- Lalonde Report
- Epp Report
- Ottawa Charter
- Healthy Cities Movement
- CIAR Population Health
- Population Health Template
- Senate Report on SDOH
- Butler-Jones Reports
- Involvement in WHO SDOH Commission

Health Promotion Actions

- *In this regard [SDOH], Canada's recent performance suggests a bleak prognosis. Canada's track record since the 1980s in five respects related to social determinants of health: (a) the overall redistributive impact of tax and transfer policies; (b) reduction of family and child poverty; (c) housing policy; (d) early childhood education and care; and (e) urban/metropolitan health policy have reduced Canada's capacity to reduce existing health inequalities.*
- Source: Bryant, T., Raphael, D., Schrecker, T., and Labonte, R. (2011). Canada: A land of missed opportunities for addressing the social determinants of health. Health Policy, 101, (1), 44-58.

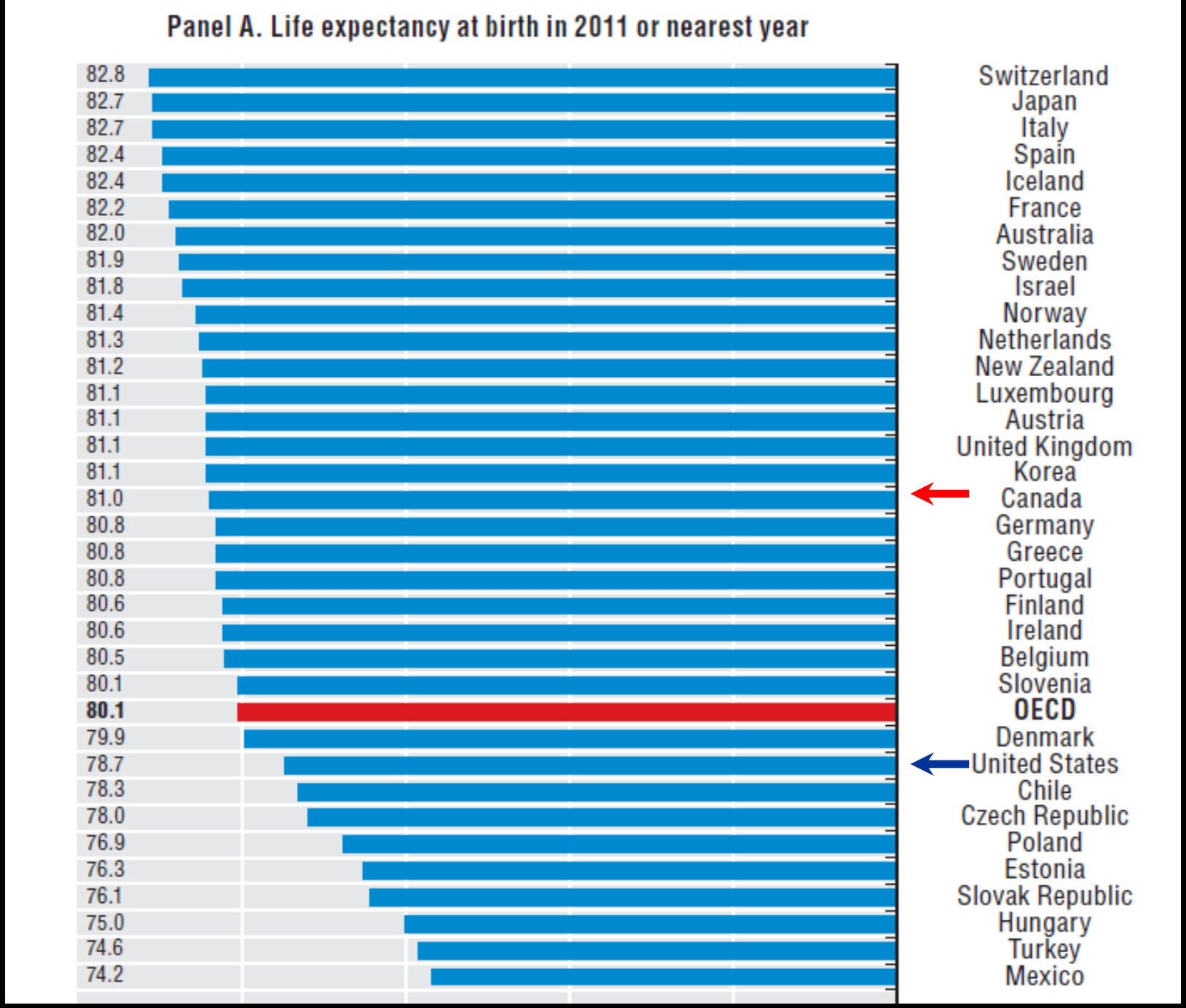
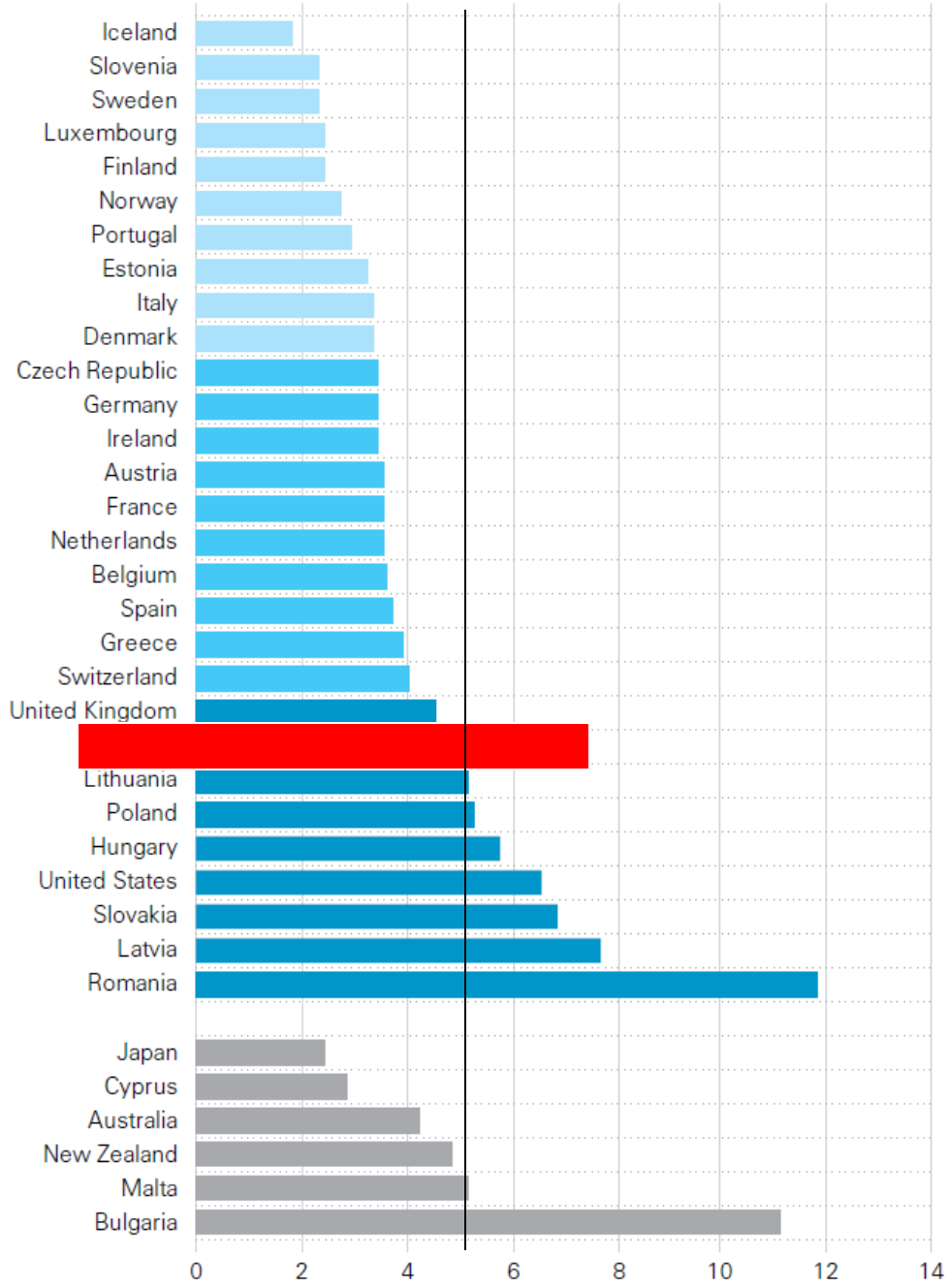

Panel A. Life expectancy at birth in 2011 or nearest year
82.8 Switzerland
82.7 Japan
82.7 Italy
82.4 Spain
82.4 Iceland
82.2 France
82.0 Australia
81.9 Sweden
81.8 Israel
81.4 Norway
81.3 Netherlands
81.2 New Zealand
81.1 Luxembourg
81.1 Austria
81.1 United Kingdom
81.1 Korea
81.0 Canada
80.8 Germany
80.8 Greece
80.8 Portugal
80.6 Finland
80.6 Ireland
80.5 Belgium
80.1 Slovenia
80.1 OECD
79.9 Denmark
78.7 United States
78.3 Chile
78.0 Czech Republic
76.9 Poland
76.3 Estonia
76.1 Slovak Republic
75.0 Hungary
74.6 Turkey
74.2 Mexico

Figure 2.1a Infant mortality rates

Deaths under 12 months old per 1,000 live births



Source: Innocenti Research Centre. (2013). *Child Well-being in Rich countries: A Comparative Overview*. Florence Italy: Innocenti Research Centre.

Losing Ground in Health: Infant Mortality

figure 14 We are losing ground among industrialized countries with respect to important health indicato
Our ranking for infant mortality (IMR) has slipped from 18th in 1980 to 25th in 2002.

1980	Rank	2002
IMR = 6.9 Sweden	1	Iceland IMR = 2.3
Japan	2	Finland
Finland	3	Japan
Iceland	4	Sweden
Norway	5	Norway
Denmark	6	Austria
Netherlands	7	Czech Republic
Switzerland	8	France
France	9	Spain
[redacted]	10	Germany
Australia	11	Belgium
Ireland	12	Denmark
Luxembourg	13	Italy
Belgium	14	Australia
United Kingdom	15	Netherlands
Spain	16	Portugal
Germany	17	Switzerland
IMR = 12.6 United States	18	Greece
New Zealand	19	Ireland
Austria	20	Luxembourg
Italy	21	United Kingdom
Czech Republic	22	Korea
Korea	23	[redacted]
Greece	24	New Zealand
Slovak Republic	25	United States IMR = 7.0
Hungary	26	Hungary
Portugal	27	Poland
Poland	28	Slovak Republic
Mexico	29	Mexico
Turkey	30	Turkey

ed for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
e: OECD Health Data 2007.

From 10th of 30 in 1980
to 23rd of 30 in 2002
to 27th of 34 in 2010

HEALTH STATUS (MORTALITY)
Infant mortality, Deaths per 1 000 live births

Iceland	2.2
Finland	2.3
Japan	2.3
Portugal	2.5
Slovenia	2.5
Sweden	2.5
Czech Republic	2.7
Norway	2.8
Korea	3.2
Spain	3.2
Estonia	3.3
Denmark	3.4
Germany	3.4
Italy	3.4
Luxembourg	3.4
Belgium	3.5
France	3.6
Israel	3.7
Greece	3.8
Ireland	3.8
Netherlands	3.8
Switzerland	3.8
Austria	3.9
Australia	4.1
United Kingdom	4.2
Poland	5.0
[redacted]	5.1
New Zealand	5.2
Hungary	5.3
Slovak Republic	5.7
United States	6.1
Chile	7.9
Turkey	10.1
Mexico	14.1

Source: OECD Health Data 2012
http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT

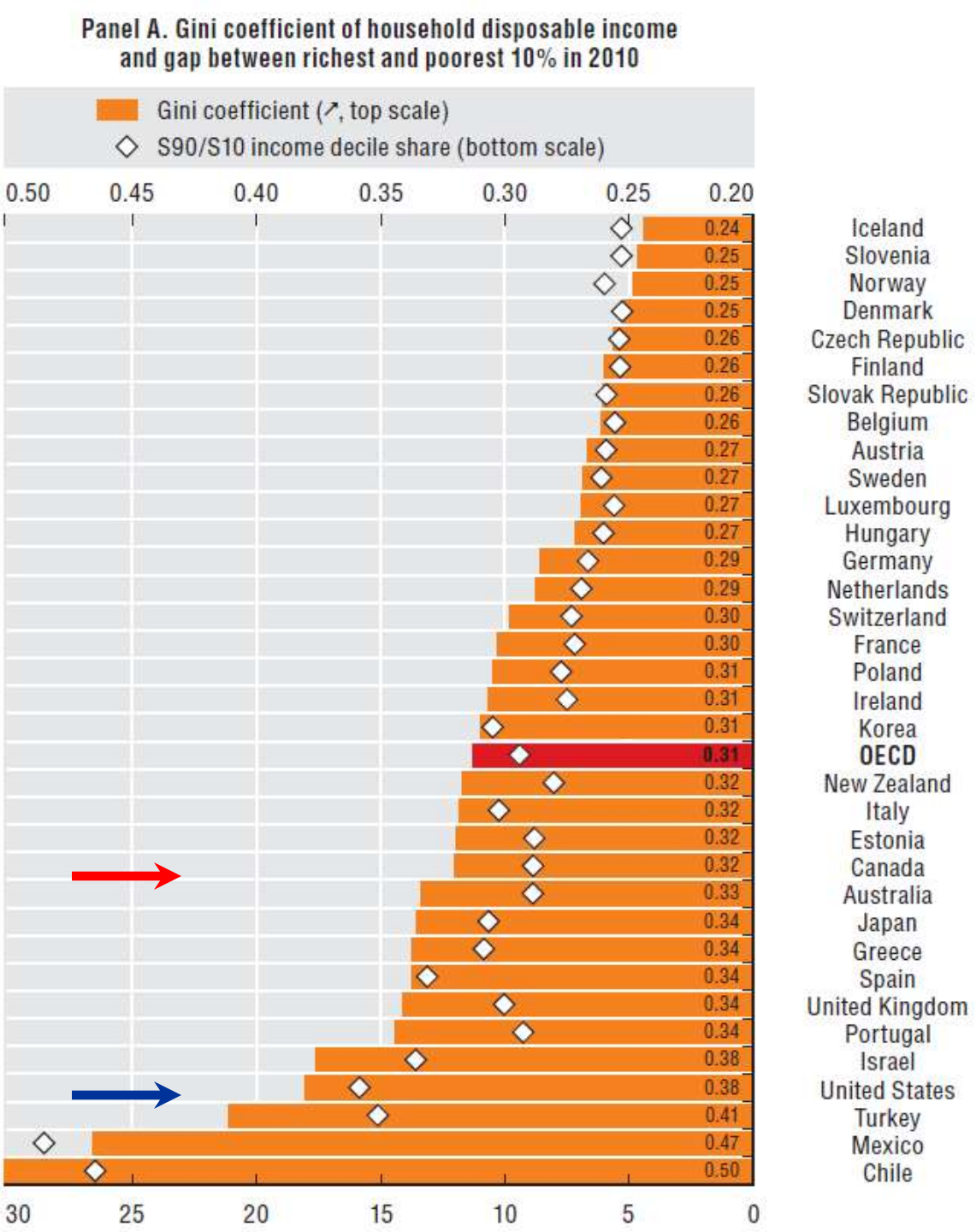
The table below ranks 29 developed countries according to the overall well-being of their children. Each country's overall rank is based on its average ranking for the five dimensions of child well-being considered in this review.

A light blue background indicates a place in the top third of the table, mid blue denotes the middle third, and dark blue the bottom third.

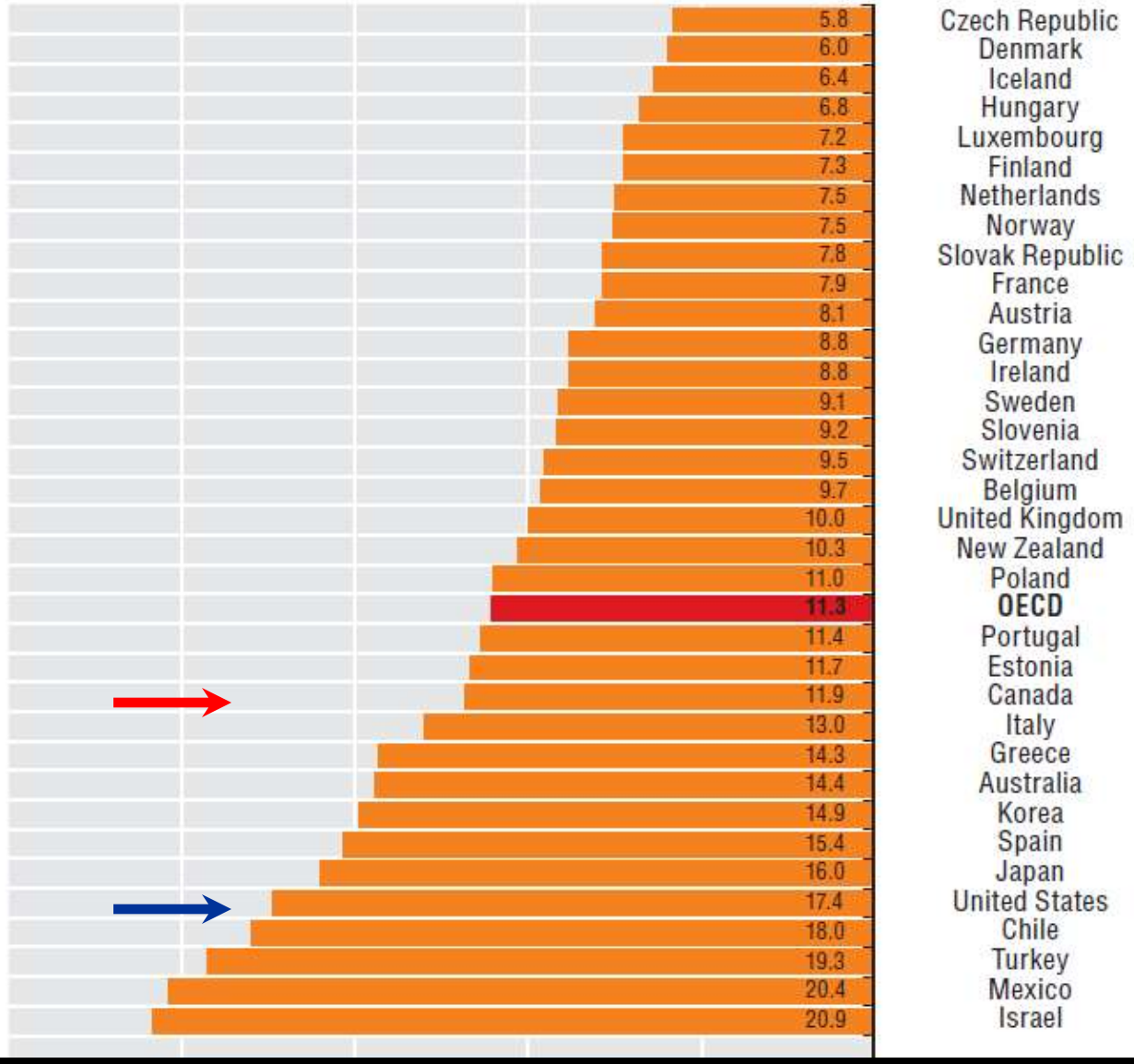
		Overall well-being	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5
		Average rank (all 5 dimensions)	Material well-being (rank)	Health and safety (rank)	Education (rank)	Behaviours and risks (rank)	Housing and environment (rank)
1	Netherlands	2.4	1	5	1	1	4
2	Norway	4.6	3	7	6	4	3
3	Iceland	5	4	1	10	3	7
4	Finland	5.4	2	3	4	12	6
5	Sweden	6.2	5	2	11	5	8
6	Germany	9	11	12	3	6	13
7	Luxembourg	9.2	6	4	22	9	5
8	Switzerland	9.6	9	11	16	11	1
9	Belgium	11.2	13	13	2	14	14
10	Ireland	11.6	17	15	17	7	2
11	Denmark	11.8	12	23	7	2	15
12	Slovenia	12	8	6	5	21	20
13	France	12.8	10	10	15	13	16
14	Czech Republic	15.2	16	8	12	22	18
15	Portugal	15.6	21	14	18	8	17
16	United Kingdom	15.8	14	16	24	15	10
18	Austria	17	7	26	23	17	12
19	Spain	17.6	24	9	26	20	9
20	Hungary	18.4	18	20	8	24	22
21	Poland	18.8	22	18	9	19	26
22	Italy	19.2	23	17	25	10	21
23	Estonia	20.8	19	22	13	26	24
23	Slovakia	20.8	25	21	21	18	19
25	Greece	23.4	20	19	28	25	25
26	United States	24.8	26	25	27	23	23
27	Lithuania	25.2	27	24	19	29	27
28	Latvia	26.4	28	28	20	28	28
29	Romania	28.6	29	29	29	27	29

Source: Innocenti Research Centre. (2013). *Child Well-being in Rich countries: A Comparative Overview*. Florence Italy: Innocenti Research Centre.

Dimensions	Components	Indicators
Dimension 1 **Material well-being** Figure 1.0	Monetary deprivation	Relative child poverty rate
		Relative child poverty gap
	Material deprivation	Child deprivation rate
		Low family affluence rate
Dimension 2 **Health and safety** Figure 2.0	Health at birth	Infant mortality rate
		Low birthweight rate
	Preventive health services	Overall immunization rate
	Childhood mortality	Child death rate, age 1 to 19
Dimension 3 **Education** Figure 3.0	Participation	Participation rate: early childhood education
		Participation rate: further education, age 15–19
		NEET rate (% age 15–19 not in education, employment or training)
	Achievement	Average PISA scores in reading, maths and science
Dimension 4 **Behaviours and risks** Figure 4.0	Health behaviours	Being overweight
		Eating breakfast
		Eating fruit
		Taking exercise
	Risk behaviours	Teenage fertility rate
		Smoking
		Alcohol
		Cannabis
	Exposure to violence	Fighting
		Being bullied
Dimension 5 **Housing and environment** Figure 5.0	Housing	Rooms per person
		Multiple housing problems
	Environmental safety	Homicide rate
		Air pollution


Panel A. Gini coefficient of household disposable income and gap between richest and poorest 10% in 2010
Gini coefficient (↗, top scale)
S90/S10 income decile share (bottom scale)
0.50
0.45
0.40
0.35
0.30
0.25
0.20
0.24 Iceland
0.25 Slovenia
0.25 Norway
0.25 Denmark
0.26 Czech Republic
0.26 Finland
0.26 Slovak Republic
0.26 Belgium
0.27 Austria
0.27 Sweden
0.27 Luxembourg
0.27 Hungary
0.29 Germany
0.29 Netherlands
0.30 Switzerland
0.30 France
0.31 Poland
0.31 Ireland
0.31 Korea
0.31 OECD
0.32 New Zealand
0.32 Italy
0.32 Estonia
0.32 Canada
0.33 Australia
0.34 Japan
0.34 Greece
0.34 Spain
0.34 United Kingdom
0.34 Portugal
0.38 Israel
0.38 United States
0.41 Turkey
0.47 Mexico
0.50 Chile
30
25
20
15
10
5
0

Panel A. Percentage of persons living with less than 50% of median equivalised household income, in 2010



5.5. Minimum-income benefits alone cannot typically prevent income poverty

Net income level provided by cash minimum-income benefit, including housing assistance or not, in percentage of median household income

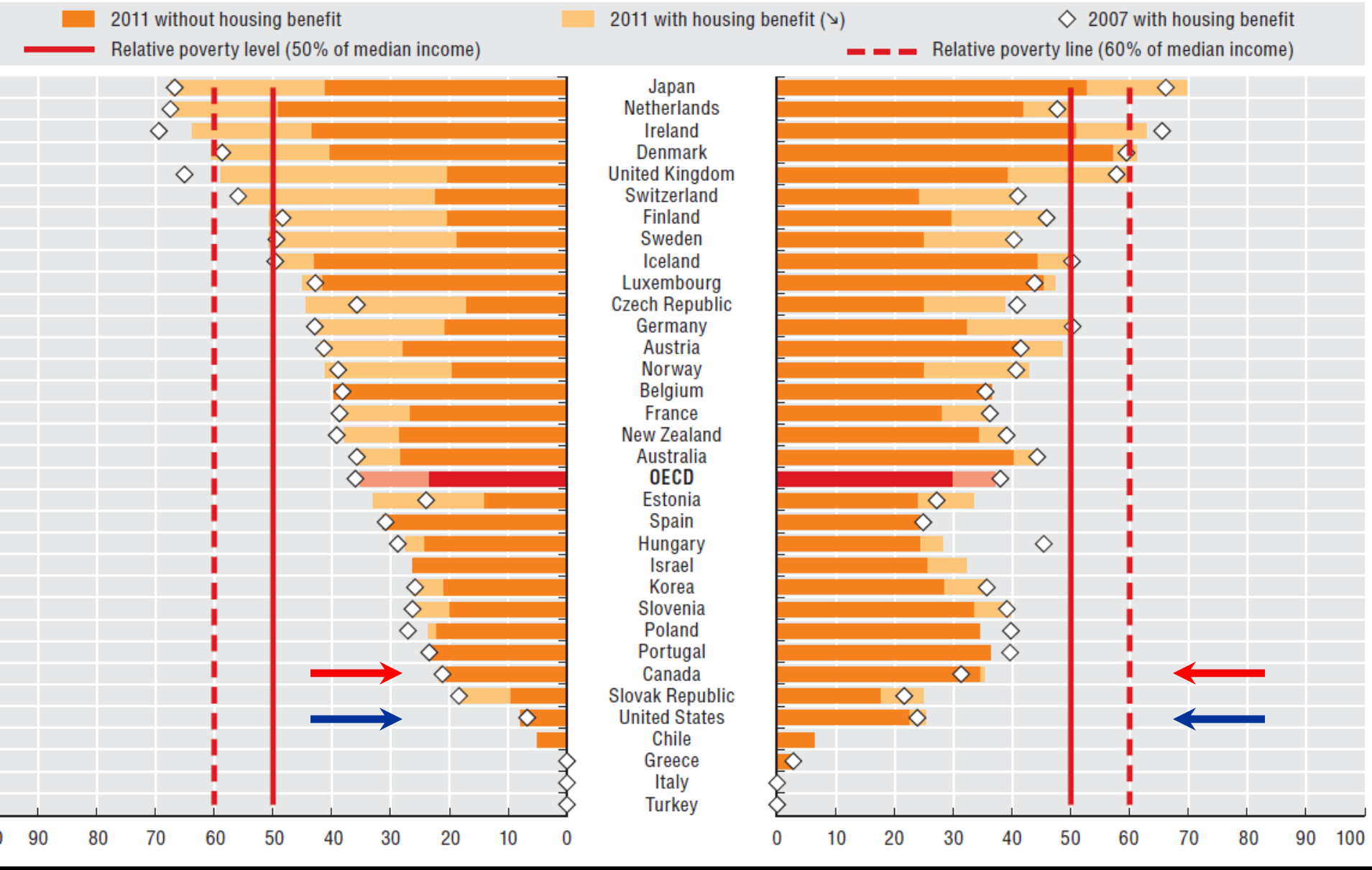


TABLE 1

Norway, Canada, and USA Rankings on Selected Social Determinants of Health & Indicators of Population Health in Comparison to other OECD Nations (circa. 2010) (n=34)

Measure	Norway	Canada	USA
Social determinants of health	Ranking (1 is best)		
% Living in Poverty [1] (2010)	8	23	30
No Money for Food During Past Year [1] (2011/2012)	9	20	29
Income Inequality [1] (2010)	3	23	31
Public Social Expenditure [1] (2010)	16	26	23
Minimum-Income Benefit (single person) [1] (2011)	14	27	29
Public Share Health Spending [4] (2012) (n=30)	3	20	30
Health			
Life Expectancy [2] (2011)	10	17	26
Infant Mortality [2] (2011)	4	26	30
Low Birth Weight [2] (2011)	5	12	28
Child Well-being [3] (2009-2011) (n=29)	2	17	26

Sources: **[1]** OECD (2014). *Society at a Glance Paris:* OECD; **[2]** OECD (2013). Health at a Glance. Paris: OECD. **[3]** Innocenti Research Centre (2013). Child Well-being in Rich Countries: A Comparative Overview. Florence: Innocenti Research Centre; **[4]** Canadian Institute for Health Information (CIHI)(2014). National Health Expenditure Trends, 1975 to 2014. Ottawa: CIHI

What is the central institution in society – in terms of shaping the distribution of resources?

- The state (government)?
- The family?
- The market?

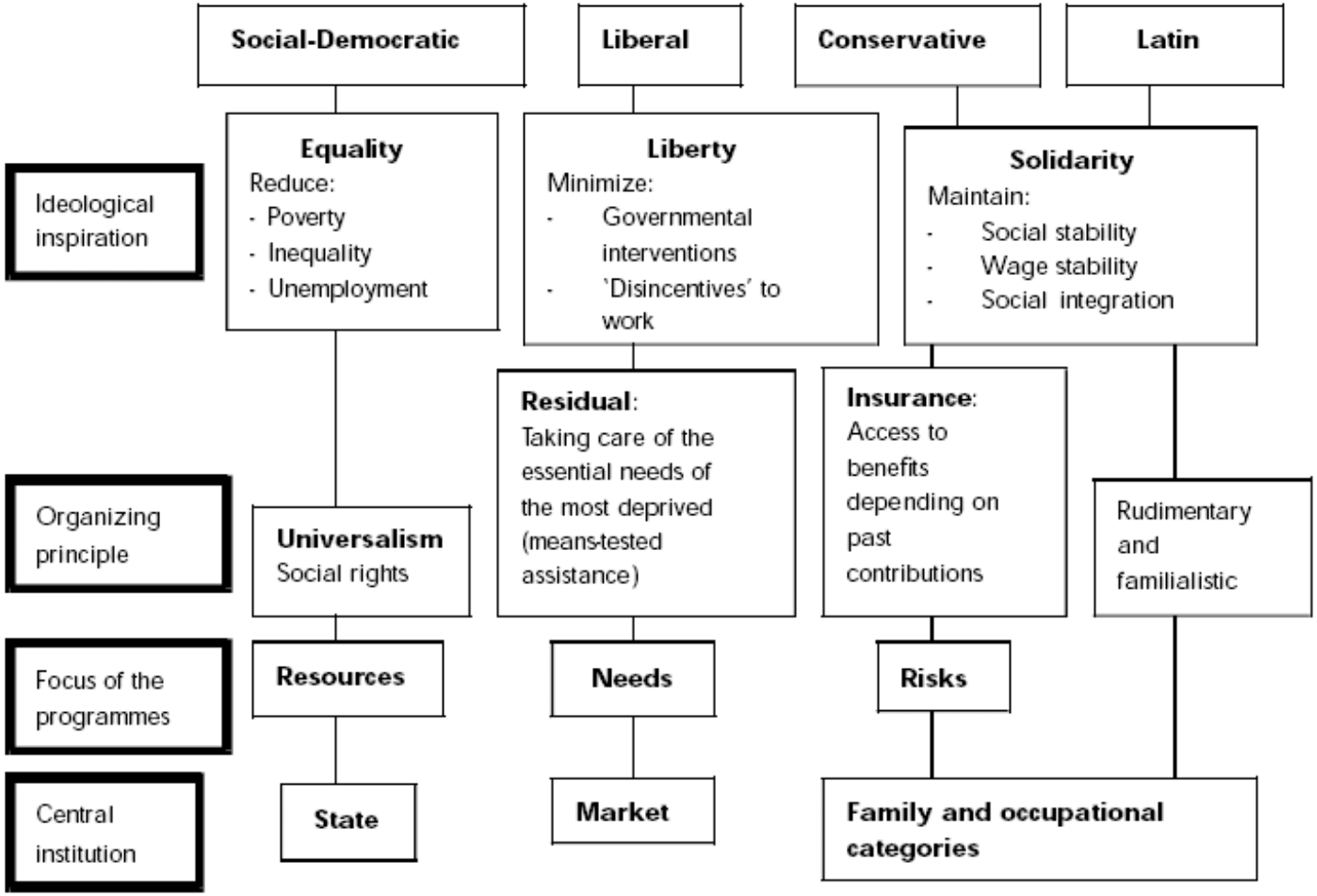
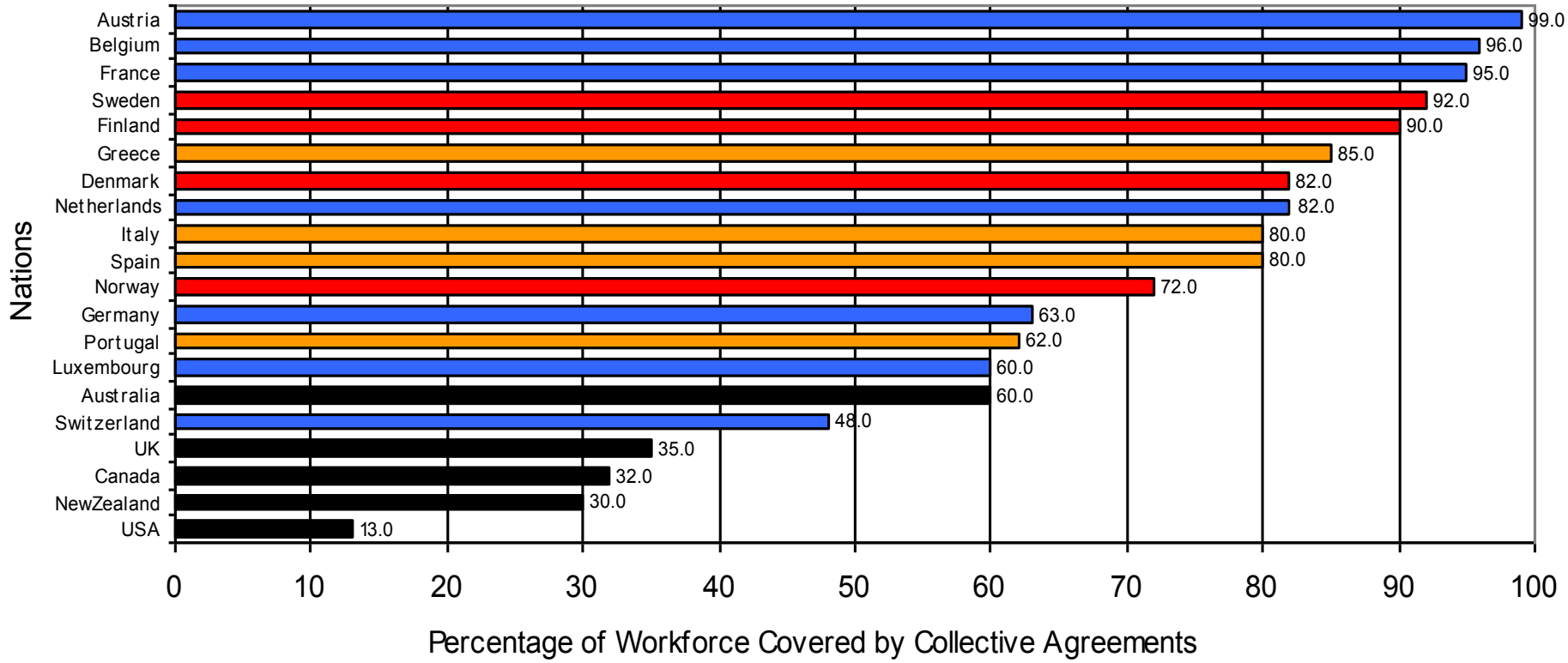


Figure 2 The Characteristics of Welfare Regimes

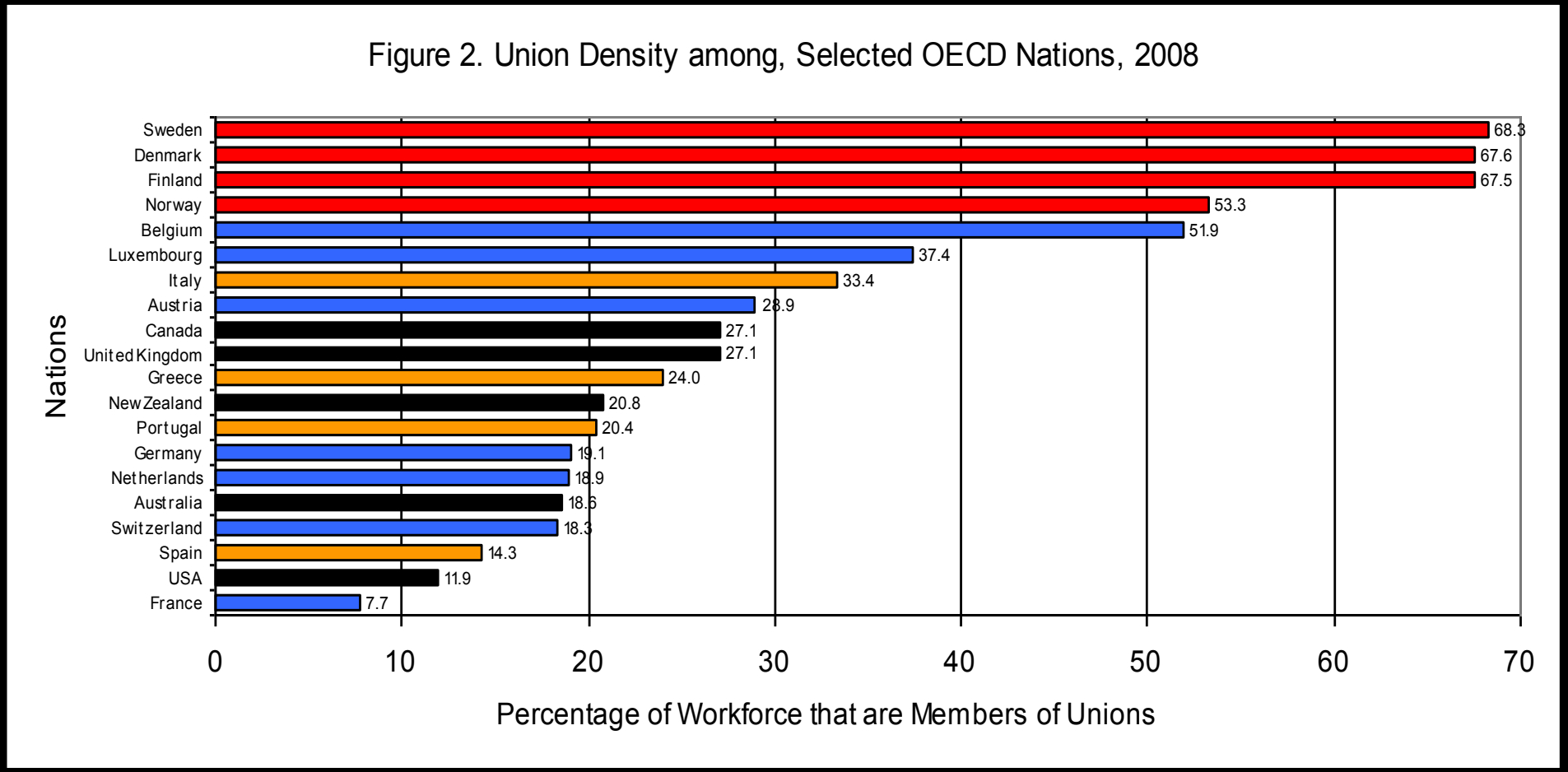
Source: Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchial cluster analysis of the welfare regimes in advanced countries. Current Sociology, 51(5), 499-527.

Figure 1. Collective Agreements Coverage among,Selected OECD Nations, 2008



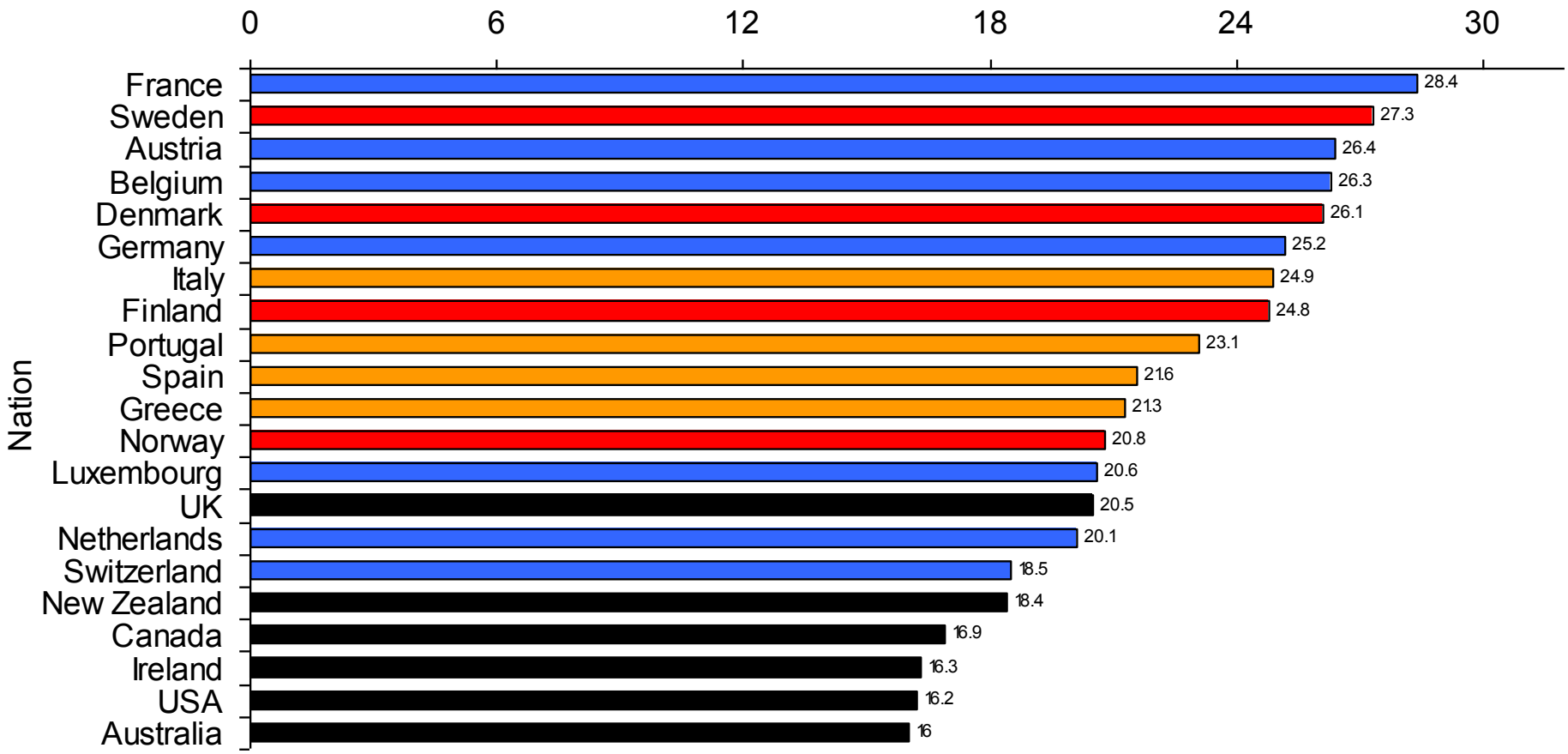
Source: Venn, D. (2009). Legislation, Collective Bargaining and Enforcement: Updating the OECD Employment Protection Indicators, OECD Social Employment and Migration Working Papers, No. 89, Paris: OECD

Figures for Ireland are from Ireland: Industrial Relations Profile, EIRO, 2009, available at http://www.eurofound.europa.eu/eiro/country/ireland.pdf.



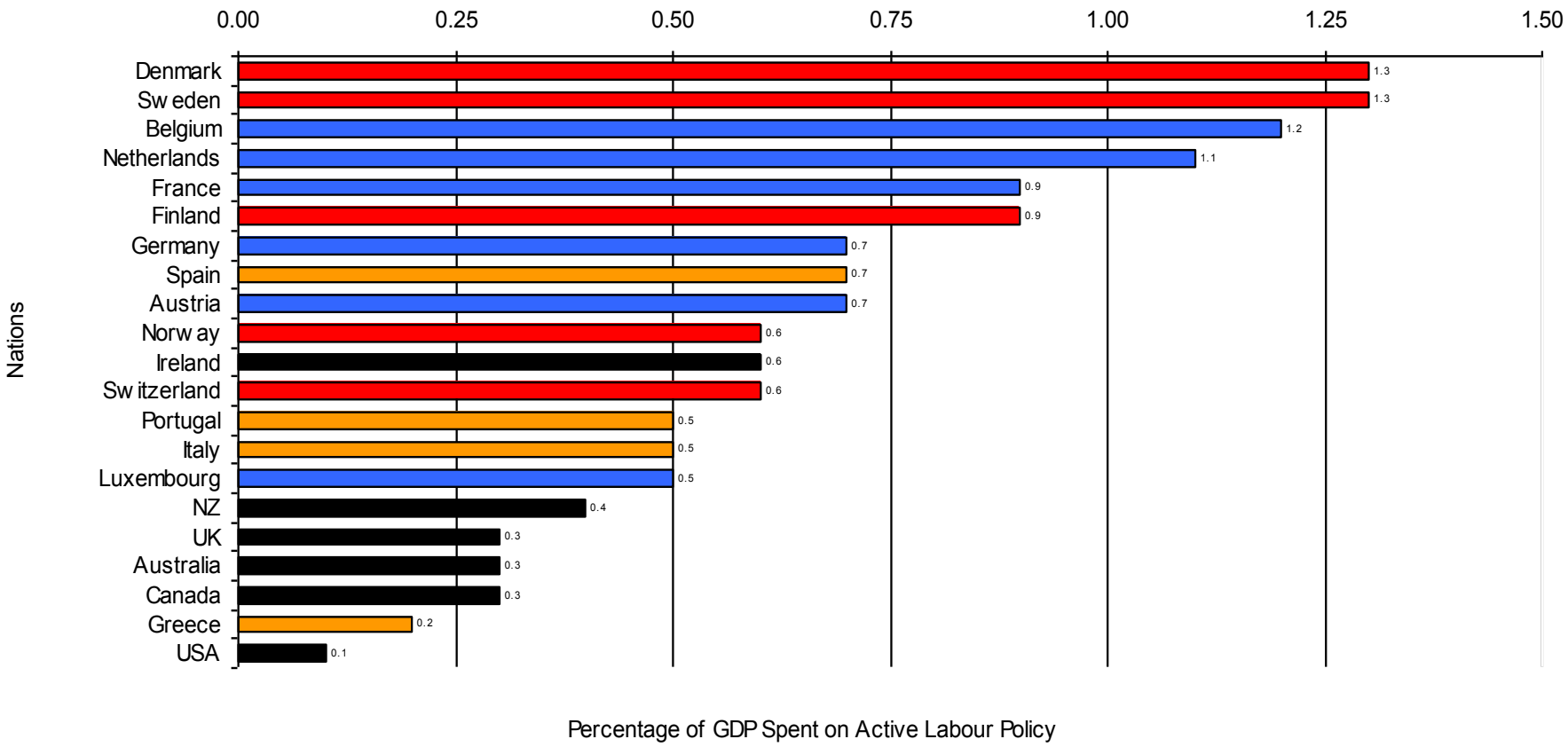
Data Source: Organization for Economic Cooperation and Development (2010). Trade Union Density. Available at http://stats.oecd.org/Index.aspx?DataSetCode=UN_DEN

Figure 3. Total Public Expenditures as Percentage of GDP, Selected OECD Nations, 2007



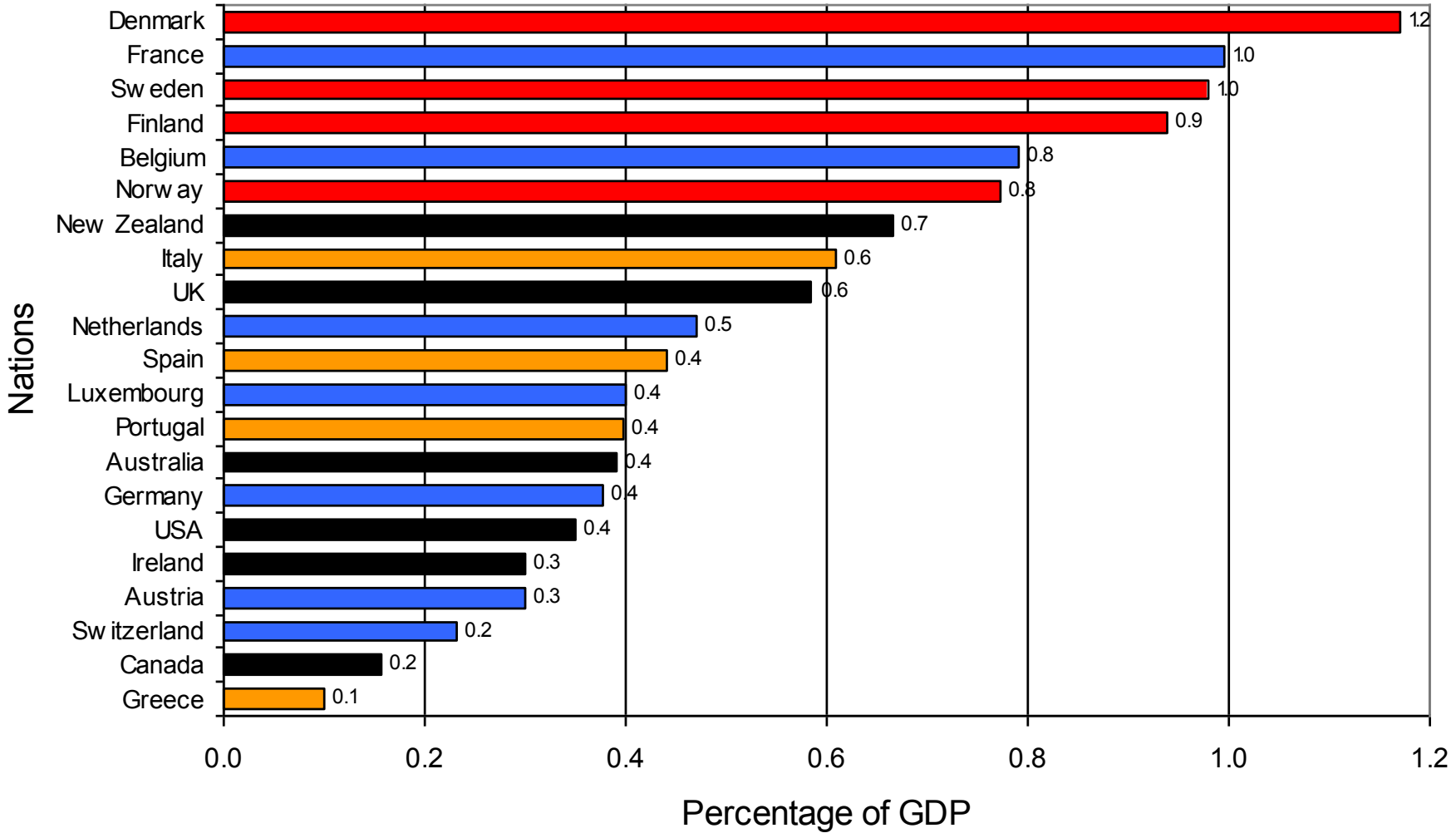
Source: OECD Social Expenditure Database, http://stats.oecd.org/Index.aspx?datasetcode=SOCX_AGG

Figure 6. Public Spending on Active Labour Policy as Percentage of GDP, Selected OECD Nations, By Welfare State Type, 2007



Source: From Social Expenditure Database, OECD 2008. Paris: OECD.

Figure 7. Public Expenditure on Childcare and Early Education Services as Percentage of GDP, Selected OECD Nations, by Welfare State, 2005



Source: OECD Family Database (2010). Available at www.oecd.org/dataoecd/45/27/37864512.pdf

Decommodification

- “Essentially, it is the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance” (p.4).

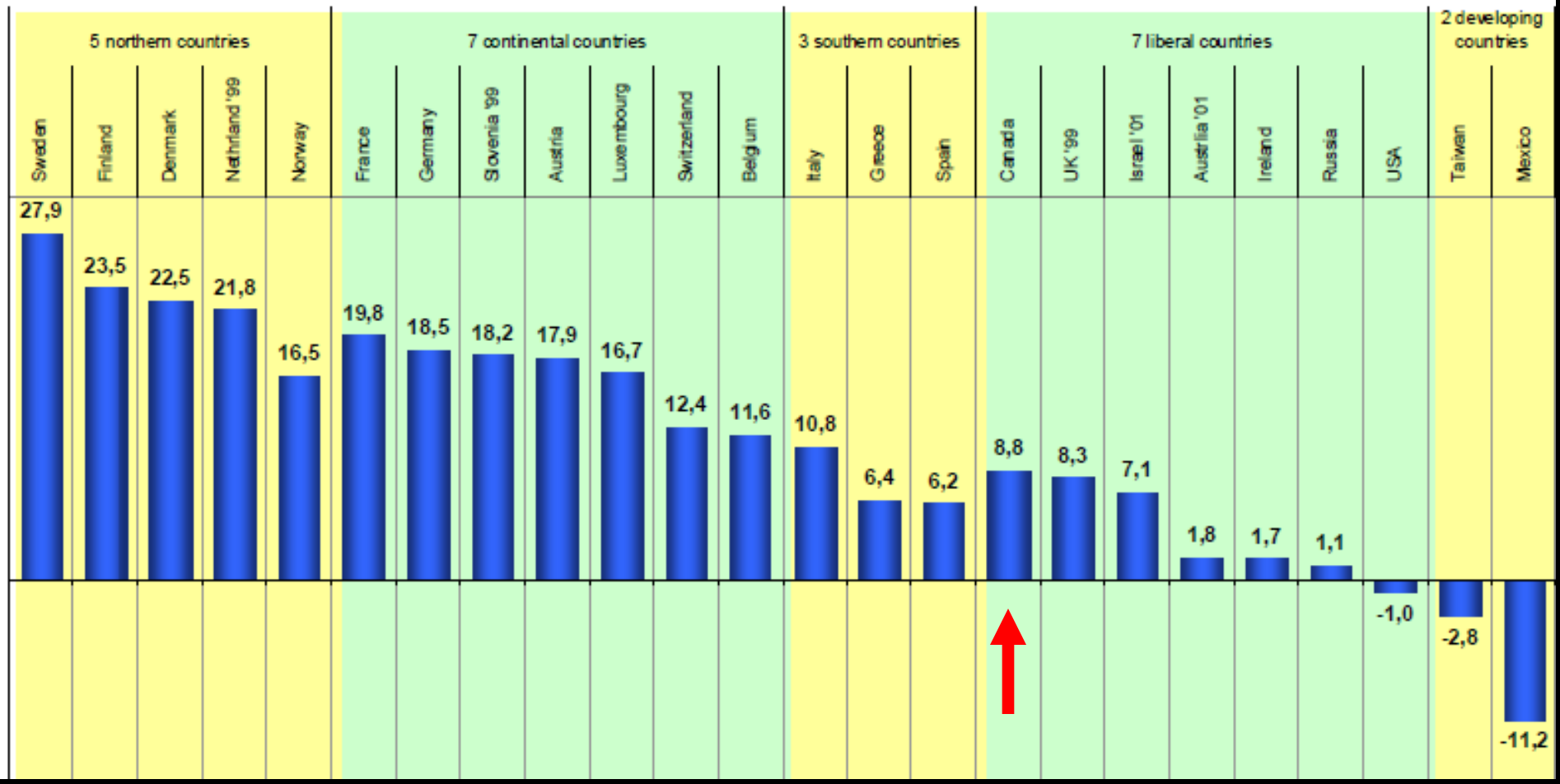
- Source: Eikemo, T. A. and Bambra, C. (2008) The welfare state: a glossary for public health. Journal of Epidemiology and Community Health, 62, 3–6.

Decommodified Security Ratio

- **Provision of three types of income:**
  - (i) replacement income for the risks of old age, unemployment, sickness and disability plus survivors' pensions;
  - (ii) reimbursements and benefits in kind: costs of health care, family allowances, housing benefits; and
  - (iii) allowances and benefits in kind paid as part of measures to combat social exclusion (income support, etc.).

  - Menahem, G. (2010) How Can The Decommodified Security Ratio Assess Social Protection Systems? LIS Working Paper No. 529. Luxembourg Income Study, Syracuse.

Figure 1. *Levels of decommodified security in 24 countries in 1999-2001*



Source: Menahem, G. (2010). LIS Working Paper No. 529, How Can the Decommodified Security Ratio Assess Social Protection Systems?

Table 1. Varying Discourses on HPP and the Distribution of the PrH/SDH	
PRH/SDH Discourse	Key Concept
1. PRH/SDH as identifying those in need of health and social services.	Health and social services should be responsive to peoples' material living circumstances. HPP aims to improve access and quality of these services.
2. PRH/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. HPP aims to make the healthy choice the easy choice.
3. PRH/SDH as indicating the material living conditions that shape health.	Material living conditions operating through various pathways – including biological -- shape health. Implicit assumption that policymakers will respond to evidence with appropriate HPP.
4. PRH/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. Implicit assumption that policymakers will respond with appropriate HPP.
5. PRH/SDH and their distribution as results of public policy decisions made by governments and other societal institutions.	Public policy analysis should form the basis of PRH/SDH analysis and advocacy efforts. Explicit call for the making of HPP to address these issues.
6. PRH/SDH and their distribution result from economic and political structures and justifying ideologies.	Public policy that shapes the PRH/SDH reflects the operation of jurisdictional economic and political systems. Explicit call for the making of HPP to address these issues with recognition that nations tend to follow established public policy paths.
7. PRH/SDH and their distribution result from the power and influence of those who create and benefit from health and social inequalities.	Explicit call for the making of HPP to address these issues with recognition that specific societal sectors both create and benefit from the existence of social and health inequalities. Need to identify these opponents and build political social movements to defeat them in the public policy domain.


DILBERT
By Scott Adams
OUR SPECIAL GUEST IS TOD, FROM OUR RESEARCH DEPARTMENT.
WE RECENTLY DID A STUDY TO ASSESS THE VALUE OF OUR PREVIOUS RESEARCH.
SADLY, ALL OF OUR PAST WORK WAS EITHER IGNORED OR TOTALLY MISINTERPRETED BY IDIOTS...
... SUCH AS YOURSELVES.
SO FROM NOW ON, RATHER THAN DO RESEARCH, WE'LL JUST LIE.
PLAY ALONG AND WE'LL MAKE SURE THE "INDUSTRY SALARIES" STUDY GOES YOUR WAY.
WELL, IT'S TWO O'CLOCK, AND THAT'S QUITTING TIME IN THE RESEARCH DEPARTMENT.
YOU'RE NOT MY ROLE MODEL ANYMORE... I'VE FOUND ANOTHER.

Beyond Policy Analysis: The Raw Politics Behind Opposition to Healthy Public Policy

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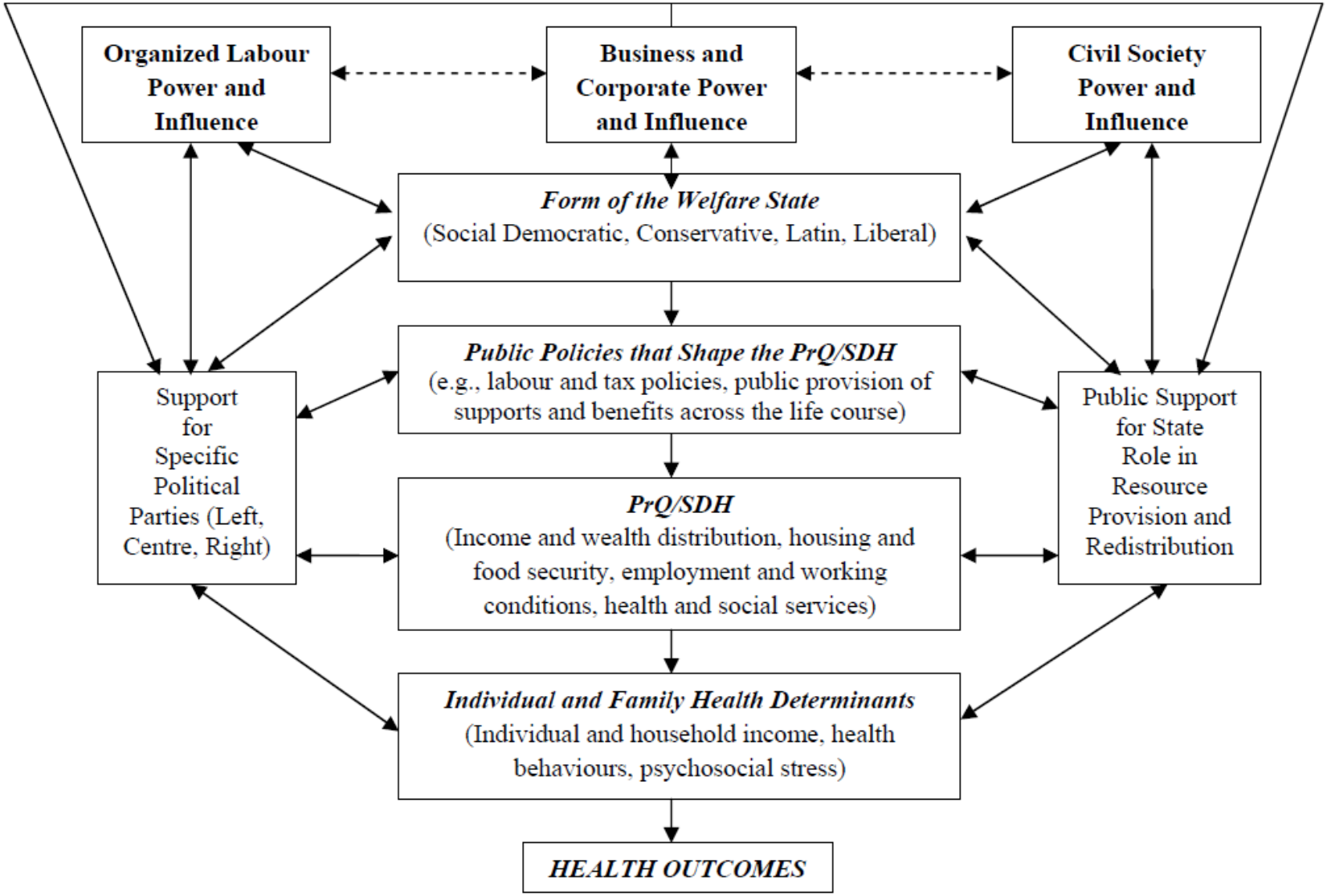
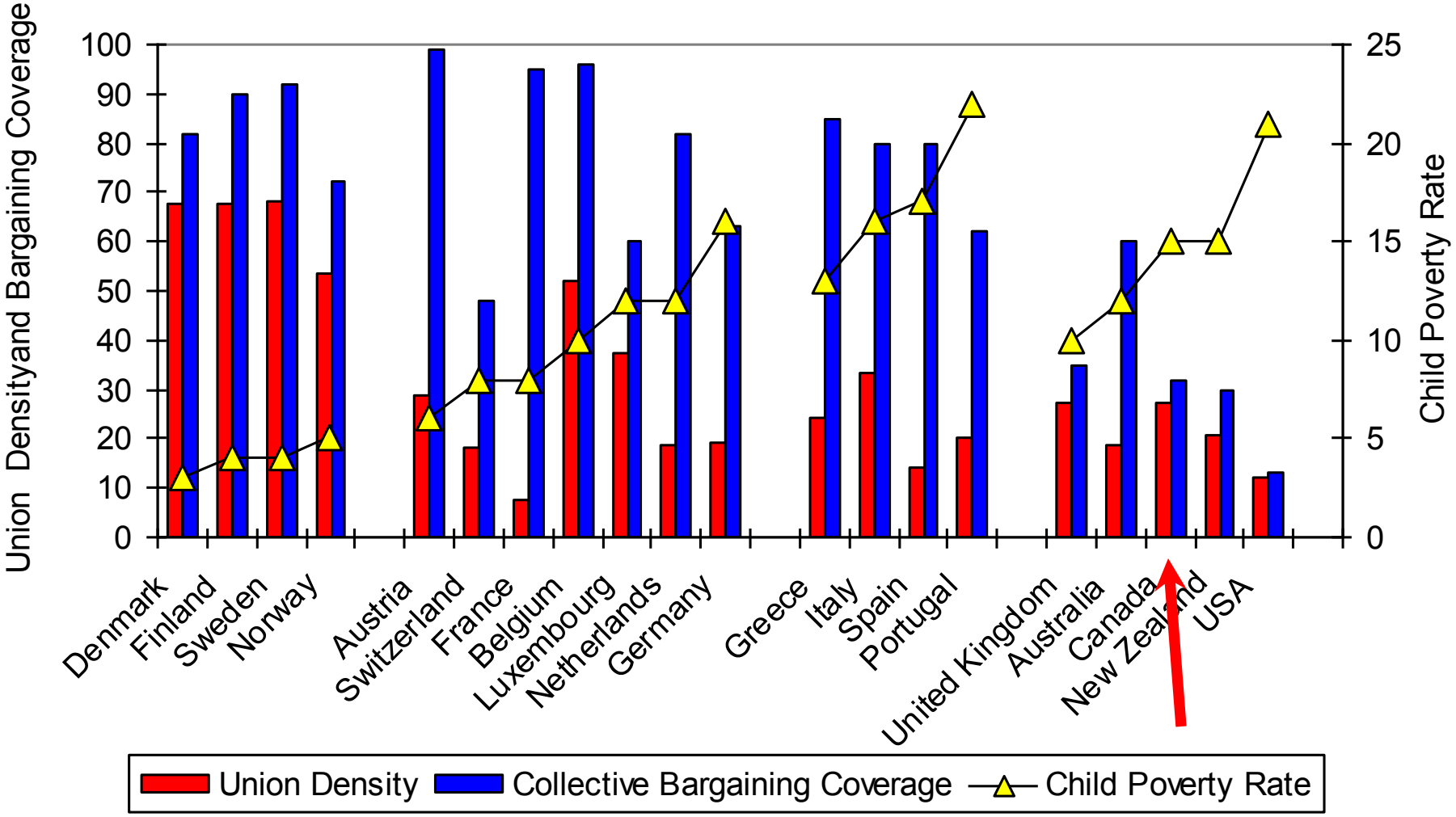


Figure 1: Depiction of Pathways by which the Relative Strengths of the Business, Labour, and Civil Society Sectors act in concert with Form of the Welfare State and Voter Political Activity and Public Opinion to produce Public Policy that shapes the Quality and Distribution of the PrQ/SDH

Adapted from Raphael, 2013.

Figure 1. Union Density, Collective Agreement Coverage and Child Poverty, 2008 (density and coverage rates) and Mid 2000s (poverty rates)



Available at http://www.oecd.org/dataoecd/8/24/31781139.xls and OECD (2009). Growing Unequal: Income Distribution and Poverty in OECD Countries Figure 5.a2.1, p.154.

David Coburn

Contemporary business dominance, and its accompanying neo-liberal ideology and policies, led to attacks on working class rights in the market (e.g., by undermining unions) and to citizenship rights as expressed even in the liberal (market-dependent) version of the welfare state enacted in most of the Anglo-American nations. Labour's lessened market power and fragmentation, and the shredding of the welfare state also led to major increases in social inequality, poverty, income inequality and social fragmentation (Coburn, 2004, p. 44).

Robert Chenomas and Ian Hudson
Income power and privilege have been shifted towards those who own and control the corporate world and away from the majority of the North American public, with the express democratic consent of that very public... The current conservative policy environment has made our society less healthy, more dangerous, less stable, more unequal, less fair, and more inefficient (Chernomas & Hudson, 2007).

David Langille

By identifying the political actors behind what are often seen as impersonal market forces, citizens come to understand that progressive change is possible—and how they might improve the social determinants of health… If citizens are to reassert their power and restore democracy, they will first have to raise public awareness about the threat of corporate control (Langiile, 2009, p. 305).

What is to be done? I

- Esping-Anderson argues the social democratic nations are marked by their history of coalition building between labour and other sectors that have led to the development of universalist public policies that have secured the loyalties of the middle class.

What is to be done? II

- Liberal nations with their modest benefits targeted to the least well-off -- representing the weakness of labour movements and the dominance of business interests -- have been less able to secure the loyalties of the middle class to the welfare state.
- Instead the middle classes have given their loyalties to the economic marketplace.

What is to be done? III

- The process of achieving collective employment bargaining could be facilitated either through the strengthening of trade unions or the introduction of cross-sectoral bargaining.
- The second policy direction would be to distribute risk across the population through introduction of universalist health and social assistance schemes that minimize individual susceptibility to adverse life-course and accidental events.

Shifting Public Policy

- State of social policy and action on health inequalities in Canada.

- Theories of Public Policy: Pluralism, Policy Paradigms, and Political Economy – How they can help.

State of Public Policy and Health Inequalities

Canada – Wanting

- Focus on changing health care.
- Lack of political will to address social inequalities in Canada.

Canada

Dominant Political Influences:

- Federalism
- Political ideology -- Neo-liberalism – Emphasis on Market.
- Declining influence of federal government – decentralizing power to provinces.
- Influence of Opposition parties – e.g. New Democratic Party, Green Party.

World Health Organization

- “Health inequities exist because the wrong policies are in place.”

-- Dr. Margaret Chan
WHO Director General



Source: www.nicholsoncartoons.com.au

Policy Change Models

- Implementing or changing policy – essential to promote health equity.

- WHO and others identify development of healthy public policy as cornerstone of new public health (Equity Action, 2012; World Health Organization, 2008, 2009).

Pluralism

- Widely used policy approach developed in North America.
- Interest groups: Key societal influence on public policy.
- State: neutral arbiter of societal interests.
- Consensus model of public policy.
- Emphasis on evidence and ideas.

Critique of Pluralism

- Undeveloped understanding of inequality.
- Assumes all citizens have equal access to political process.
- Citizens should not experience undo resistance to their ideas from government.
- Benevolent state will weigh evidence and merit of ideas.

Policy Paradigms

Three levels of policy change:

- 1st -order: change in policy settings; e.g. increase number of community health centres.
- 2nd order: change in policy instruments. e.g. to discourage smoking, use public education (voluntary). If ineffective, increase taxes on tobacco products (involuntary).
- 3rd order: paradigmatic/radical policy change with radical overhaul of policy goals and objectives. e.g. government shifts focus from health care to social determinants of health; development of welfare state in developed nations in post-WWII era and more recently, privatization in health care or selling off of Ontario Hydro.

Policy Paradigms

- Paradigm shifts: based on ideas; politically rather than scientifically based.
- Anomalies of received paradigm (e.g., biomedicine) mount.
- Paradigm replaced by alternative paradigm (e.g. social determinants).
- Consensus – rational approach.

Political Economy

- Materialist perspective on politics and political process.
- Societal organization of production and distribution of social and economic resources give rise to ideas and institutions.
- Politics and economics – interrelated, shape public policy process and living conditions.
- Political, economic and social forces interact with social locations (i.e. class, gender, race, etc.)

Political Economy

- Influence of political ideology, specifically Neo-liberalism (ideology of market); political power.
- Compatible with social determinants and how political and economic environments shape distribution of resources within society.
- Focus on income-related health inequalities.

Table 10.1 State Institutions and Models of Policy Change – Welfare Regime, Electoral Process, Central vs. Federal System

	Finland, Norway, and Sweden	Australia and Britain and Northern Ireland	Canada and the USA
Pluralism	Maintain public support for the Nordic welfare state.	Continue to build public support for policy initiatives.	Public education as to the social determinants of health inequalities.
Policy Paradigms	Evaluate and communicate the Nordic welfare state paradigm's successes in promoting health and well-being.	Work to maintain state structures and interest in intervening in operation of the established market economy.	Recognize the profound barriers to paradigmatic shifts among well-established liberal welfare state.
Political Economy	Work to maintain social democratic ideals behind the Nordic welfare state	Recognize that forward movement will require ongoing vigilance against market forces.	Work to offset dominance of the policy agenda by corporate and business interests.
Proportional Representation	Maintain proportional representation in the electoral process.	All three policy models suggest means of promoting electoral reform towards proportional representation through public education, restructuring government, and balancing political power.	

Table 10.2 Power Relations and Models of Policy Change – Electoral Behaviour, Trade Union Strength, and Civil Society Coalitions			
	Finland, Norway, and Sweden	Australia and Britain and Northern Ireland	Canada and the USA
Pluralism	Plurality of interests has historically supported public policies that promote health equity.	Plurality of interests that support health equity has varied over time such that policy directions are inconsistent.	Plurality of interests has never coalesced around tackling health inequalities through public policy action.
Policy Paradigms	Long-standing Nordic traditions promote receptivity to tackling health inequalities.	Shifting political fortunes of social democratic parties limit longstanding institutional commitments.	Dominance of corporate and business interests make tackling health inequalities by governments difficult.
Political Economy	Relative balance between business, labour, and civil society promotes progressive public policy.	Shifting political fortunes of social democratic parties provide inconsistent public policy activity.	Dominance of economic interests makes the raising of issues of health inequalities difficult.

Table 10.3 SDOH-Related Public Policy and Models of Policy Change			
	Finland, Norway, and Sweden	Australia and Britain and Northern Ireland	Canada and the USA
Pluralism	Continue to advocate for strong welfare state.	Advocate for continuing strengthening of commitment to address health inequalities.	Educate the public as to the deficiencies of the Canadian and USA welfare states.
Policy Paradigms	Maintain strong commitments to provision of economic and social security to citizens.	Strengthen institutional support for provision of economic and social security to citizens.	Confront and lobby for changes to weak and inadequate economic and social security provided to citizens.
Political Economy	Maintain strong commitment to social democratic principles in public policy.	Recognize significant sectors that resist state provision of economic and social security.	Strengthen citizen action that supports public policy in the service of all.

What is happening?

RESEARCH PAPER

The Untold Story: Examining Ontario's Community Health Centres' Initiatives to Address Upstream Determinants of Health

L'histoire inconnue : examen des initiatives des centres de santé communautaire en Ontario sur la question des déterminants en amont de la santé

Conclusions: Despite minimal attention from researchers and funders, our findings suggest that CIs play key capacity-building roles in vulnerable communities across Ontario, and warrant further investigation.

HEALTHCARE POLICY *Vol.10 No.1, 2014*

Sudbury & District Health Unit
Service de santé publique

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

and Not Talk About *Health Care* at All

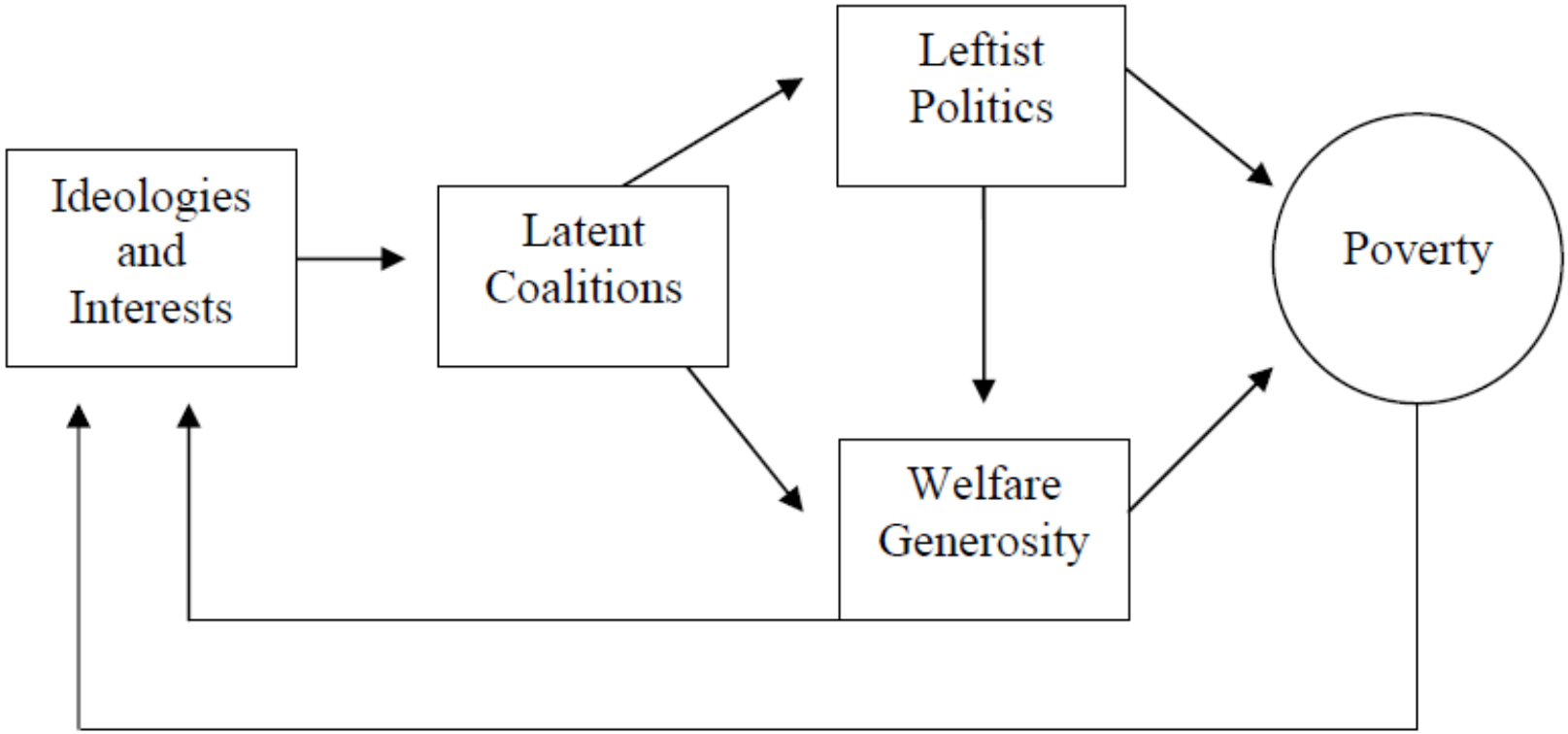
USER GUIDE



A Majority Of Units!

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

Figure 14.2: Components of Brady's Institutionalized Power Relations Theory



Source: Brady, D, (2009). *Rich Democracies, Poor People: How Politics Explain Poverty,* Figure 1.2, p. 14. New York: Oxford University Press.



CANADA WITHOUT POVERTY
CANADA SANS PAUVRETÉ

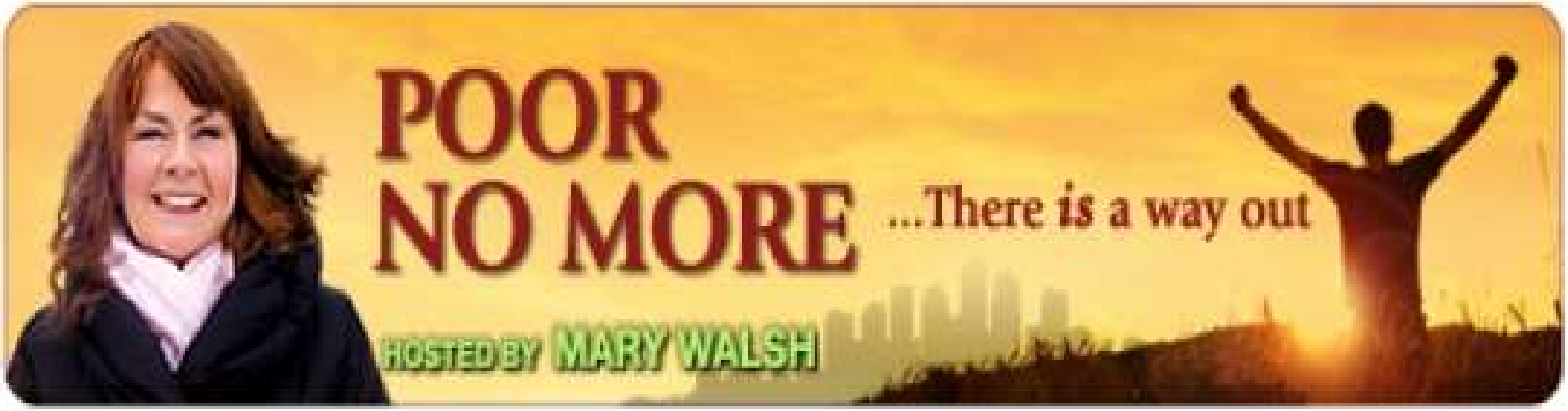
imagine... *imaginez...*

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Canadian Labour Congress

Congrès du travail du Canada




POOR
NO MORE
...There is a way out
HOSTED BY MARY WALSH



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BROADBENT

INSTITUTE



CCPA

CANADIAN CENTRE
for POLICY ALTERNATIVES


THE
COUNCIL
OF CANADIANS
LE
CONSEIL
DES CANADIENS
ACTING FOR SOCIAL JUSTICE



upstream


“THE WEIGHT OF THE EVIDENCE FOR THE SOCIAL DETERMINANTS OF HEALTH, AND THE NEED FOR CREATIVE, SYSTEM-WIDE POLICY CHANGES TO ADDRESS THEM, IS SIMPLY TOO GREAT TO IGNORE.”
Dr. Ryan Meili, University of Saskatchewan
Evidence Network .ca

Component of Statistics Canada Catalogue no. 82-003-X
Health Reports

Article

Cause-specific mortality by income adequacy in Canada: A 16-year follow-up study



by Michael Tjepkema, Russell Wilkins and Andrea Long

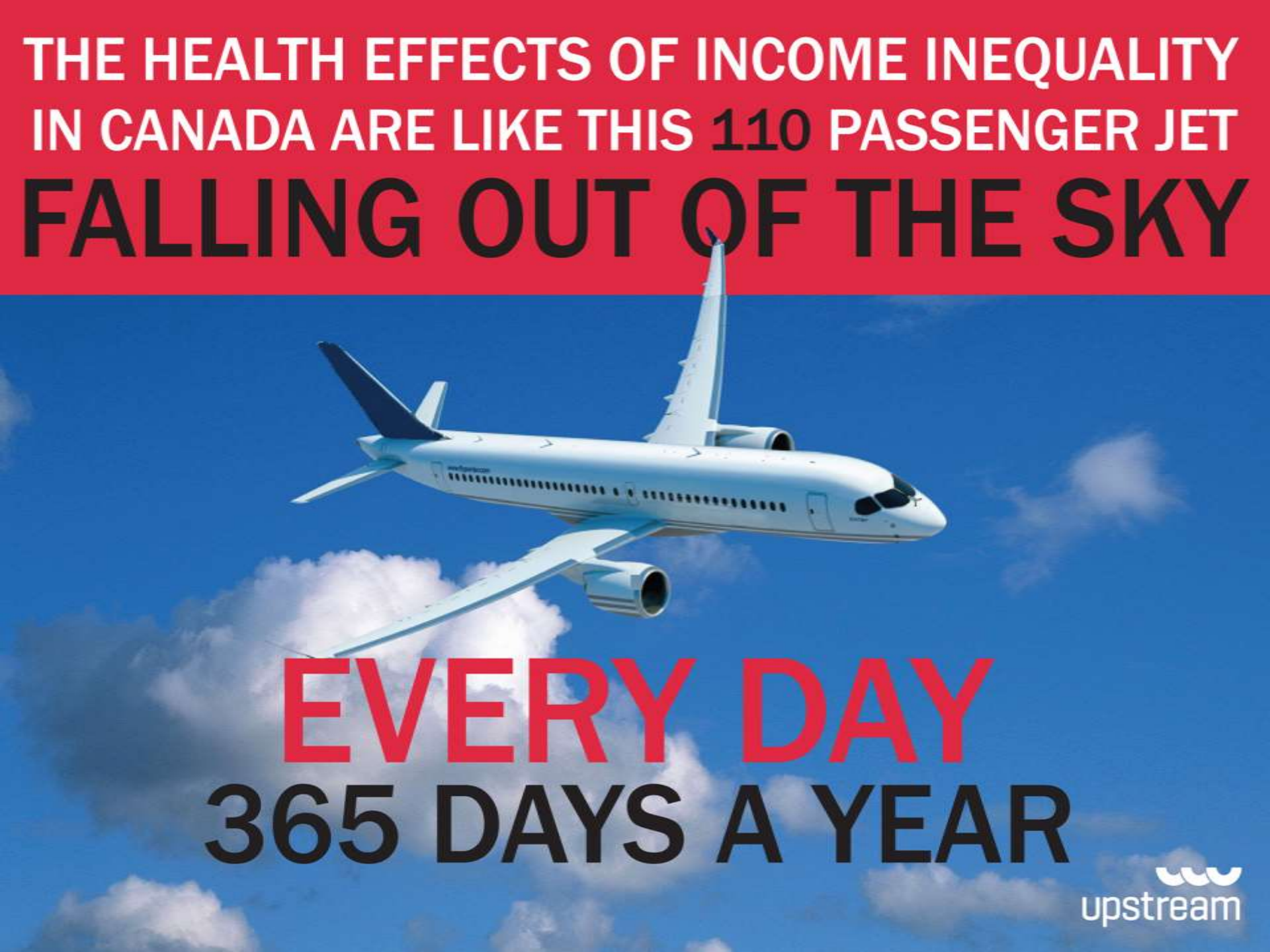
July, 2013

Statistics Canada Statistique Canada

Canada

THE HEALTH EFFECTS OF INCOME INEQUALITY IN CANADA ARE LIKE THIS 110 PASSENGER JET

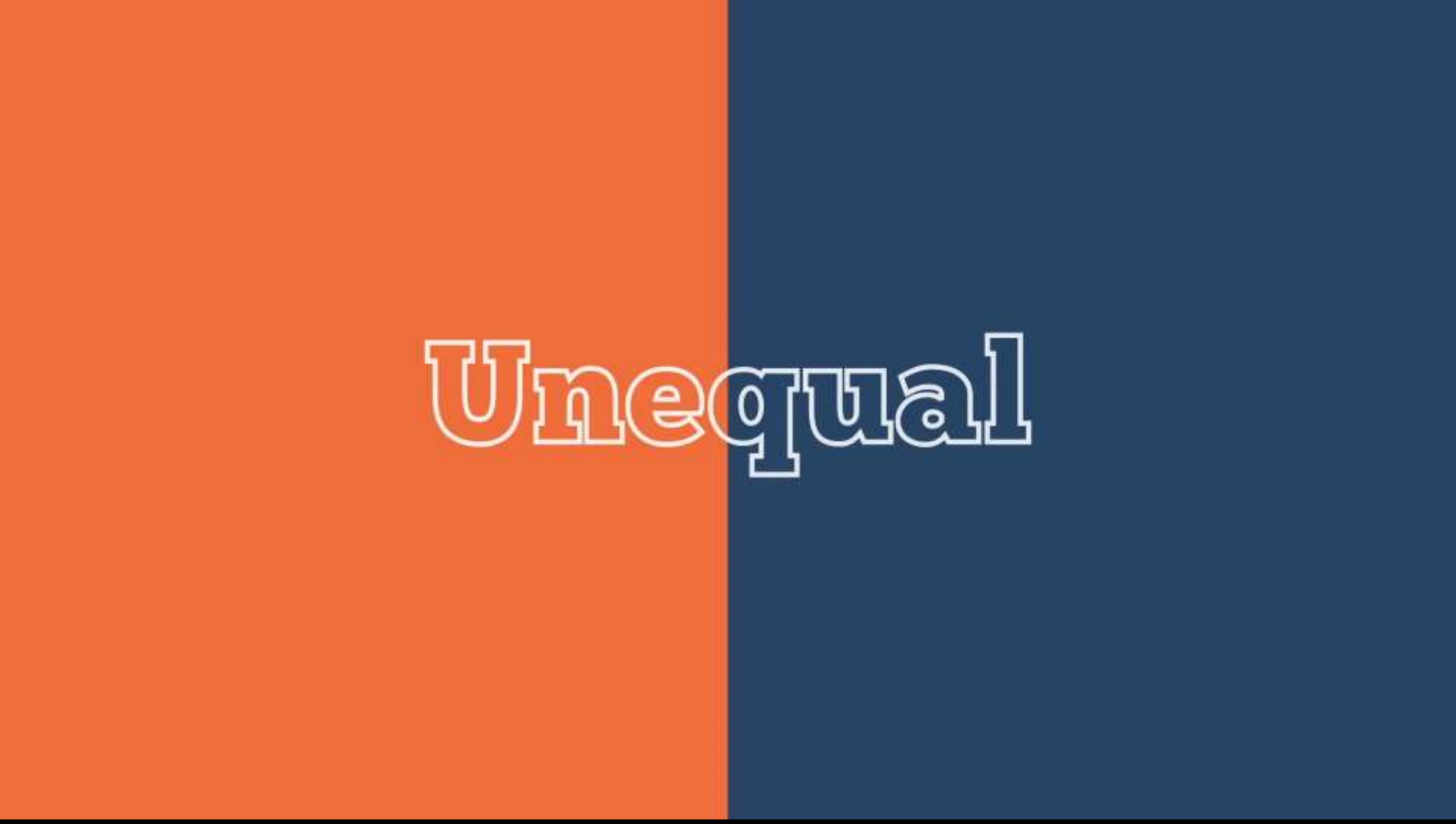
FALLING OUT OF THE SKY



EVERY DAY

365 DAYS A YEAR

upstream



Unequal - Social Inequalities in Health

YouTube


green party


Liberal


NDP


BLOC
QUÉBÉCOIS



Current as of April 26/11

END CHILD & FAMILY POVERTY IN CANADA

Campaign 2000 wrote to each national party leader on these issues. Campaign 2000 received responses to its questions from 3 out of 4 parties represented across Canada. The Conservative Party did not respond. These charts were developed using responses from the political parties and information from the publicly-released platforms. Their responses are summarized with a check (√) if their party has committed to Campaign 2000's policy recommendations:

ISSUE	CONSERVATIVE	LIBERAL	NDP	GREEN
Develop a plan with specific targets and/or timetables for poverty reduction?	X	√	√	√
Increase Canada Child Tax Benefit or equivalent to $5,400/child per year?	X	X	√*	X
Establish a system of universally accessible, high quality early childhood education and care (ECEC) services?	X	√	√	√
Develop a national strategy for affordable housing including funds for social housing?	X	√	√	√
Re-establish federal minimum wage at $11 per hour and develop jobs with sustaining wages?	X	X	√	X
Increase WITB to $2,400 per year for all employed adults?	X	X	X	X
Restore eligibility for Employment Insurance (EI)?	X	X**	√	√***
New immigrants and racialized communities: Steps to recognize foreign credentials?	√****	√****	√****	√****
Establish a poverty reduction strategy for First Nation communities?	X	√*****	√*****	√*****
For urban Aboriginal Peoples?	X	X	X	X
Improve access to both postsecondary education and training/skills upgrading?	X	√	√	√
Establish a basic income for individuals with a disability?	X	X******	X******	√

*Committed to increase child benefit by $700;
**Liberals will do comprehensive review of the EI program to ensure it continues to meet the needs of Canadians and their families
*** Greens will provide EI benefits retroactively
****None of the parties adopts equity strategies for racialized communities
*****While no party adopted a specific strategy for First Nations, each announced initiatives that would be part of a sound strategy
******While neither party would establish a basic income, each supported plan to implement UN Convention on the Rights of Persons with Disabilities.
Other notes: Campaign 2000 has not received a response from the Conservative Party as of April 26, 2011 and has obtained platform information from their website.

Source: Campaign 2000 (2011). www.campaign2000.ca/election2011/FedElectionShortPartyGrid.pdf

NEW DEMOCRATIC PARTY OF CANADA

Health care: Now is the time

Prevention is better than cure

Every Canadian should have the opportunity to lead a healthy life, and the federal government can help them by making sure they have a decent income, access to healthy food, affordable housing, and a social safety net-what experts call **the social determinants of health**. After all, an apple a day keeps the doctor away.

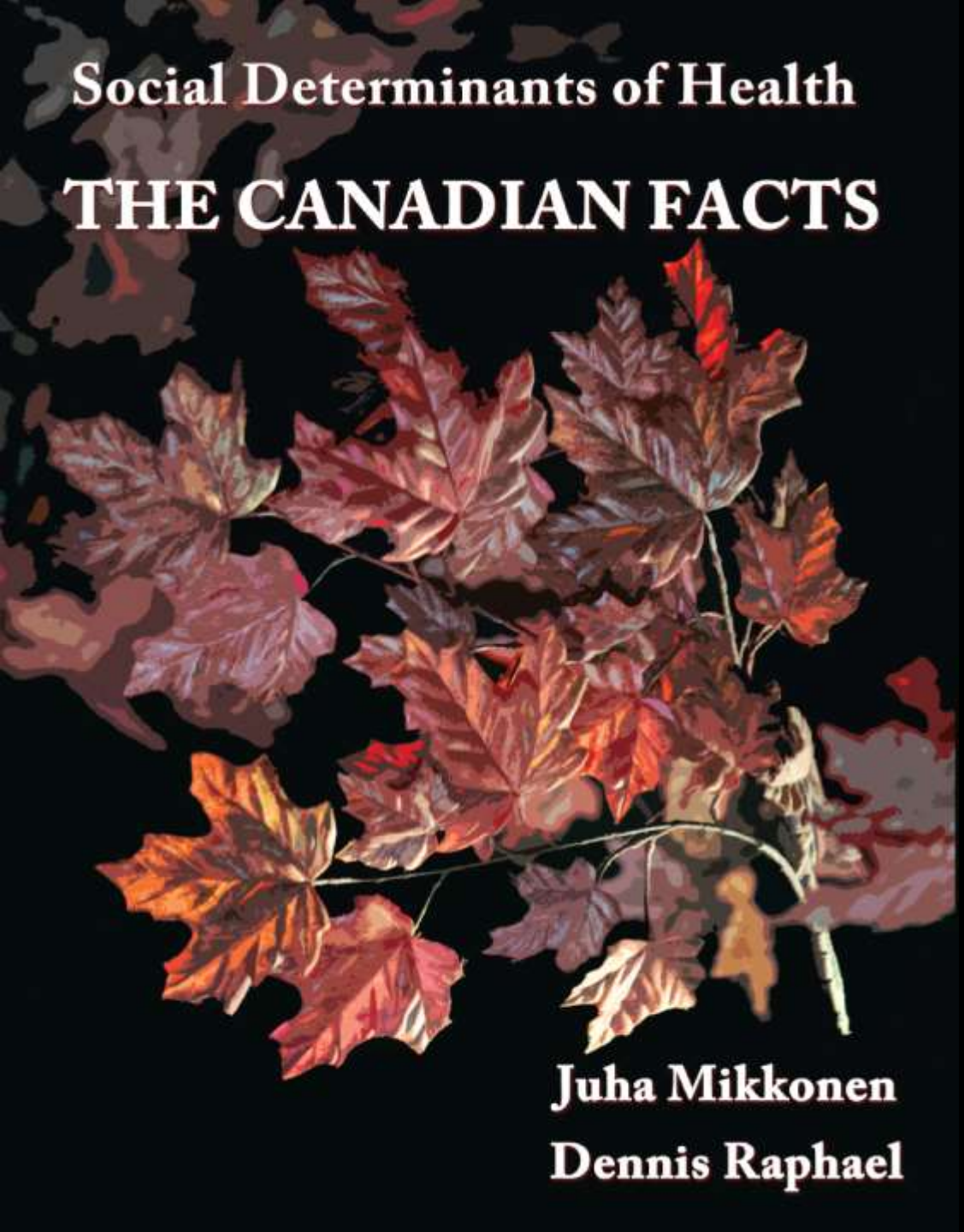
What the federal government should do:

Offer living conditions that support good health through many different initiatives:

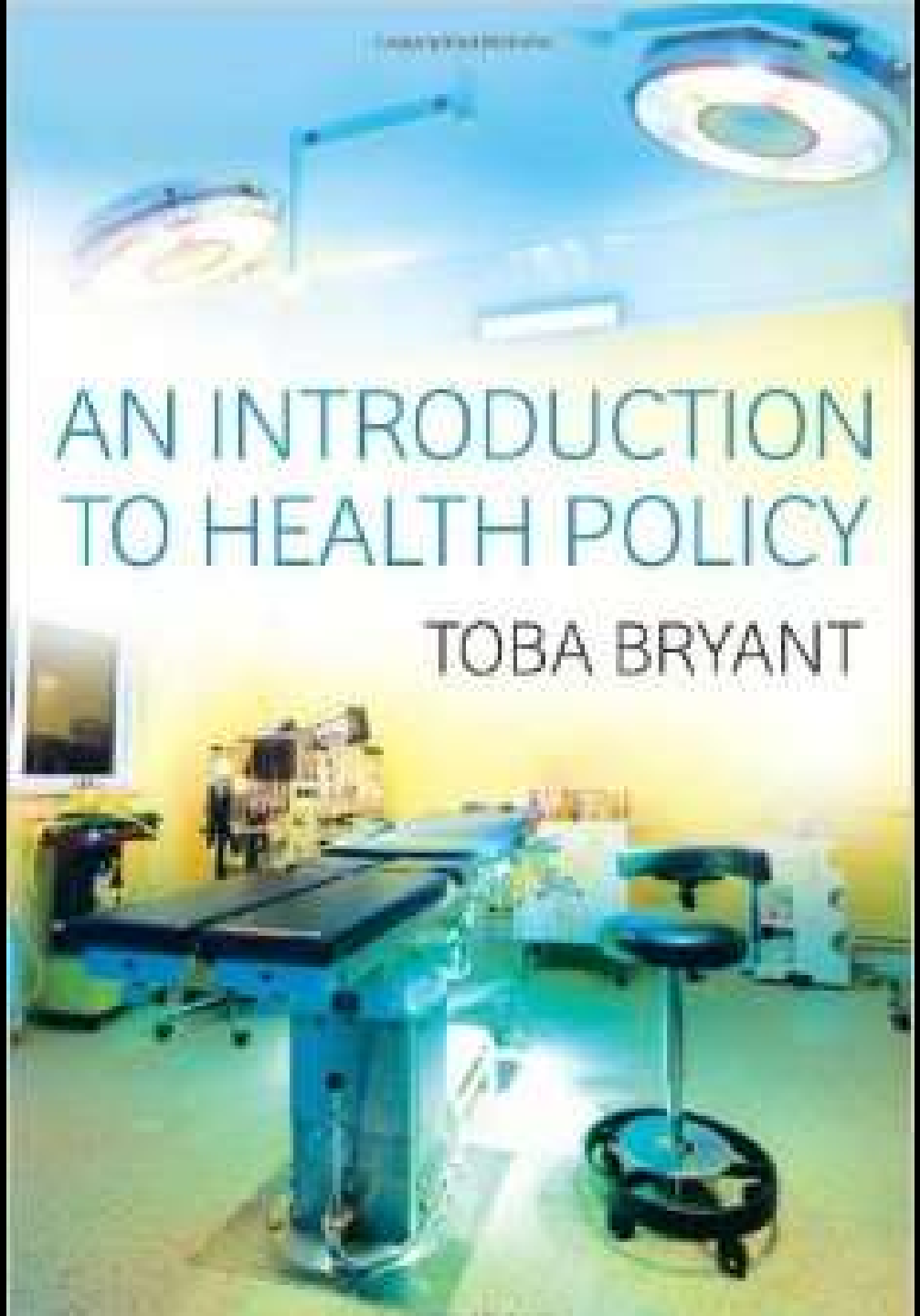
- **Decent incomes:** making sure every Canadian has access to decent jobs and working conditions;
- **Food:** establishing a pan-Canadian strategy for ensuring access to quality food;
- **Housing:** working with the provinces to establish a national affordable housing strategy;
- **Strong social safety net:** ensuring secure pensions, accessible Employment Insurance and policies to end poverty;
- **Aboriginal living conditions:** the federal government has failed in its responsibility to ensure proper health services, education, housing and clean water in aboriginal communities. It is time these communities had the resources they need.

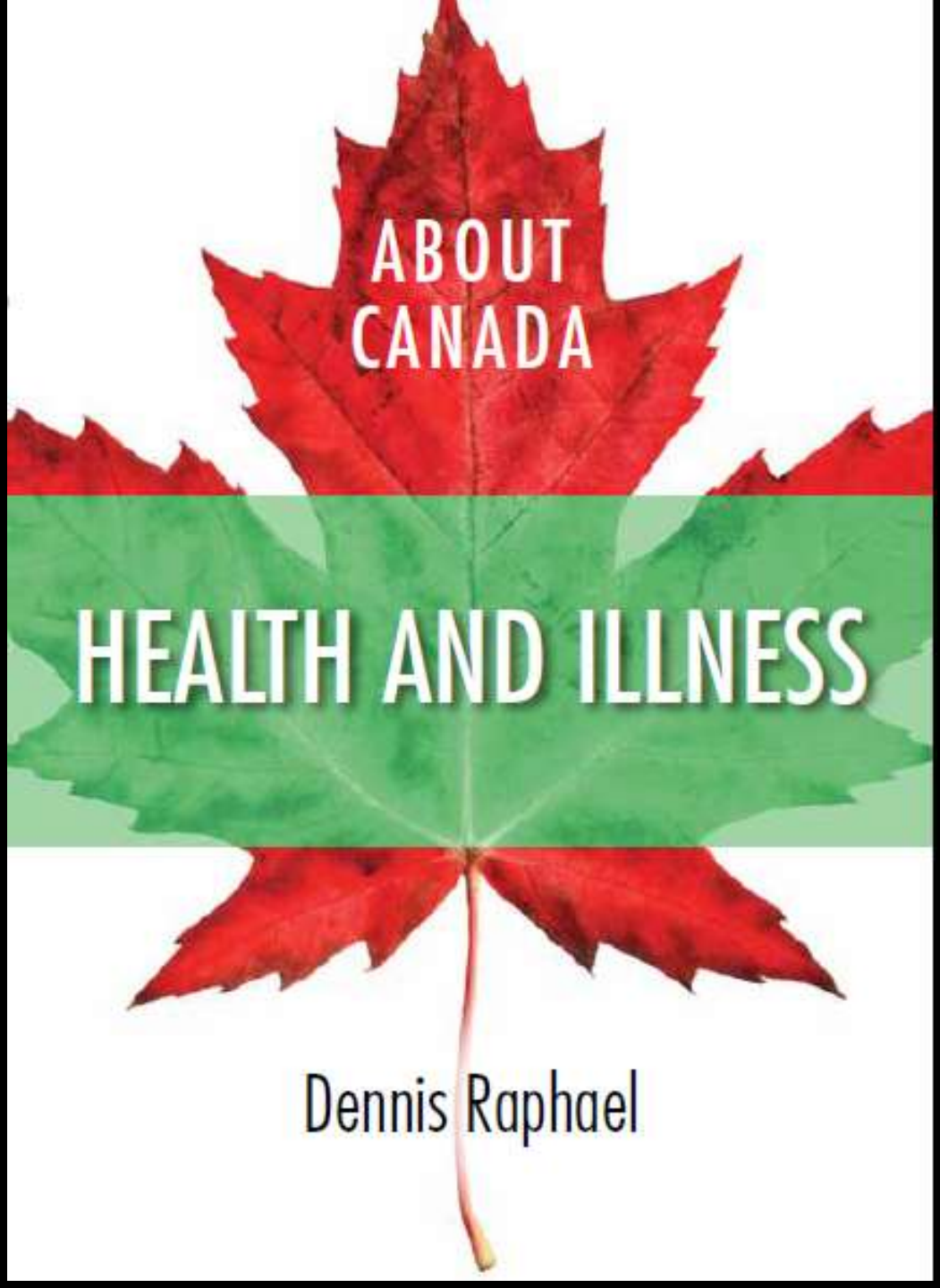
Where do we go from here?

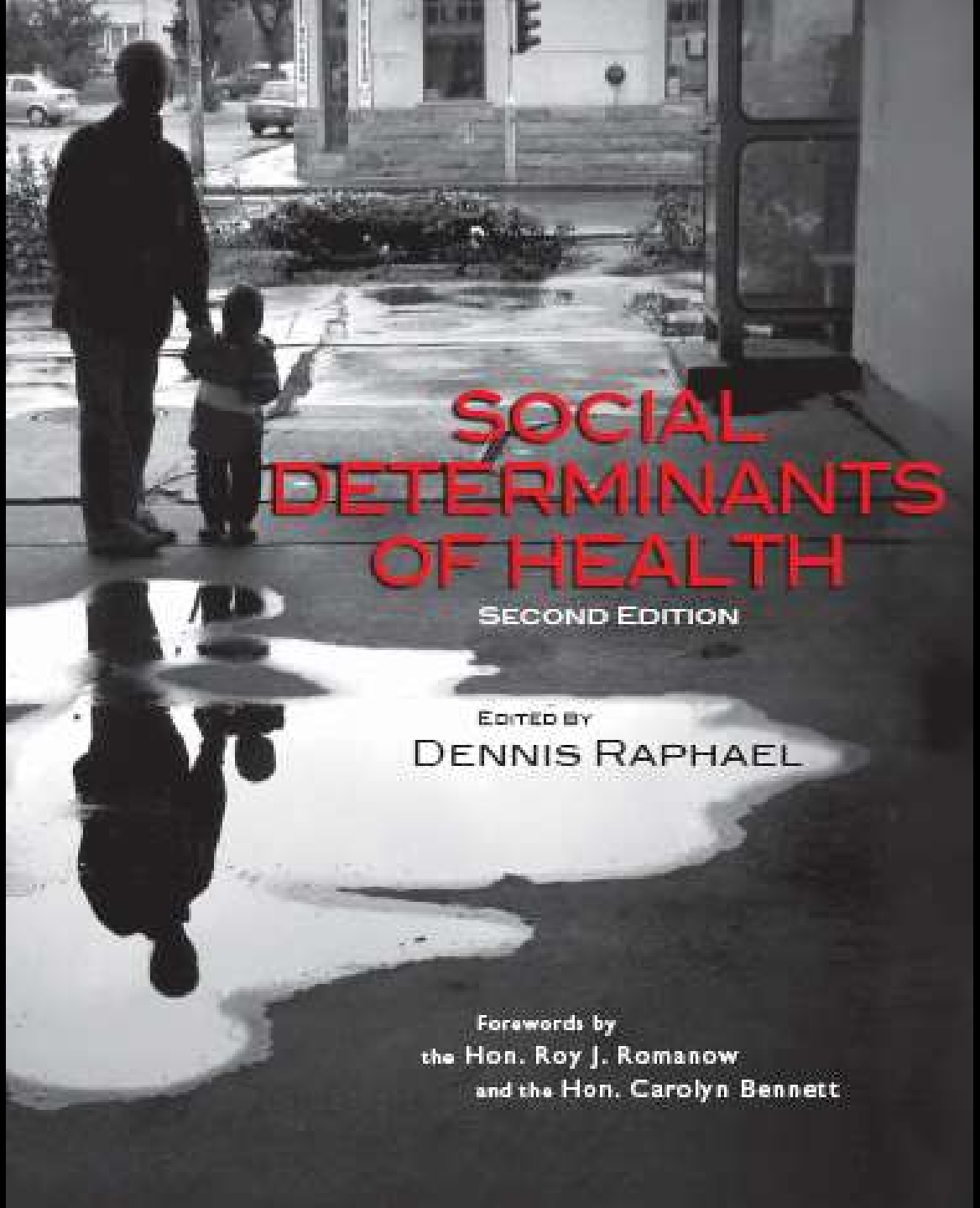
Learn more…

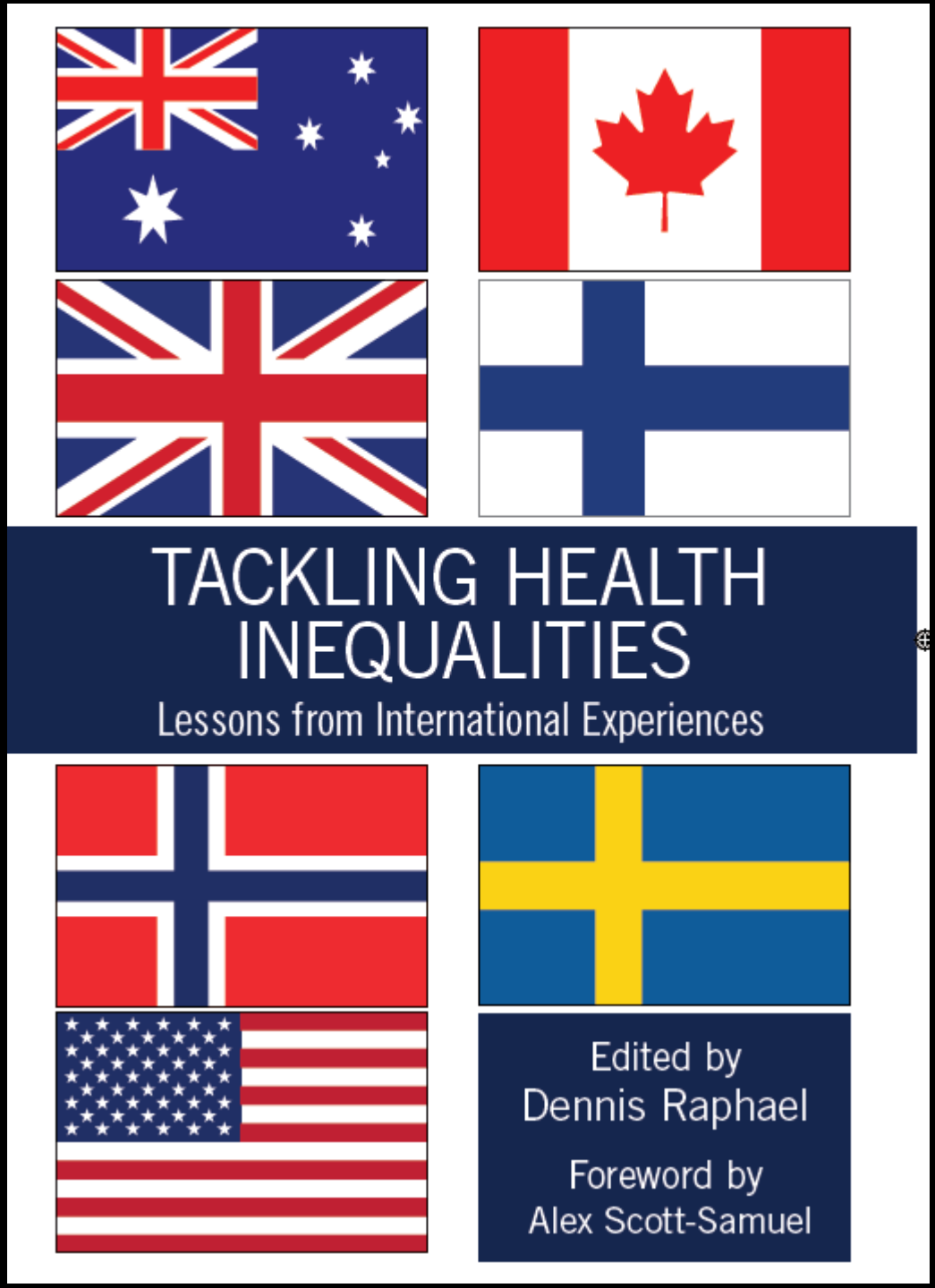


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AN INTRODUCTION
TO HEALTH POLICY
TOBA BRYANT


ABOUT
CANADA
HEALTH AND ILLNESS
Dennis Raphael


SOCIAL DETERMINANTS OF HEALTH
SECOND EDITION
EDITED BY
DENNIS RAPHAEL
Forewords by
the Hon. Roy J. Romanow
and the Hon. Carolyn Bennett


TACKLING HEALTH INEQUALITIES
Lessons from International Experiences
Edited by
Dennis Raphael
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Alex Scott-Samuel

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