Toward a Healthy Future

As Canadians stand poised to enter a new millennium, we have much to celebrate. By almost any measure, Canada is a highly desirable, healthy place in which to live. For the past two years, the United Nations has ranked Canada in the top spot on its Human Development Index, which takes life expectancy, educational attainment and income into account. Canadians are living longer with fewer disabilities in old age. Fewer babies are dying in the first year of life and early deaths from heart disease continue to decline. Many Canadians are taking positive steps to improve their health: overall, we smoke less and exercise more. The safety of our food and the quality of our air and drinking water are among the best in the world. And, despite recent stresses in the health-care system, Canadians continue to enjoy and value universal access to medically insured health services.

This overall high standard of health, however, is not shared equally by all sectors of society. There are clear disparities in health status by gender, age, socioeconomic status and place of residence. Indeed, the 1998 United Nations Report on Human Development took Canada to task for failing to ensure that everyone has a chance to take advantage of its enviable living standards. In its annual report, the UN said that "Canada and France have significant problems with poverty and their progress in human development has been poorly distributed."[1]

In addition to problems relating to inequities, the current report shows that the majority of early deaths and illnesses that Canadians suffer are preventable. For example, almost all disease, disability and early death caused by tobacco use, intentional injuries and unintentional injuries can be prevented.

Interprovincial/territorial differences are presented in Appendix B. No province or territory emerges as the healthiest overall, and there are, in some cases, large differences between the provinces and territories on specific indicators of health. These data should be interpreted with caution, however, due to differences in sampling and information collection methods. Unfortunately, data from the Yukon Territory and Northwest Territories (NWT) are limited because the results of the National Population Health Survey in those jurisdictions were still in the process of analysis. Nunavut data were included in the NWT database and had not yet been separated out.

In the chapters that follow, we will see how a variety of factors affect health, including gender, age, genetics, personal health practices, coping skills, social support, working conditions, the physical environment and early childhood experience. Perhaps the most powerful influence on health, however, is socioeconomic status, which is measured in this report by income and education levels. Whether we look at how people rate their own health, premature mortality, psychological well-being or the incidence of chronic disease, socioeconomic status remains strongly related to health status. The evidence presented in this report also shows that an active socioeconomic gradient is at work. In other words, people's health improves on virtually all measures and in all of the factors that influence health as levels of income and education increase.

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This report also concludes that there is a persistent gap in health status between Canadians with high incomes and those with low incomes. Chapter 2 explains why the distribution of income within a given society is just as important to population health as the overall income level of that society. Indeed, it is estimated that if the same death rates as for the highest income earners applied to all Canadians, over one-fifth of all potential years of life lost before age 65 could be prevented.

Despite the persistence of troubling inequities in health, most Canadians are living longer and their overall health continues to improve. In an aging society, this is good news. As we enter a new century, our progress and potential for technological advances are cause for optimism. As we look forward to a healthy future, it is especially important to invest in our most precious human resources. While Canadian children and young people may be at the peak of their physical health, this report suggests some disturbing findings on their economic and social well-being.

We can give no greater gift to the next generation than a healthy future. This report helps us take stock of where we stand in terms of health and will help us measure our progress by looking at changes over time. This is an essential first step in addressing the challenges to health in the next millennium.

About This Report

This report summarizes the most current national information we have on the health of Canadians and invites the reader to consider the implications of these findings for current and future policies, practices and research. It is not a report card on the health-care system. Rather, it is a tool to alert policy makers, practitioners and the public to current and future challenges in health and to identify broad strategies that can address the major factors that influence health. Since it is the second in a series of reports on the health of Canadians, it also serves as an important monitoring tool by offering benchmarks for gauging progress in the future.

In this report, health is viewed as far more than the absence of disease. It uses the World Health Organization's definition in which health is seen as a complete state of physical, mental, social and emotional well-being. Health is a resource for living that enables people of all ages to realize their hopes and needs, and to change or cope with the environments around them.[2]

In keeping with this broad understanding of health, this report has been structured around the major factors that influence health. These factors — which include but extend beyond traditional health-care services — were identified as "prerequisites for health" in the 1986 *Ottawa Charter for Health Promotion*.[3] In 1994, the Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) released a document entitled *Strategies for Population Health: Investing in the Health of Canadians*[4] that expanded on this concept. This paper identified the following key influences or "determinants" of health: living and working conditions (the socioeconomic environment), the physical environment, health services, early childhood development, social support, personal health practices and coping skills, and biology and genetic endowment. While each of these influences is dealt with in a separate section of this report, it is the interplay of all of these factors that ultimately determines the health of individuals, families and communities. This way of examining health is termed the population health approach.

In addition to the factors mentioned above, gender, culture and membership in specific population groups have significant effects on health status. Within the limits of data availability, every attempt was made in this report to comment on the influence of these factors on health status and the determinants of health.

Toward a Healthy Future: Second Report on the Health of Canadians was prepared by the ACPH in collaboration with Statistics Canada, Health Canada, the Canadian Institute for Health Information and a project team from the Centre for Health Promotion, University of Toronto. As the title suggests, it is the second report to summarize and comment on the state of the nation's health. The first, *Report on the Health of Canadians*, was released in September 1996.[5]

The current report differs from the first one in several ways. It assumes a greater focus on inequities and the influence of gender on health. Chapters on healthy child development and biology and genetics have been added in order to paint an overall picture that includes all of the major determinants of health. The section on the physical environment has been expanded to provide a better understanding of how this determinant impacts on the health of Canadians.

Each chapter begins with a highlights section that provides a snapshot of the key information, which is followed by a more detailed discussion of selected aspects of the population's health and a brief discussion of the major findings and challenges arising from the information in the chapter. The final chapter suggests a vision of health for the new millennium and points to recurring themes, challenges and strategies brought out in the preceding chapters. As such, it provides a menu of key challenges for both short- and long-term action.

Data Sources and Limitations of This Report

Each year in Canada, massive amounts of information are collected on the health of Canadians. This includes vital statistics such as births and deaths, information on people's contacts with the health-care system, and information from outside the traditional health sector on such important matters as traffic injuries, housing and employment. These data are collected through surveillance systems that monitor new and emerging health problems, as well as national, provincial and local health surveys.

There is no one easy, comprehensive way to summarize all of this information in a single, manageable report. It was necessary, therefore, to select and focus on a limited range of issues and emerging trends that describe key aspects of the health of Canadians, and the factors that affect health. This report draws primarily on data contained in the *Statistical Report on the Health of Canadians*,[6] which were drawn from a variety of sources that are topical, recent and national in scope. The 1994–95 and 1996–97 cycles of the National Population Health Survey (NPHS), the 1996 Census and the National Longitudinal Survey on Children and Youth (1994–95 and 1996–97) are major information sources for this report. The reader is encouraged to turn to the *Statistical Report on the Health of Canadians* and the publications from the National Longitudinal Survey on Children and Youth for information on topics not covered in this report.

Whenever possible, other reliable data sources and reports were consulted and credited in discussions of health issues; however, it was impossible to fully address the diversity of Canada's population in one national report. Information on Aboriginal people, newcomers to Canada and provincial/territorial differences have been included when reliable national data were available, but reporting is inconsistent throughout the text. In this regard, there may be a need to produce a number of supplementary reports that take a more specific and detailed look at provincial comparisons and influences on health such as gender, income, culture and membership in a specific population group.

In other cases, such as the exploration of early child development and health, a number of other excellent reports already exist (see Appendix C). This report is not intended to duplicate these efforts but to summarize what we know from a broad, national perspective about healthy child development as a key factor in the current and future health status of Canadians. The chapter on biology and genetics provides an introductory look at this important determinant of health. A specific, more detailed report on this topic would be extremely useful.

The use of a number of different sources means that there are discrepancies in the age categories that are reported. The 1996–97 NPHS has a distinct advantage over other national surveys in that age classifications are more detailed than those used in past surveys. This allows the reader to see differences among youth, for example, who look

and act very differently at ages 12 and 19. It also allows the reader to consider the "cohort effect." For example, the generation of Canadians who are now over the age of 75 may have had a very different life experience than Canadians in younger generations. The cohort effect is especially relevant when we think about predictions for the future. At the same time, the factors that influence health are likely to have an intergenerational effect unless they are reversed. For example, children who grow up in low-income, disadvantaged neighbourhoods are more likely to raise their own children in the same kind of neighbourhood, unless they are given opportunities to break out of this cycle.

This report also looks at time trends, with a concentration on changes in the various indicators contained in the previous report. In some cases, longer periods of time are used to provide a more balanced look at changes over time. However, time trends between the two NPHS surveys offer the most reliable comparisons, since the methodology and sample size were similar.

While the use of large, national data sources ensures an accurate overall perspective on the health of Canadians, there are often insufficient numbers to make reliable observations about subcategories within specific demographic groups or populations, such as Aboriginal people. Provincial comparisons of health indicators in Appendix B should be interpreted with caution because of small sample sizes in some provinces. Even statistics within provinces tend to mask the heterogeneous nature of groups within a particular jurisdiction. For example, while overall measures of health may be high in a particular province, there may be large differences among cultural or socioeconomic subpopulations within that jurisdiction that are not captured by large databases. Unless otherwise noted, provincial and territorial estimates in this report are not age-standardized.

At the time of writing, data from the 1996–97 National Population Health Survey in the Northwest Territories and the Yukon Territory were still in the process of analysis by Statistics Canada. As well, the new territory of Nunavut officially came into being — an historic and important event for Canada. Data from Nunavut, however, were not yet separated from the NWT database. While every attempt was made to glean information from other surveys and documents, this report falls short of providing a clear picture of the health of Canada's Northern residents.

Information on Aboriginal people should be treated with caution, since undercoverage in the 1996 Census was considerably higher among Aboriginal people than other segments of the population. Some 77 Indian and Inuit reserves and settlements (containing an estimated 44,000 people) were incompletely enumerated. In addition, there was very little information available distinguishing findings among the diverse subgroups within the Aboriginal population (e.g. Inuit, Métis, Registered Indians [on and off reserve], and Unregistered Indians). Fortunately, initial results from the First Nations and Inuit Regional Health Survey — which included questions similar to those in the National Population Health Survey and was carried out with First Nations peoples living on reserve and with Inuit communities in Labrador — became available toward the end of the writing process. Further analysis of this survey will add important information to what is contained here.

While a number of specific gaps in data are identified throughout the report, two areas deserve special mention. The first relates to the lack of data on the quality of health services (not the quantity) and the fact that most health service data are hospital-based. As the health system increasingly moves into the community, more information on

community-based care is required. The second gap relates to the paucity of population-based measures of health. As discussed in Chapter 1, virtually all the information in this report is based on individual health measures. Future reports of this type would benefit from additional measures of collective well-being based on sound methodologies and a combination of indices.

The Canadian Population

The age and sex composition of a population can have a dramatic effect on aspects of health such as fertility rates and the use of health services. The following paragraphs contain some key statistics based on the 1996 Census.

In 1996, there were just over 30 million people living in Canada. About 27% of the population was aged 19 or younger and some 12% were 65 years of age or older. This reflects a significant decline in the proportion of the population made up of children and young people in Canada, as well as the aging of the population as a whole. The number of Canadians aged 20 to 64 rose from 53% in 1971 to 61% in 1996; over the same time period, the population aged 65 and over increased from 8% to 12%. Because of the longer life expectancy of women, there were more women than men past age 65; in all of the younger age groups, the numbers of males and females were virtually equal. The proportion of Canadians aged 65-plus is expected to more than double by 2041 to approximately 10 million people (representing between 22% and 25% of the population).

About 3% of the Canadian population is Aboriginal in origin. In 1996, there were approximately 1,192,600 Aboriginal persons living in Canada, of whom 507,200 were Registered Indians, 57,000 Inuit, 205,800 Métis and 422,600 non-status/other.

Canada's Aboriginal population is much younger than the general population. The average age of the Aboriginal population included in the 1996 Census was 25.5 years, some 10 years younger than the average of the general population. Children under age 15 accounted for 35% of all Aboriginal people, as compared with only 20% of the general population.

The majority of Canadians live in Ontario (38%) and Quebec (24%). There are vast differences in provincial population size and the territorial populations are smaller than that of the smallest province (Prince Edward Island). While the majority of Canadians live in large urban centres, a substantial number of people live and work in rural areas.

In 1996, 17% of the Canadian population — some 5 million people — were immigrants. Immigrants (people born outside Canada whose parents are not Canadian) have been a vital part of Canadian society for more than 400 years. Canada's population is becoming increasngly diverse. Earlier waves of immigrants from Europe have largely been replaced by newcomers from Asia, the Middle East and Africa. In 1996, there were some 226,000 newly-landed immigrants in Canada; about one in six immigrants were classified as refugees. Forty-seven percent of 1996 immigrants were between 25 and 44 years of age. Three-quarters of recent immigrants settled in Ontario or British Columbia, with Quebec and Alberta attracting the next largest proportions of Canada's newest arrivals. Recent immigrants have been especially attracted to Canada's three largest urban areas: Toronto, Vancouver and Montréal.

Recent immigrants, regardless of their country of birth, tend to be in better health than Canadian-born residents. This is probably a function of the immigration process — people in good health are more inclined to emigrate than those in poor health, and potential immigrants must first undergo medical screening for serious conditions. The longer immigrants remain in Canada, however, the more their health is likely to resemble that of Canadian-born citizens.[7]

A Population Health Approach

In January 1997, the ACPH defined population health as follows:

> *Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.*
>
> *As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.*

Definitions

- **First Nations** population refers to those persons who are registered as Indians under the terms of the *Indian Act* and whose names appear in the Indian Register maintained by the Department of Indian Affairs and Northern Development.
- **Aboriginal** refers to all indigenous persons of Canada of North American, Indian, Inuit or Métis ancestry, including those in the Indian Register.
- Statistics Canada defines **immigrants** as "people who are, or have been at one time, landed immigrants in Canada." A **landed immigrant** is a person who has been granted the right to live in Canada permanently by immigration authorities. Some are recent arrivals, while others have resided in Canada for a number of years. **Recent immigrants** are people who came to Canada within the last five years.

The goal of a population health approach is to maintain and improve the health status of the entire population and to reduce inequities in health status between groups. This requires a thorough, ongoing examination of both health status and the factors that determine or influence health. Current data and evidence from the literature are then used to make decisions about future efforts in research, policy and programs. This report and its predecessor are important tools for understanding and implementing a population health approach in Canada.

Endnotes for Introduction

1. United Nations Development Program. *Human Development Report 1998*. New York: Oxford University Press, 1998.
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3. Ibid.
4. Federal, Provincial and Territorial Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians*. Ottawa: Minister of Supply and Services Canada, 1994.
5. Federal, Provincial and Territorial Advisory Committee on Population Health. *Report on the Health of Canadians*. Prepared for the Meeting of Ministers of Health, Toronto, September 1996. Ottawa: Health Canada, 1996.
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7. Chen, J., Ng, E., Wilkins, R. (Statistics Canada). “The Health of Canada’s Immigrants in 1994–95.” *Health Reports* 7, 4 (Spring 1996): 33–45 (Statistics Canada Cat. No. 82-003-XPB).