The Chief Public Health Officer's

Report on The State of Public Health in Canada

Helping Canadians achieve the best health possible

2008

REPORT·AT·A·GLANCE

Canada

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A few words from the Chief Public Health Officer

My first annual Report on the State of Public Health in Canada is intended to inform Canadians and stimulate discussion of the many factors that contribute to good health and what can be done individually and collectively to advance public health in Canada.

I am happy to report that the majority of Canadians enjoy good to excellent physical and mental health, reinforcing that Canada is one of the best places in the world in which to live. Thanks in part to public health efforts — such as the introduction of mass immunization, and smoking cessation and seat-belt awareness programs — we are living longer and have reduced our infant mortality rates.

Despite this progress, there are Canadians in every corner of the country who continue to experience high rates of injury, chronic or infectious diseases and addictions. These individuals are at a higher risk of poor health and premature death. They are also more likely to need the health-care system for what are largely preventable health issues. Poor health also results in higher rates of absenteeism and lowers productivity in our workplaces.

While certain disadvantaged segments of the population have poorer health than most of us, none of us is immune to the health inequalities that limit our potential as individuals and as a nation. For this reason, my first report focuses on inequalities in health. With few exceptions, the evidence shows that people with better incomes, better education and better social supports enjoy better health than those with fewer social and economic opportunities.

We cannot rate our collective health and well-being by looking only at those who are healthiest. Nor can we focus only on averages, as these mask important differences between the least and most healthy. We must also consider those left behind: those who are less healthy, illiterate, on the streets, or have little or no resources.

We can change this. As a country, we have the evidence, the means and the talent to address the range of issues that can adversely affect the health and well-being of Canadians. There are examples of policies and programs, both large and small, making real differences in the lives of Canadians and reducing both social and health inequalities. These successes provide strong foundations from which we can build the healthiest nation with the smallest gap in health disparities. It is a goal well within our reach through a firm commitment by individuals, community members and decision-makers to effect change.

David Butler-Jones

Dr. David Butler-Jones

Chief Public Health Officer of Canada

What we mean by public health

Canada is known throughout the world for its universal health-care system which is a major contributor to Canadians' health. But, as vital as its contributions are, there is more to health than good health care.

While health care focuses mainly on treating individuals, public health targets entire populations to keep people from becoming sick or getting sicker. Both work to limit the impacts of disease and disability.

One of the goals of public health is to promote physical and mental health as intricately connected to the environment and society we live in. The way Canada, as a society, deals with issues such as poverty, housing, sanitation and environmental protection influences the health of our population. Other factors also influence our health, including the presence or lack of family support and social networks, access to education and jobs, workplace safety, and strong communities.

***Public health** involves the organized efforts of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians.*

Last, J.(2001). A Dictionary of epidemiology. 4th Edition. Oxford University Press

Whose responsibility is public health?

Public health is a shared responsibility. While governments enact laws, develop policies and provide resources to fund public health activities, it takes the combined efforts of a variety of organizations, sectors, and people, both within and outside government, to address health challenges.

These joint efforts include everyone from physicians, nurses, public health inspectors and nutritionists, to community agencies, volunteer organizations, and the academic community; indirect players, such as the media that report health-related news; fitness instructors, adults who set good examples for children by taking care of their own health and employers who provide a work-life balance for their employees. To this list we can also add engineers and transportation workers who make Canada's highways safer, food producers who follow regulations to ensure that our food is safe, and not-for-profit groups who fight poverty and encourage Canadians to get active, recycle and reduce energy consumption.

About this report

The Chief Public Health Officer (CPHO) is required to report annually on the state of public health in Canada. The 2008 report is the first since the Public Health Agency of Canada became a legal entity in 2006. It provides both a snapshot of Canadians' current health status and a benchmark against which we can measure future progress.

What we found

The overall health of Canada's population is considered very good, especially in comparison to many other countries. But a closer inspection of disease, disability and death rates shows that some groups of Canadians are less healthy and have a lower quality of life than others.

Because good health is not equally shared by all Canadians, it is essential that we understand the many factors that contribute to what we call health "inequalities" if we hope to develop solutions to turn this around.

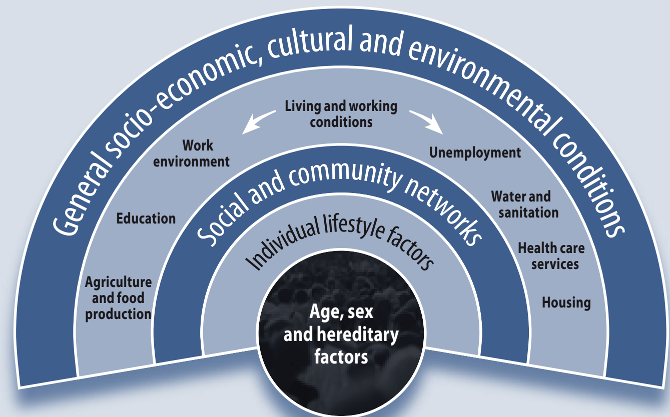
***Health inequalities** are differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made, or by chance; but often they are because of unequal access to key factors that influence health, like income, education, employment and social supports.*

We know that age, sex and heredity are key factors that determine health. We also know that our lifestyle and behavioural choices matter, and that these factors are influenced by our environments, experiences, cultures and other factors. Finally, we know that for some, even when the best choices known are made, their health outcomes are limited by these broader influences.

There is good evidence that the following key factors have a profound effect on people's individual health behaviours and health outcomes:

- **Social and economic influences**, including income/poverty, early childhood development, education and literacy, and housing/homelessness.
- **Our food security**, that is, having access to enough nutritious and safe food to meet our health needs.
- **How Canadian society is structured**, from employment opportunities and working conditions, to the quality of our neighbourhood environments and even aspects of community design.
- **Our social status** and the work we do.
- **Where we live**, whether in urban or rural areas, whether in vibrant and prosperous communities or communities that are struggling economically and/or socially.
- **Our social supports and connections**, whether we have close family and friends who are there for us when we need them.
- **Access to health care** which gives us access to prevention therapies, like vaccines, as well as access to advice about healthy living.

Factors that influence our health[1]



[1] Dahlgreen, G. & Whitehead, M. (2006). *European stategies for tackling social inequities in health: Levelling up Part 2.*

Why it matters

Our goal is to be healthy for as long as possible. Disease and disability take a toll on affected individuals and their families as they suffer the physical, emotional, economic and social fall-out of poor health.

Aside from personal health and quality-of-life considerations, people who are less healthy put pressures on the health and welfare systems. This could lead to longer wait times and increase costs for Canadian taxpayers. There are also other costs to society, such as high rates of absenteeism and lower productivity in the workplace, which ultimately affect the standard of living and quality of life of all Canadians.

Public health asks two questions: What are the causes of poor health? How do we address those causes before they lead to health problems?

The face of health and social inequalities

Below are examples of some of the key health and social inequalities that exist in Canada that impact health. For some of these inequalities, the connections to health are very clear. However, for others, such as income and education, the causal links are less clear. Our income, or lack thereof, significantly impacts our ability to obtain/provide nutritious food and acceptable housing, among other things. Our level of education impacts the types of employment we qualify for, and our ability to understand and comply with healthy living activities, including health therapies. For more detailed information on the inequalities outlined below and other such inequalities, please see the full CPHO Report on the State of Public Health in Canada 2008 at www.publichealth.gc.ca/chiefpublichealthofficer.

Health

- The rate of premature death among all Canadians could be reduced by 20% if all Canadians were as healthy as the richest 20% of Canadians.

- Although the number of years lost to premature death has been declining overall, Canadians living in Northern regions lose more years to premature death than the national average. This is due mainly to unintentional injuries, suicides and self-inflicted injuries.
- Over time the infant death rate has declined for the overall population; however, it is higher in lower income neighbourhoods.
- In urban Canada, people with lower levels of education as well as those living in lower-income neighbourhoods have lower life expectancies. They are also less likely to report having excellent or very good general or mental health.
- With few exceptions, Aboriginal Peoples experience some of the most significant health disparities in Canada. On average, Aboriginal Peoples have:
  - Lower life expectancies;
  - Higher rates of accident and injury; chronic diseases such as diabetes, heart disease, cancer and asthma; and infectious diseases, like tuberculosis;
  - Higher suicide rates (among certain Aboriginal Peoples).

Income

- While overall personal income has increased over time due to increases in employment and basic wages, the poverty rate has not decreased proportionately.
- 11% of the Canadian population lives in poverty. The gap between those with the highest and lowest incomes is widening as incomes of the richest 20% of the population are increasing faster than the incomes of the poorest 20%.
- Poverty rates are significantly higher for certain populations, such as:
  - Lone parents (26%);
  - Work limited persons (21%);
  - Recent immigrants (19%);
  - Off-reserve Aboriginal Peoples (17%).
- An estimated 788,000 children under the age of 18 currently live in poverty, a decrease from a peak of 18.6% of all children in 1996 to 11.7% in 2005.

Employment and Working Conditions

- In 2003, blue collar workers experienced over 4 times the injury rates of white collar workers.
- Men experience more than double the rate of work-related injuries as women: 5.2% vs. 2.2%.

- Men earning over $60,000 and women earning over $40,000 were less likely to experience injury than those at lower income levels.

Food security

- 1 in 10 households with children, particularly young children, don't always have enough food.
- Reliance on food banks has increased 91% over the last 18 years.

Environment and Housing

- 13.7% of Canadians report being unable to access acceptable housing.
- Overcrowding and poorly ventilated houses can impact the physical and mental health of their inhabitants, including raising the risk of acquiring tuberculosis. This is especially true for many Aboriginal Peoples and for some immigrants.
- Low-income neighbourhoods often have limited grocery stores, offer nutritious foods at a higher cost and have a greater concentration of fast food services — potentially contributing to poorer eating habits.

Early Childhood Development

- Children who live in lower-income families scored lower for school readiness in areas such as knowledge, skills, maturity, language and cognitive development.

Education

- About 9 million Canadians (42% of those aged 16 to 65) perform below the literacy level considered the minimum necessary to succeed in today's economy and society. The percentage is even higher for certain groups, including seniors, immigrants and Aboriginal Peoples.
- First Nations[2] populations have lower levels of education than the Canadian average, with just under 50% having graduated from high school.
- Obesity rates are higher among Canadians aged 19 to 45 years who do not complete high school than among those who have some post-secondary education.
- 47% of individuals living in households with a Grade 8 education or less report excellent or very good health, whereas 60% of the general population report excellent or very good health.

Social support and connectedness

- More than 6% of Canadians over 65 report not having any friends, compared to 3% of those aged 55 to 64. Seniors who reported having no friends are less likely to report being in excellent or very good health.

[2] The term 'Aboriginal' is used to refer collectively to all three constitutionally recognized groups — Indian, Inuit and Métis. Although not constitutionally recognized, the newer term 'First Nation' is used to describe Status Indians recognized under the *federal Indian Act.*

- First Nations residential school survivors report that the experience negatively affected their mental and physical health through isolation from family, separation from community and a loss of identity and language. Among their children, 43% believe the residential school experience had a negative effect on their parents' parenting skills.
- Women report experiencing more serious forms of violence than men, and are more likely to incur injuries as a result of violence.
- Reported spousal abuse among Aboriginal women and men off reserve is much higher than the national average.

Healthy Behaviours

- The highest smoking rates are among lower-income Canadians, Aboriginal Peoples and people living in Northern Canada.
- About 9% of children under the age of 12 and 15% of Canadian households are regularly exposed to tobacco smoke. Of these Canadians, 51% live in the lowest-income households compared to 18% who live in the highest-income households.
- About 62% of Canadians over age 12 in the highest-income households report being physically active compared to 44% among the lowest-income households.
- Street youth have sexually transmitted infection (STI) rates 10 to 12 times higher than their peers in the general population and a greater susceptibility to the hepatitis B virus.

Access to Health Care

Access to health care gives us access to prevention therapies, like vaccines, as well as access to advice about healthy living.

- Immigrant women experience more difficulty accessing the resources needed to stay healthy than Canadian-born women. Reasons for this include: language difficulties; lack of cultural sensitivity among health-care providers; lack of social support; and time constraints among lower income immigrant families.

- 20% of Aboriginal Peoples living off reserve are more likely to report having unmet health-care needs compared to 13% of the overall population.
- Canadians in remote communities have difficulties accessing the health-care system. In the Northwest Territories, 59% of Aboriginal Peoples and 76% of non-Aboriginal people report lower rates of contact with a health-care professional than the general population (79%).

What is being done

Governments, the private sector, not-for-profit organizations, communities and individuals are undertaking initiatives across the country to close the gap on health and social inequalities. The successful Canadian initiatives listed below are examples of promising models for future consideration:

Focus on Poverty

- **Saskatchewan** introduced an initiative in 1997 comprised of employment supplements, child benefits, and family health benefits that have helped low-income people achieve financial security. Since 2004, the province has seen 41% fewer families dependent on social assistance (6,800 families and almost 15,000 children) and a substantial increase in after-tax disposable income among families working for minimum wage.
- **Quebec's Family Policy**, introduced in 1997, includes an integrated child allowance, enhanced maternity and parental leave, extended benefits for self-employed women, and subsidized early childhood education and childcare services. Over the last 10 years, Quebec has experienced a steady decline in its poverty rate that has resulted in the greatest overall decrease among provinces. Economic growth and government programming are reported to have contributed to this decline.

Education

- **Regent Park Community Health Centre's (Toronto) Pathways to Education** program provides academic, social, financial and advocacy supports to at-risk and economically disadvantaged youth. The program has dramatically decreased dropout and absenteeism rates, quadrupled the number of young people from the community attending college or university, and reduced teen pregnancy rates by 75%. The Pathways to Education program is now expanding to five other cities with plans to reach 20 communities across Canada.

Food Security / Nutrition

- **Breakfast for Learning** provides funding, nutrition education and other resources to community based student nutrition programs across the country. Since 1992, the program has served healthy breakfasts, lunches and snacks to over 1.5 million Canadian school children.
- **Food Banks**. In 2006, the Canadian Association of Food Banks (CAFB) moved over 8.5 million pounds of food-industry donations (worth $18 million) to its members through the National Food Sharing System. In addition to food received from the CAFB, community run food banks collect and distribute an estimated 150 million pounds of food per year.

- **Canada Prenatal Nutrition Program** (CPNP) provides long-term funding to community groups to develop or enhance programs for at-risk pregnant women and their children. The CPNP program participants were found to have higher birth weights with increased program participation and higher breastfeeding rates than the general population.

Building healthier communities

- The **Vancouver Agreement** between the governments of Canada, British Columbia and Vancouver opened new health clinics in the downtown east side of Vancouver, expanded addiction treatment services, and services for at-risk youth and sex-trade workers. Results: reduced death rates from risky behaviours as well as greater access to health services.

- **Habitat for Humanity Canada** provides low-income Canadian families with safe, affordable housing. Since 1985, the organization has built more than 1,200 homes across the country that have resulted in less reliance on social services and improved health for these families.
- **Healthy Cities** initiative aims to encourage communities to create age-friendly physical and social urban environments that will better support older citizens in making choices that enhance their health and well-being and that will allow them to participate in their communities, contributing their skills, knowledge and experience.

Early childhood development

- The **Community Action Program for Children** (CAPC) provides long-term funding to community groups and coalitions offering programs to address the health and development of children (aged 0 to 6 years) who are living in conditions of risk (e.g., low income, single parents, newcomers to Canada). Results include lower rates of maternal depression and sense of isolation, and fewer emotional and behavioural issues reported among children.
- **Canada's Aboriginal Head Start in Urban and Northern Communities** and **Aboriginal Head Start On Reserve** programs for preschoolers, parents and caregivers provide an opportunity for children to learn traditional languages, culture and values, along with school readiness skills and healthy living habits. A recent evaluation of *Aboriginal Head Start in Urban and Northern Communities* reported significant gains in children's physical, personal and social development and health, among other benefits.
- **Healthy Child Manitoba** promotes and supports community based programs that reflect each community's diversity and unique needs. Results from program specific evaluations have ranged from improved parenting skills to an 80% enrolment rate in the STOP FAS program — an alcohol and drug treatment program for women who have used alcohol or drugs during current or previous pregnancies.

Improving access to health care

- **Toronto's Mobile Health Unit**, part of the Immigrant Women's Health Centre, provides women in factories, shelters, community centres and other locations with the opportunity to receive free primary care from female health-care providers experienced in cultural and gender sensitivity and the challenges facing immigrant women. Employers at work sites visited by the unit report experiencing lower employee absenteeism caused by health issues and off-site medical appointments.

- **TeleHomeCare in Prince Eward Island** enables nurses in the West Prince health region to monitor patients with complex health needs who are living at home. Since launching the service, the health region has seen a 73% reduction in days of hospitalization, 15% fewer emergency room visits, 46% fewer hospital admissions and a 20% drop in doctor's office appointments among clients.
- **Nova Scotia's Eskasoni Primary Care Project** built a new health centre for a Mi'kmaq community on Cape Breton Island. Annual visits to the family doctor are down from a high of 11 visits per year to approximately 4; trips to the outpatient/emergency department at the regional hospital are down 40% and medical transportation costs were reduced by $200,000 in the three-year period after the centre was opened. In 2004, the five Cape Breton Bands came together through the Tui'kn Initiative to build upon and expand the model to all Cape Breton First Nations communities.

Social support and connectedness

- **Montreal's Santropol Roulant** forges unique connections, providing inexpensive, nutritious meals and friendship to seniors and other vulnerable people, and meaningful work experience to unemployed youth. Given the soaring costs of hospitalization to treat a malnourished patient, the potential savings to taxpayers from this service is estimated at $2.4 million over the last five years.

Encouraging healthy lifestyles

- **ActNow BC** champions programs and initiatives that encourage healthy behaviours. To date, more than 130 towns, cities and First Nations communities have registered as "Active Communities," 100% of school districts have additional physical activity throughout the school day, and the BC Ministry of Health has piloted a Workplace Wellness initiative that extends the approach to workplaces across the province.

No Smoking

A hundred years ago, it was believed that tobacco was beneficial and its use was encouraged. By 1965, more than 50% of the Canadian population over 15 smoked. As smoking rates continued to rise, research uncovered the truth — tobacco use is an addiction that harms the health of the smoker and those exposed to second-hand smoke. Once these dangers were understood, Canada began to take action through tobacco control strategies involving education and promotion, taxation, introduction of smoking by-laws and cessation support. Today, only 19% of the Canadian population smokes.

What more can we do *Priority areas for action*

Evidence indicates that the following priority areas can make a difference in reducing health inequalities:

- **Social investments**, particularly investments in families with children living in poverty and in early child development programs.
- **Community capacity** through direct involvement in solutions, enhanced co-operation among different sectors, better defined stakeholder roles and increased measuring of outcomes.
- **Inter-sectoral action** through integrated, coherent policies and joint actions among parties within and outside the formal health sector at all levels.
- **Knowledge development** through a better understanding of different groups of Canadians, how socio-economic factors interact to create health inequalities, how best practices from other jurisdictions can be adapted to improve our efforts, and through more advanced measurement of the outcomes of the various interventions undertaken.
- **Leadership** at the public health, health and cross-sectoral levels.

Moving forward

Conditions are ripe for Canadians to aim to be the healthiest nation with the smallest gap in health between the most and least advantaged individuals.

What can be done?
• Foster collective will and leadership
• Reduce child poverty
• Strengthen communities

Greater health equality is possible

The Role of the Chief Public Health Officer of Canada

The position of Canada's Chief Public Health Officer (CPHO) was created in 2004, along with the Public Health Agency of Canada, to guide the Government of Canada's efforts in public health. These actions were taken, in part, in response to the SARS (Severe Acute Respiratory Syndrome) outbreak of 2003.

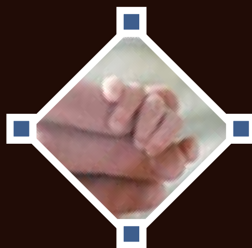
Heading the Public Health Agency of Canada (PHAC), the CPHO is responsible for both advising the Minister of Health on matters of public health and for overseeing the day-to-day functions of the Agency. As Canada's lead public health professional, the CPHO is also required to report on an annual basis on the state of public health in Canada.

At the same time, the CPHO may communicate directly with Canadians and governments on important public health matters. One means of doing this is through his annual Report on the State of Public Health in Canada.

Find out more

To view the full report, ***The Chief Public Health Officer's Report on the State of Public Health in Canada 2008***, visit: www.publichealth.gc.ca/chiefpublichealthofficer

To learn more about public health and the work of the Public Health Agency of Canada, visit: www.publichealth.gc.ca



ABOUT THE PUBLIC HEALTH AGENCY OF CANADA

Mission

To promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.

Vision

Healthy Canadians and communities in a healthier world.

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