

# The Chief Public Health Officer's Report on Health Inequalities: What Are the Implications for Public Health Practitioners and Researchers?

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## ABSTRACT

The first annual report of the Chief Public Health Officer on the State of Public Health in Canada draws notable attention to health inequalities in Canada. This report provides a compelling presentation of our current health status and the uneven distribution of health across the population, noting persistent and sizeable gaps in life expectancy, infant mortality, self-reported health, prevalence of chronic diseases, and other health indicators between higher- and lower-income groups, as well as the extraordinary disadvantage experienced by Canada's Aboriginal peoples. However, the report falls short of offering a critical approach to addressing and reducing health inequalities. It fails to stimulate thinking about integrated strategies by profiling current responses that do little to address the underlying structural drivers of health inequalities and ignoring the population health framework's recognition of the complex interactions among the determinants of health. Despite its shortcomings, the report shines a light on major health inequalities in Canada, providing a foundation for further action. Public health workers in this country must build on this foundation, working together and with all sectors and levels of government to identify and implement integrated strategies to reduce health inequalities and inequities in Canada.

**Key words:** Health inequalities; health inequities; population health; social inequalities; Chief Public Health Officer

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In June 2008, Canada's first Chief Public Health Officer (CPHO), Dr. David Butler-Jones, released his first annual report on the State of Public Health in Canada.<sup>1</sup> The report represents a parliamentary requirement of the CPHO, a position created in the aftermath of the SARS crisis in response to the recommendations of the National Advisory Committee on SARS and Public Health.<sup>2</sup> However, rather than focus on the potential threat of pandemic infectious diseases such as avian influenza, Dr. Butler-Jones chose to use his first report to draw attention to health inequalities and inequities in Canada. We highlight some of the strengths and limitations of the report, and reflect on the opportunity that it presents for public health practitioners and researchers working towards the recognition and reduction of health inequalities in Canada.

The report begins by describing the legacy of public health in Canada, celebrating our successes including the reduction of vaccine-preventable diseases and achievements in tobacco control. These and the report's other historical success stories illustrate the importance of strong epidemiological evidence, a population perspective, the evaluation of innovative interventions, and the mobilization of intersectoral partners. In speaking to the leadership role that Canada has played in health promotion and in stimulating widespread recognition of the range of factors at the collective and individual levels that influence health, the report also makes clear that there are many challenges that we have yet to tackle in improving the health of the population.

Subsequent chapters provide a compelling and graphic presentation of our current population health status and the uneven distribution of health across the population. The epidemiological

evidence presented demonstrates the presence of persistent and sizeable gaps in life expectancy, infant mortality, self-reported health, prevalence of chronic diseases, and other health indicators between higher- and lower-income groups, as well as the extraordinary disadvantage experienced by Canada's Aboriginal peoples. Further, while it is recognized that we have made progress in narrowing the gap between more and less well-off Canadians, for example in cardiovascular disease mortality, it is also noted that much of this progress occurred in the 1970s and 80s, with little improvement apparent in recent years. While the case for inequalities is made, less is made of the case for inequities, distinguished by the latter's conceptualization as health differences that are unjust rather than merely unfortunate.<sup>3</sup> The report also fails to adequately emphasize that poor health is not only a problem for the poor, but for everyone below the top echelon of the social ladder.

Rather than offering a strategic approach to addressing and reducing health inequalities, the CPHO report provides a long list of actions: social investments to ameliorate the effects of poverty; improved community capacity for the design and application of strategies to address determinants of health; improved inter- and multi-sectoral action and integrated, coherent policies; an

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improved infrastructure for building an understanding of the health of subgroups of the population, the interactions between determinants of health, and how to address health inequalities; and improved public health leadership at all levels. While each of these elements could form a critical part of an integrated and holistic strategy to address health inequalities and inequities, this is not a call to action; this is a call for activity. What is missing is a call for governments to act. In contrast, the World Health Organization (WHO) Commission on Social Determinants of Health's report "Closing the gap in a generation: Health equity through action on the social determinants of health",<sup>3</sup> released shortly after the CPHO report, made the imperative of government commitment the centerpiece of its call to reduce inequities in a generation. Almost as bold were the 2008 report of the Canadian Senate Subcommittee on Population Health<sup>4</sup> on the social determinants of health with its call for a whole-of-government approach and the 2008 policy options paper from the British Columbia Health Officers' Council which points to government engagement and multi-sectorality as essential factors in moving forward to reduce health inequities.<sup>5</sup> Similarly, reports from Quebec have urged decision-makers in all sectors of government to play a role in addressing health inequalities<sup>6</sup> and provide examples of how equity could be enhanced through an integration of the health and social services.<sup>7</sup> Further afield, the United Kingdom proposed a government-wide strategy in its Tackling Health Inequalities report<sup>8</sup> and the Swedish government's report on social protection and social inclusion is lauded as an exemplar of a social justice model of government action.<sup>9</sup>

The CPHO report's failure to emphasize the essential role of government action is reinforced by the examples used to illustrate "successful interventions that... may serve to reduce Canada's health inequalities and improve quality of life for all Canadians" (p.1). In fact, the interventions highlighted tend to be community-based programs that are unable to address the structural determinants of health inequalities. For example, children's feeding programs are offered as a promising response to problems of food insecurity and it is noted that "the importance of these types of programs cannot be overstated" (p. 41), despite evidence challenging the presumption that these and other community-based programs have the capacity to address problems of food insecurity arising in the context of financial constraints (e.g., refs. 10,11). Similarly, the work of a non-profit organization is noted as a promising intervention with respect to problems of housing affordability and homelessness; yet, despite its merits, the work of this organization or others with a similar approach cannot be expected to compensate for the withdrawal of federal and provincial governments from social housing and other changes to the social welfare system over recent decades that have compounded the vulnerability of those at the lower end of the socio-economic gradient.<sup>12</sup>

The lack of recognition of the inadequacy of responses that do little to address the underlying structural drivers of health inequalities and the treatment of basic needs, including access to adequate food and housing, as isolated determinants of health are inconsistent with the population health approach.<sup>13</sup> Further, by profiling current community-based activities, some of which have emerged to fill a policy gap left by government retractions, the report does little to stimulate thinking about what broader, more integrated policies and strategies might look like. The reliance on solutions

that "fall short of an upstream approach"<sup>14</sup> and a disregard for the primacy of structural determinants can only be interpreted as an indication of a lack of political will to truly acknowledge and act upon inequalities in Canada. A lack of political will is also suggested by the fact that the release of the CPHO's first report, a landmark publication of the highest-ranking public health worker in the country, was not accompanied by a press release and consequently received little, if any, media coverage.

Given constraints that may preclude the CPHO from going further in calling for government action,<sup>15</sup> where do we as public health practitioners and researchers go from here in our efforts to reduce health inequalities in Canada? One of the stated primary purposes of the CPHO report is to stimulate national dialogue and, despite its limitations, the report shines a light on major inequalities in this country, providing a foundation for discussion and action towards their reduction. Health practitioners and researchers must build upon the strong tradition of public health in Canada by seizing the opportunity provided by the CPHO report and other recent initiatives, including the work of the WHO Commission on the Social Determinants of Health,<sup>3</sup> to further our thinking on and action towards innovations that would meaningfully and structurally reduce health inequalities. This requires working together with the Public Health Agency of Canada and other stakeholders to create the political will and capacity needed to support a whole-of-government approach to address health inequalities in Canada. Imagine a CPHO report written within a generation that discusses the success story of reducing inequities in Canada!

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## RÉSUMÉ

Le premier rapport annuel de l'administrateur en chef de la santé publique sur l'état de la santé publique au Canada a attiré l'attention sur les inégalités notables en matière de santé au Canada. Ce rapport présente de façon convaincante l'état de santé actuel et la distribution irrégulière de la santé parmi la population, indiquant les lacunes constantes et assez considérables en matière d'indicateurs pour l'espérance de vie, la mortalité infantile, l'état de santé déclaré, la prévalence des maladies chroniques, et autres indicateurs sur la santé entre les groupes à revenu plus élevé et les groupes à plus faible revenu,

ainsi que le désavantage extraordinaire que connaissent les Autochtones. Toutefois, le rapport n'offre pas une approche critique pour traiter et réduire les inégalités en matière de santé. Il ne stimule pas la réflexion sur des stratégies intégrées en définissant les réactions actuelles qui n'aident que très peu à traiter les facteurs structurels des inégalités relatives à la santé et ne tient pas compte de la reconnaissance des interactions complexes du cadre de santé de la population parmi les déterminants de la santé. Malgré ses lacunes, le rapport met en lumière les principales inégalités relatives à la santé au Canada, fournissant ainsi un fondement pour d'autres mesures. Les travailleurs du réseau de la santé publique de ce pays doivent miser sur ce fondement, travailler ensemble et avec tous les secteurs et ordres de gouvernement afin de déterminer et de mettre en œuvre des stratégies intégrées pour réduire les inégalités et les iniquités au Canada.

**Mots clés :** inégalités en matière de santé; santé de la population; inégalités sociales; administrateur en chef de la santé publique



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