Wealth, Health and Medicare

Despite our universal-access medical system, the wealth in your wallet affects the health of your body and mind

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PHOTOGRAPHY BY BERNARD CLARK

You're only as healthy as your neighbourhood. It sounds like an odd truism, but if you reside in an area where income bracket, education levels and job prestige — the combined measures that most commonly define socio-economic status (SES) — are all high, chances are you're in better physical shape than someone living in a poorer district.

That has been documented by the September 2008 final report of the World Health Organization (WHO) Commission on Social Determinants of Health. It demonstrates that real health inequalities persist between rich and poor communities in every part of the world, including Canada.

Health care is supposedly available equally to all Canadians, but as many as five million people in this country go without consistent primary care because of a shortage of general practitioners in their areas. And depending on which province you live in, the average wait time for a specialist consultation ranges from seven weeks (in Ontario) to more than 13 weeks (in Newfoundland and Labrador), while total wait time (between seeing a GP and receiving treatment) can range from 13 weeks (in Ontario) to almost 29 weeks (in Saskatchewan). The problem is especially acute in Aboriginal communities, where diabetes rates are three to five times higher than in the general population and where type 2 diabetes — once mainly associated with middle age — is becoming increasingly prevalent in children.

But even in large urban centres, where medical services are most heavily concentrated, inequalities can still be found. "In Montreal, there is a 12-year gap between the life expectancy of residents in the richest and poorest neighbourhoods," says Dr. Nancy Ross, a professor of geography at McGill University and a leading researcher in the health effects of income inequality

Determinants of health

Socio-economic status — income bracket, education level and job prestige — has a tremendous impact on health. The Senate Subcommittee on Population Health, 2008, estimated that 50% of a person's health is attributable to social and economic environment, compared with just 25% to the health-care system. Some 15% can be ascribed to biology and genetic factors and 10% to a person's physical environment.

Poverty and health

- In 2005, 15% of all Canadians were living in poverty. The wealthy live longer than the poor and also experience less chronic illness, obesity and mental distress.
- In 2000/01, twice as many men and women in Canada's highest income group rated their health as excellent compared with those in the lowest income group.

Education and health

- Almost half of adults are not literate enough to participate fully in Canada's knowledge-based economy. They face unemployment, poor living conditions and health risks stemming, for example, from difficulty reading instructions for baby formula and taking medications.
- The diets of higher-SES families more closely follow nutritional guidelines. An inadequate diet is linked to the development of many diseases.

Aboriginal status and health

- The socioeconomic status — and by implication the health — of Canada's First Nations, Inuit and Metis people — is lower than that of non-Aboriginal Canadians on virtually every standard measure (income, unemployment and educational attainment).
- On average, First Nations and Inuit peoples' life expectancies are five to 10 years shorter than that of the general population.
- Youth suicide rates in First Nations people are five to seven times higher and in Inuit youth 11 times higher than in their non-Aboriginal peers.

— Senate Subcommittee on Population Health, 2008

on the North American population. As she points out, even though the overall health of all Canadians has improved under publicly funded health care, the gap between the haves and have-nots remains mostly unchanged. Similar differences in the health of low- and higher-income people were documented last year in *The Unequal City,* a Toronto Public Health report.

That said, it would be wrong to pin all the blame for the SES health gap on the shortcomings of Canada's public health-care system. The evidence points to a wide range of determinants of health outside the government's direct influence: smoking, excess alcohol, poor diet, obesity and lack of physical activity. All are major risk factors for chronic disease and premature death, and all are closely linked to poverty.

"Simply put, every step down the socioeconomic ladder results in shorter life expectancies and higher mortality rates for some diseases," says Ross. For example, rates for lung cancer death — the leading cause of cancer deaths in Canada — are significantly higher in the bottom socioeconomic quintile (20%) versus the top. There are similar gaps favouring affluent Canadians over their underprivileged counterparts for gastrointestinal cancers, diabetes, mental disorders and infectious diseases, particularly AIDS.

Interestingly, the relationship is reversed for a few mortality causes — such as the rates of motor vehicle death, which are highest among the most well-off segment of the population. Those in lower-SES groups are simply less likely to drive a car, putting them at lower risk.

The two most puzzling exceptions are breast and prostate cancers, which tend to be most prevalent in the highest SES groups. With breast cancer, it may be that women with higher SES tend to delay or forgo having children, which are risk factors for breast cancer, while low-SES moms are more likely to have their children younger, which is associated with risk reduction. It is not known why prostate cancer rates are higher in the high-SES population.

However, when Canadians of low SES do develop breast or prostate cancer, the prognosis is worse than for their well-off counterparts. Diagnosis for poor Canadians typically arrives when cancer is at a more advanced stage. Furthermore, treatment in this group may be less aggressive, thus resulting in lower five-year survival rates.

"The problem is that people who live in communities with lower SES have the greatest health-care needs, but generally worse access to health care than people who live in more affluent communities," says Dr. Irfan Dhalla, a staff physician of internal medicine at St. Michael's Hospital and a lecturer in the University of Toronto's department of medicine.

Although governments in Canada have taken steps to address this phenomenon — community health centres such as those in Ontario are heavily concentrated in lower-income areas — health inequalities persist. "Some of these inequalities are almost certainly avoidable, but better health care is only one piece of the puzzle," says Dhalla. Clearly, cultural norms and lifestyle choices play a role.

Still, ensuring that health-care services are available on the basis of need, not income, plays a large part in improving health and minimizing avoidable inequality. So in Dhalla's view, two-tier health care, or even private delivery within the publicly funded system, poses risks to Canadians. "But the risks are even greater for those with relatively low incomes, since they are less likely to afford out-of-pocket health-care expenses," he says.

Reducing disparities would appear to deliver a two-pronged payoff since the lowest 20% of income earners account for about 31% of the $94 billion per year spent on the health care of Canada's household population —

Life expectancy

In 2001, the probability of survival to age 75 for men was 73% in Canada's richest urban neighbourhoods and only 57% in the poorest. For women, the probabilities were 81% and 74%, respectively. There were 31,876 deaths in the poorest urban neighbourhoods but only 18,662 in the richest

— Canadian Institute for Health Information

Perils of poverty

Low-SES Canadians are more apt to...

- smoke
- be overweight
- eat a poor diet or drink to excess
- be sedentary
- have poor oral health
- have unsafe sex
- live in crowded, damp, mouldy or underheated housing
- be teenage mothers
- have STIs as youths
- deliver low-birth-weight babies
- give birth to an infant who dies
- live in areas with higher levels of soil contamination and air pollution
- be exposed to street violence
- be shorter than their peers as children
- commit suicide as teenagers
- die prematurely

— *The Urban Lens*, Canadian Institute for Health Information, 2008; *The Unequal City*, Toronto Public Health, 2008; *Health Disparity by Neighbourhood Income*, Saskatoon Health Region, 2006

double the amount for the highest 20% of income earners. According to a 2004 report by the joint federal-provincial Health Disparities Task Group, introducing measures to improve the health status and also the health-care utilization patterns of people with lower incomes to the levels of those with mid-range incomes would yield significant savings. Furthermore, reducing the costs of lost productivity due to illness-related absenteeism by as little as 10% to 20% could add billions of dollars to the economy.

In an article published in the *Globe and Mail,* Dhalla described the novel approach taken by the U.K. to improve its population's overall health. In 2004, it launched a bold pay-for-performance scheme to reward doctors for doing the right things in their practices, such as immunizing children and helping patients achieve healthy blood pressure goals. Surpassing all expectations, they met 97% of their targets in the first year. Similarly, the government reduced wait times dramatically by paying hospitals to meet benchmarks. Now, 98% of MRIs and 92% of colonoscopies are performed within six weeks.

"Canada needs to get primary care right, especially for populations where the health gap is widest," says Ross. Each sector must do its share to address systemic problems, but, she adds, "The WHO report's recommendations aren't about how poor people need to pull themselves up by their bootstraps. They advocate better governance to improve health outcomes right across the board."

As the WHO report noted, "Heart disease is caused, not by a lack of coronary care units, but by the lives people lead, which are shaped by the environments in which they live." Consequently, the report recommends that the health sector, both nationally and globally, focus attention on addressing the root causes of inequities in health — to make health equity a marker for government performance. But as things stand now, Ross doubts that the report will affect policy — despite Canada's participation in it. "Canada has no specific targets to eliminate the disparities," she says.

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