Introductory Materials

✓ How to Use This Kit
✓ Sample Presentation

> *...the greatest challenge that the world faces... is the growing chasm between the richest and poorest people on earth. Citizens of the 10 wealthiest countries are now 75 times richer than those who live in the 10 poorest ones, and the separation is increasing every year, not only between nations but also within them. The results of this disparity are root causes of most of the world's unresolved problems, including starvation, illiteracy, environmental degradation, violent conflict, and unnecessary illnesses that range from Guinea worm to HIV/AIDS.*
>
> **Jimmy Carter, former President of the United States**
> **Nobel Lecture, December 10, 2002**

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How to Use This Kit

I. About This Tool Kit

This Tool Kit is a condensed and summary version of a research paper—*The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.* This research was done by GPI Atlantic for the Population and Public Health Branch of the Atlantic Regional Office of Health Canada. A copy of the full paper is included on the CD in this package.

This Tool Kit has several goals:

- to increase awareness and understanding of the links between inequity and chronic disease in Atlantic Canada
- to increase awareness and understanding of the impact of social and economic policy on chronic disease and the need to consider these impacts when developing policy
- to encourage community groups and organizations to examine their work and their policies in light of this information and think about what they could do differently

Inequity occurs when things are unfair or unjust. There can be inequities because of gender, race, income, resources and other social and economic factors.

Inequities arise from exclusion.

Exclusion can be economic—related to jobs and income – or social—related to health care, education, housing or support from others. Inequity can happen when people don't have—and can't get—the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.

Health inequities occur when some people – because they have more money, higher status, more education, etc. – have a better chance of being healthy.

For more information on exclusion, see "Basic Information about Social and Economic Exclusion" on the website of the Atlantic Centre of Excellence for Women's Health:
www.acewh.dal.ca/inclusion-preface.htm

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II. What's in The Kit?

Turning the Tide: Why Acting on Inequity Can Help Reduce Chronic Disease is designed to help you understand the complex links between inequity and chronic disease. As well, it gives you the tools to make presentations about this research. You'll find all of the material in the Kit on the CD included in this package. The original research paper is also on the CD. All the material is in PDF format, ready to be printed. The overheads are also included as a set of PowerPoint slides.

Understanding the Links Between Inequity and Chronic Disease
The Tool Kit contains photocopy masters for nine **Information Sheets**, two **Action Sheets** and five **Statistics Sheets**.

Information Sheet 1
Provides an overview of the research
Information Sheet 2
Summarizes the key messages from the research
Information Sheets 3, 4 and 5
Expand on key messages discussed in the overview
Information Sheets 6, 7 and 8
Provide basic background information
Information Sheet 9
Defines useful terms
Action Sheet 1
Recommends actions for population health strategies
Action Sheet 2
Recommends actions by various levels of government
Statistics Sheets
Provide statistics on chronic disease for each Atlantic province and the Atlantic region

Presentation Tools
The Tool Kit also contains a sample presentation outline and 13 accompanying PowerPoint slides/printable overheads. The first three slides set the stage by defining key words—social and economic exclusion, inequity and chronic disease. The next six slides are the key messages of the research linking inequity and chronic disease. The final four slides offer strategies for action.

III. Ways to Use This Kit

1. Get started
Read through the information contained in this Kit. Start with Information Sheet 1—it provides an overview of the research. Sheet 2 is a summary of the key messages, and Sheets 3 – 5 enhance some of the information in the overview. Depending on your background, use Sheets 6 – 8 and the Statistics Sheets for a greater level of detail.

2. Present what you have learned
The Kit contains an outline for a 30 to 60-minute presentation that covers the key messages highlighted by the research. It includes time for the group to reflect on and discuss the messages, and look for ways to apply what they have learned. It is a sample and is meant to serve as a guide for you to create your own presentation.

Do not feel you have to use ALL the sheets for every presentation. Tailor your presentation to meet the needs of your audience and to suit the time you have available. For example, you may decide to focus only on Information Sheet 1, Overview of the Research. Or, you may decide to address just one of the key messages. If you have time, you may consider a series of presentations. For example, start with a brief overview of the topic then follow up later with the topics discussed in Information Sheets 3, 4 and 5. If your group has very little background in this area, start your presentation with the 12 Determinants of Health (Information Sheet 6).

3. Other ways to use the Information and Action Sheets

In addition to using them as supporting material to accompany your presentations, there are other ways you can use the Information and Action Sheets:

- Photocopy the sheets and circulate them at places like public meetings, workshops, conferences, community gatherings and health fairs.
- If you are meeting with a politician, community leader or public servant, leave copies of one or more of the sheets with them.
- Give a copy of all or part of the Kit to local libraries and schools.
- Reprint all or part of the sheets in community and organizational newsletters.

IV. Advice for Effective Presentations

Plan, prepare and practice

Plan

Answer these questions:

- Who will you be talking to?
- How big is the group?
- Why are you giving the presentation? What do you want to achieve?
- How much time will you have, including time for questions and discussion at the end?
- What facilities are available? (For example, there's no point in planning a PowerPoint presentation if the space isn't set up for it.)

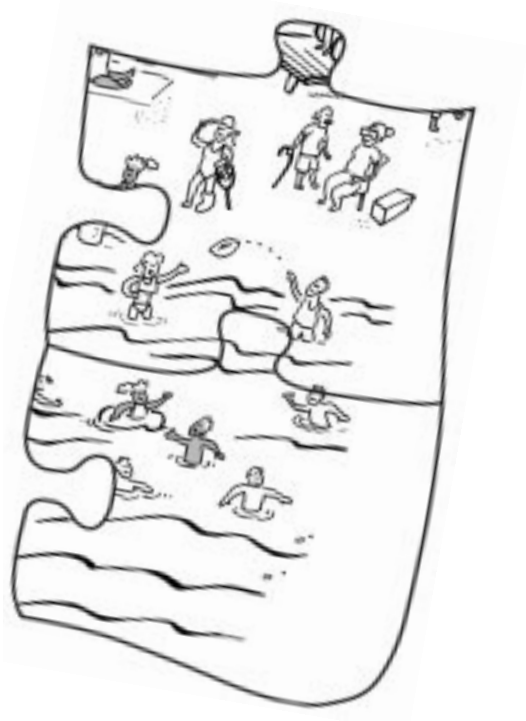
Prepare

Effective presentations are short, clear and to the point. This can only happen if the presentation is thought out carefully and well in advance. Good presentations have three parts:

- A beginning, in which you introduce yourself, thank your audience for being there to listen, and summarize what you're going to say.
- A middle, in which you make your points. If you are using slides or overheads, make sure they support your points and use no more than one slide every two minutes.
- An end, in which you summarize what you've said, open the floor for questions, and begin a discussion with your audience.

Practice

Practice your presentation by saying it out loud, standing up. Most people get bored listening to someone read a presentation, so make notes you can refer to to keep yourself on track, but don't plan on just reading a speech. Your talk will be more natural and much more interesting if you use your own words. Keep practicing until you are relaxed and comfortable with your material. If your friends or family are willing, rehearse in front of them. Let them ask questions and practice leading them in a discussion. If you'll be using slides or overheads, practice using them, too.



V. Summary of Sheets and Overheads

Information Sheets, Action Sheets, Statistics Sheets and Overheads contained in the Tool Kit

Information Sheets		# of sheets
#1	Overview of the Research	3
#2	What the Research Tells Us: Definitions, Links and Strategies	1
#3	Linking Inequity to Social and Economic Exclusion	1
#4	Linking Inequity and Chronic Disease to Vulnerable Groups	1
#5	Linking Inequity to Everyone	1
#6	The Determinants of Health	1
#7	Frequently Asked Questions About Inequity and Health	1
#8	The Most Common Chronic Diseases in Atlantic Canada	2
#9	Definitions	1
Action Sheets		
#1	Recommendations for Population Health Strategies	2
#2	Suggestions for Governments and Community Health Boards	1
Statistics Sheets		
#1	Chronic Disease Statistics for New Brunswick	1
#2	Chronic Disease Statistics for Newfoundland and Labrador	1
#3	Chronic Disease Statistics for Nova Scotia	1
#4	Chronic Disease Statistics for Prince Edward Island	1
#5	Economic Facts and Chronic Disease Statistics for the Atlantic Region	1
Overheads		
Setting the Stage: Definitions		
#1	Social and economic exclusion happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.	
#2	Inequity occurs when things are unfair, or unjust. There can be inequities because of gender, race, income, resources and other social and economic factors.	
#3	A chronic disease is an illness or condition that continues over a long period of time. It cannot be cured easily or quickly, if at all.	

Making the Links: Key Messages	
#4	Research shows that there are strong, complex and real links between inequity and chronic disease.
#5	Physical, psychological, social and economic factors all combine to make individuals and communities healthy (or unhealthy).
#6	Inequity makes people vulnerable — groups of people facing inequity have much higher rates of chronic disease than other, less vulnerable groups.
#7	Inequity affects everyone, not just people who are poor and excluded. Research tells us that the more equal the spread of wealth the healthier the society.
#8	Inequity — through poverty and exclusion — has more impact on health than the choices people make in their daily life.
#9	The provinces of Atlantic Canada have more social, economic and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

Turning the Tide: Strategies	
#10	Social and economic factors that lead to chronic disease can be changed. Strategies addressing the root causes of inequities will be most effective in reducing the levels of chronic disease.
#11	Like the diseases they cause, the social and economic factors leading to inequity are chronic — they are long-standing and not easily or quickly resolved. But public policies can change social and economic conditions.
#12	Chronic disease patterns are a cause for concern in Atlantic Canada. Strategies must be based on an understanding of regional inequities, social and economic risk factors, and chronic disease patterns in the region. They must be specific to local economic, social and cultural conditions. And the groups most affected must be involved.
#13	The Atlantic region has social strengths that can help inspire healthy policy changes. By following the Atlantic Canadian traditions of cooperation, fairness and compassion, we can work to reduce inequity. This will lead to more inclusive and healthier communities.

VI. Acknowledgements

The opinions expressed in this Tool Kit are those of the authors and do not necessarily reflect the views of Public Health Agency of Canada.

Based on an original research paper, *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.*
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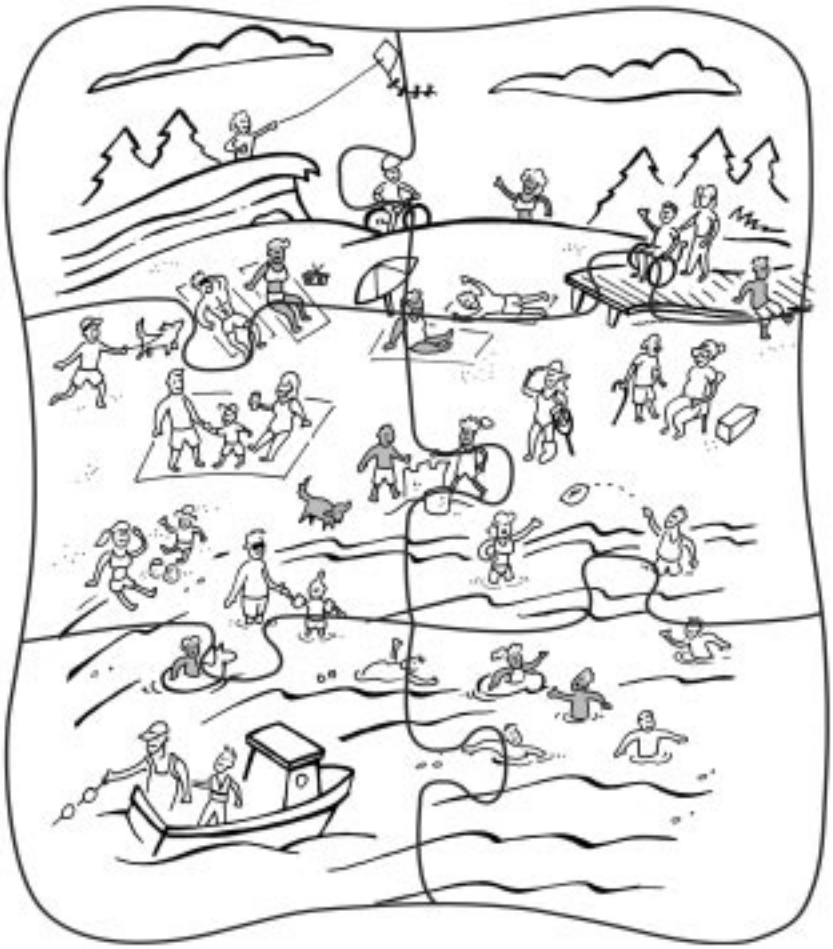

Sample Presentation

Materials You'll Need

Choose the Information Sheets and Action Sheets you will need. Base this choice on the group you will be working with. How much do they know already? What best meets their needs and interests? You'll need one copy of each handout for each participant. Also, provide a copy of the Learning Sheet Handout (included) for each participant.

Estimated time
This presentation should take between 30 – 60 minutes, depending on the length of the discussions and the size of your group.

Sample presentation outline

1. *Welcome and introductions*

2. *Present the information from the research paper*
   - Use the content of the **Information Sheet(s)** and **Action Sheets** with accompanying speaking points and slides/overheads.
   - Provide the Learning Sheet Handout so people can jot down their thoughts and ideas as they listen to the presentation.

3. *Discuss what has been learned*
   - Encourage the group to reflect on and discuss what has been learned. Ask, "What did you hear? What have you learned?"

4. *Apply the information*
   - Work with the group on how to use what has been learned. Ask, "Can we use this information? How can we use it?"

5. *Follow-up*
   - Provide the **Information Sheets** and **Action Sheets** for the group to keep.

Worried about time? Not sure you want to make a formal presentation?
Use a shorter version of the presentation if you have less than 30 minutes and/or if you are not comfortable leading a group.

In advance:
Provide whichever of the **Information** and **Action Sheets** you plan to use and give people time to read them. This could be anywhere from one week to one hour.

During the session:
Ask, "What did you understand?" "What have you learned?" Discuss.

Ask, "Can we use this information?" "How?" Discuss. Work with your group to discuss what you have learned. Together, plan ways to apply what you have learned to your work — projects, policies and activities.

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Sample Presentation

1. Welcome and introductions (5 minutes)

Welcome participants. Introduce yourself. If people don't know each other, ask them to introduce themselves to the rest of the group.

2. Presentation content (26 minutes)

Give each participant a copy of the Learning Sheet Handout (included). Ask them to use this sheet to take notes during the presentation. They can write down their thoughts in the left-hand column as they arise. Let people know these notes don't have to be structured. They are simply writing down the "light bulbs" that go off in their head as they listen to the information being presented. Tell people that later, participants will use the right-hand column to figure out practical ways to use what has been learned.

Use the slides to help focus your presentation. Allow about two minutes for presenting information on the point addressed by each slide. Speaking points for each slide are included below.

Slide #1

Social and economic exclusion happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.

- Social and economic exclusion creates inequity.

Ask, "*What are some examples of ways people are excluded?*"

(From Information Sheet #1: Page 1 of 6)

Slide #2

Inequity occurs when things are unfair or unjust. For example, the gap between the rich and poor, lack of access to housing and education, and low levels of social support.

- There can be inequities due to gender, race, income, resources and other social and economic factors.
- Inequity has an impact on all the many factors that make a person or a community healthy or unhealthy.
- Health is a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease.
- Health inequity occurs when some people have a better chance than others of being healthy.

Ask, "*What does this mean? What does inequity look like in our community? In our country? In the world?*"

(From Information Sheet #1: Page 1 of 6)

Slide #3

A chronic disease is an illness or condition that lasts for a long period of time. It cannot be cured easily or quickly, if at all.

- It can be physical or mental.
- It can be communicable or non-communicable.

Ask *for examples of chronic diseases.*

Common examples: cardiovascular disease (heart disease and stroke), cancer, diabetes, respiratory illness (like asthma), Hepatitis C, HIV/AIDS, stress, anxiety disorder, depression, schizophrenia

(From Information Sheet #1: Page 1 of 6)

Slide #4

Research shows that there are strong, complex and real links between inequity and chronic disease.

- The next key messages outline that research.

(From Information Sheet #1: Page 2 of 6)

Slide #5

Physical, psychological, social and economic factors all combine to make individuals and communities healthy (or unhealthy).

- Health is more than just not being sick.
- What happens in all parts of our lives affects our health — for better or for worse.

Ask, "*What parts of life affect health?*"

- Examples are having enough income, good jobs, a connection to community, the love of friends and family and so on.

Ask, "*Can you name some of the determinants of health?*"

- Review the 12 Determinants of Health (Information Sheet #6) if required.
- The single most important determinant is income and social status, which is related to your level of education.
- One study showed that when people were divided into five income groups, those in the lowest income groups had a higher rate of all chronic diseases than did people in the three upper income groups.

(From Information Sheet #1: Page 2 of 6)

Slide #6

Inequity makes people vulnerable — groups of people facing inequity have much higher rates of chronic disease than other, less vulnerable groups.

- Inequity and chronic disease connect through overlapping layers:
  - First layer: physical effects of inequity
  - Second layer: social and psychological effects of inequity and how they lead to chronic disease
  - Third layer: links inequity broadly to underlying political, economic, cultural and historical pressures

Ask, "What vulnerable groups might have higher rates of chronic disease than others?"

(From Information Sheet #1: Page 2 of 6)

Slide #7

Inequity affects everyone, not just people who are poor and excluded. Research tells us that the more equal the spread of wealth, the healthier the society.

- These layers impact most strongly on vulnerable groups, but they do affect everyone.
- Studies show that health is related to the social and economic well-being of your neighbourhood, community and/or region. This is more important than how well off you are compared to others in your community, or whether you are part of a vulnerable group.

(From Information Sheet #1: Page 3 of 6)

Slide #8

Ask, "What does this all mean?"

Inequity — through poverty and exclusion — has more impact on health than the choices people make in their daily life.

- There are strong, complex and real links between inequity and chronic disease.
- To reduce the incidence of chronic disease, we need to get to its root causes.
- Focusing on lifestyle and risk factors is not enough.
- Lifestyle programs cannot reduce the deeper influences of poverty and social exclusion on health.

(From Information Sheet #1: Page 4 of 6)

Slide #9

Ask, "What's the link with Atlantic Canada?"

The provinces of Atlantic Canada have more social, economic and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

- Atlantic Canada has lower incomes, higher rates of unemployment and a smaller share of the national wealth than the rest of the country.
- Also has higher risk factors for chronic disease and poorer health than the rest of the country.
- This relationship is not straightforward. There are differences between the four provinces and differences within regions of the same province.
- However, disadvantaged areas in all four provinces show higher levels of chronic disease but some urban areas have rates closer to the Canadian average.

(From Information Sheet #1: Page 4 of 6)

Slide #10

Ask, "What can we do?"

Social and economic factors that lead to chronic disease can be changed. Strategies addressing the root causes of inequities will be most effective in reducing the levels of chronic disease.

- Prevention strategies need to work on root causes.
- Social and economic root causes are chronic — long-standing and not easy to resolve. But, it can be done.

(From Information Sheet #1: Page 5 of 6)

Slide #11

Like the diseases they cause, the social and economic factors leading to inequity are chronic — they are long-standing and not easily or quickly resolved. But public policies can change social and economic conditions.

- Use youth and seniors as an example. (see paper)

(From Information Sheet #1: Page 5 of 6)

Slide #12

Chronic disease patterns are a cause for concern in Atlantic Canada. Strategies must be based on an understanding of regional inequities, social and economic risk factors, and chronic disease patterns in the region. They must be specific to local economic, social and cultural conditions. And the groups most affected must be involved.

- Government has tried to reduce inequity and poverty through policy, with some success.
- But, underlying social and economic inequities are the same, so chronic disease patterns have not changed.
- Problem — no plan that looks at all these factors together. Health care reform doesn't look at reducing inequity and poverty.
- Coordinated, complete population health plans are needed, that address all the determinants of health and the ways they are linked. (see the five suggestions in paper)

(From Information Sheet #1: Page 5 of 6)

Slide #13

Ask, "How can we change things?"

The Atlantic region has social strengths that can help inspire healthy policy changes. By following the Atlantic Canadian traditions of cooperation, fairness and compassion, we can work to reduce inequity. This will lead to more inclusive and healthier communities.

- There are strong social support networks in Atlantic Canada.
- We must build on the assets of strong families and social and community supports.
- Look at the "Newfoundland advantage": despite high unemployment and low incomes, Newfoundland and Labrador residents have better mental health than other Canadians and lower levels of stress and high levels of psychological well-being. The province also has lower rates of many chronic diseases. Why?
- We all have role to play in helping to change social and economic conditions.

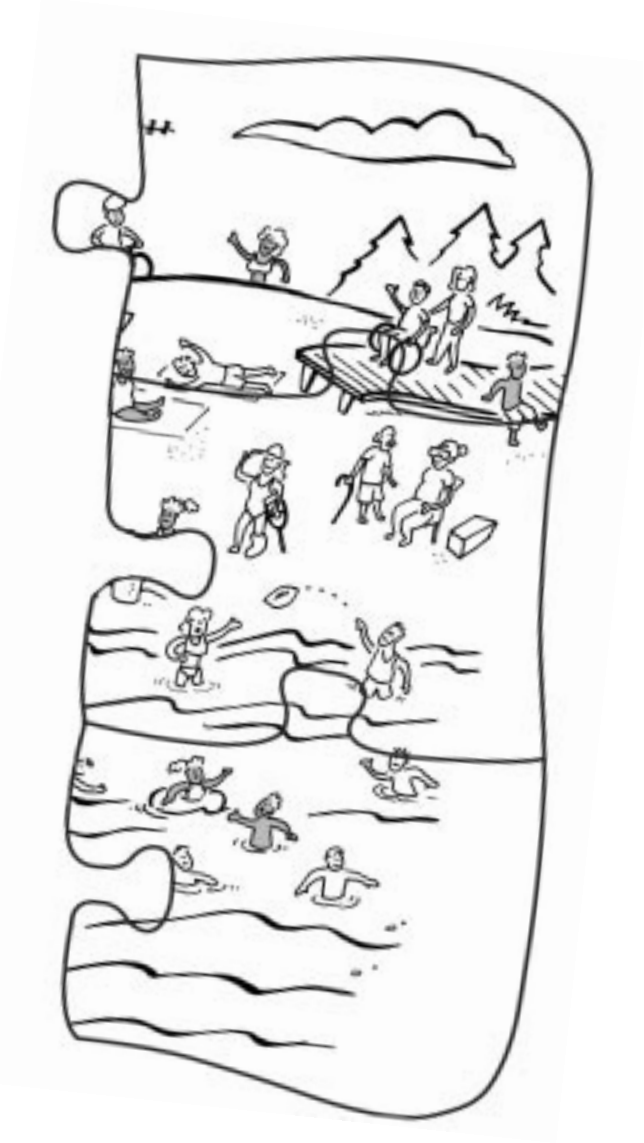
Ask, "What can we do as a result?"

We all have a role to play in helping to change social and economic conditions.

Here are some options:

- In our paid and volunteer work, we can be aware of the links between inequity and chronic disease. By working to reduce poverty and inequity, we will be working to reduce chronic disease.
- We can acknowledge that equity and social inclusion are necessary for everyone's health and well-being.
- We can add our voice to the policy process.
- We can commit ourselves, and our organizations, to supporting population health principles aimed at achieving a fair and just society.

(From Information Sheet #1: Page 6 of 6)



3. Discuss what has been learned (15 minutes)

Follow your presentation with some time for the group to reflect on and discuss what they have learned.
Ask,"What did you hear?"
"Did you know this information already?"
"What is your opinion?" "What have you learned?"
"What have we learned as a group?"

4. Apply the information (15 minutes)

Work with the group on how to use what has been learned. It is important to work through the many ways the group might want to apply this knowledge. Consider using it to adapt or change your policies, procedures, goals, or the focus of your projects.

Ask participants to share what they have written on their learning sheets. Ask, "What light bulbs were going off as you heard this information?" Ask, "Can we use this information? If so, HOW can we use it?"

Use the right-hand column of the learning sheet as a place for participants to write down some ideas for applying what they have learned.

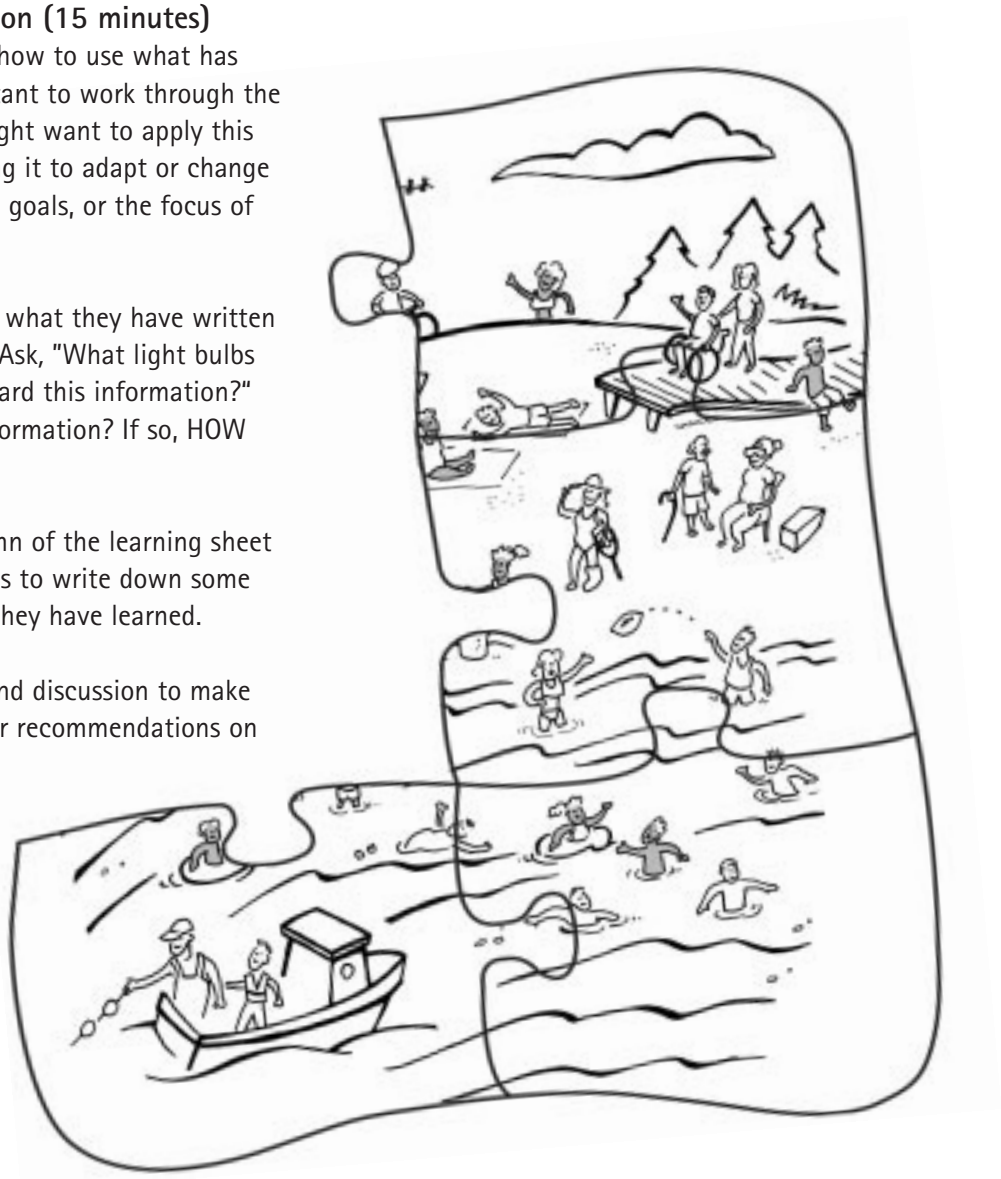
Work from these notes and discussion to make some clear suggestions or recommendations on how to proceed.

5. Follow-up

Provide the **Information Sheets** and **Action Sheets** for the group to keep

6. Summary and thank you (3 minutes)

Close your presentation with a few key summary sentences and then thank everyone for coming.



Learning Sheet Handout

Use this sheet for taking notes during the presentation. Jot your thoughts down in the left-hand column as they arise. These are the "light bulbs" that go off in your head as you listen to the presentation. Later, we'll use the right-hand column to figure out practical applications for what we have learned.

Your thoughts ("light bulbs")	How can we use this?

Photocopy Masters for 13 Overheads

Setting the Stage: Definitions	
#1	Defines social and economic exclusion
#2	Defines inequity
#3	Defines chronic disease
Making the Links: Key Messages	
#4	States the link between inequity and chronic disease
#5	Explains the factors that combine to make people and communities healthy (or unhealthy)
#6	Links vulnerable groups and inequity to chronic disease
#7	Explains that equity affects the health of everyone, not just those who are poor and excluded
#8	Targets inequity versus the choices people make in daily life
#9	Describes social, economic and health inequities and rates of chronic disease in Atlantic Canada
Turning the Tide: Strategies	
#10	Suggests that strategies addressing the root causes of inequities will be most effective
#11	Targets public policy change
#12	Explains the focus for strategies to reduce chronic disease and inequity
#13	Presents a goal—to build on social strengths within Atlantic Canada to foster inclusion and equity

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Social and economic exclusion happens when people don't have – and can't get – the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.

Inequity occurs when things are unfair or unjust. For example, the gap between the rich and poor, lack of access to housing and education, and low levels of social support.

Health is a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease (WHO). Health inequities occur when some people – because they have more money, higher status, more education, etc. – have a better chance of being healthy.

Health equity means that everyone has an equal chance to be healthy.

A chronic disease is an illness or condition that continues over a long period of time. It cannot be cured easily or quickly, if it can be cured at all.

Research shows that there are strong, complex and real links between inequity and chronic disease.

Physical, psychological, social and economic factors all combine to make individuals and communities healthy (or unhealthy).

Inequity makes people vulnerable – groups of people facing inequity have much higher rates of chronic disease than other, less vulnerable groups.

Inequity affects everyone, not just people who are poor and excluded. Research tells us that the more equal the spread of wealth, the healthier the society.

Inequity – through poverty and exclusion – has more impact on health than the choices people make in their daily life.

The provinces of Atlantic Canada have more social, economic and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

Social and economic factors that lead to chronic disease can be changed. Strategies addressing the root causes of inequities will be most effective in reducing the levels of chronic disease.

Like the diseases they cause, the social and economic factors leading to inequity are chronic – they are long-standing and not easily or quickly resolved. But public policies can change social and economic conditions.

Chronic disease patterns are a cause for concern in Atlantic Canada. Strategies must be based on an understanding of regional inequities, social and economic risk factors, and chronic disease patterns in the region. They must be specific to local economic, social and cultural conditions. And the groups most affected must be involved.

The Atlantic region has social strengths that can help inspire healthy policy changes. By following the Atlantic Canadian traditions of cooperation, fairness and compassion, we can work to reduce inequity. This will lead to more inclusive and healthier communities.

Photocopy Masters for 9 Information Sheets

Information Sheets

#1	Overview of the Research	3 sheets (6 pages)
#2	What the Research Tells Us: Definitions, Links and Strategies	1 sheet (1 page)
#3	Linking Inequity to Social and Economic Exclusion	1 sheet (2 pages)
#4	Linking Inequity and Chronic Disease to Vulnerable Groups	1 sheet (1 page)
#5	Linking Inequity to Everyone	1 sheet (2 pages)
#6	The Determinants of Health	1 sheet (1 page)
#7	Frequently Asked Questions About Inequity and Health	1 sheet (2 pages)
#8	The Most Common Chronic Diseases in Atlantic Canada	2 sheets (3 pages)
#9	Setting the Stage: Definitions	1 sheet (1 page)

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Overview of the Research

Setting the Stage: Definitions

This paper is about the research linking inequity to the development of chronic disease. To understand this research, you'll need to know some important terms: social and economic exclusion, inequity, health, and chronic disease.

Social and economic exclusion happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.

Social and economic exclusion creates inequity.

Inequity occurs when things are unfair or unjust. For example, the gap between the rich and poor, lack of access to housing and education, and low levels of social support. There can be inequities because of gender, race, income, resources and other social and economic factors. Inequity has an impact on all of the many factors that make a person or a community healthy or unhealthy.

Health is a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease. (WHO)

Health inequity occurs when some people — because they have more money, higher status, more education, etc. — have a better chance of being healthy.

Health equity means that everyone has an equal chance to be healthy.

A chronic disease is an illness or condition that continues over a long period of time and cannot be cured easily or quickly, if it can be cured at all. Chronic diseases can be physical or mental. They can be non-communicable (this means you can't catch the disease from someone else) or communicable (this means you can catch it from someone else).

The most common non-communicable chronic diseases in Atlantic Canada are:

- cardiovascular diseases (like heart disease and stroke)
- cancer
- diabetes
- respiratory illnesses (like asthma)

The most common communicable chronic diseases in Atlantic Canada are:

- hepatitis C
- HIV/AIDS

Chronic mental health problems include stress, anxiety, depression and schizophrenia.

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Making the Links: Key Messages

What are the links between inequity and chronic disease?

Research shows there are strong, complex and real links between inequity and chronic disease. This section outlines that research.

Physical, psychological, social and economic factors all combine to make individuals and communities healthy (or unhealthy). We know that being healthy means more than just not being sick. What happens in all parts of our life affects our health — for better or worse. For example, in order to be healthy we need enough money, good jobs, a connection to our community, and the love and support of friends and family. The 12 factors that affect our health are called the determinants of health. These include income and social status, social support, education, employment, gender, culture and healthy child development.

The single most important determinant of health is income and social status. This is because the effects of income and social status ripple through all the other determinants of health. This makes sense — for example, the more education you have the more likely you are to have a better job and earn more money. This means you can afford to live in a better neighbourhood and give your children a better education and more opportunities.

This is where the link between inequity and disease comes in: people living on low incomes who do not have these advantages are more likely to get chronic diseases and are more likely to die from them than people with higher incomes. For example, in 1994-95 and again in 1996-97, Statistics Canada's National Population Health Survey showed that when people were divided into five income groups, those in the two lowest income groups had a higher rate of all chronic diseases than did people in the three upper income groups. **Inequity makes people vulnerable — groups of people facing inequity have much higher rates of chronic disease than other, less vulnerable groups.**

Why does this happen? Why are people with low incomes so much more likely to get sick? Researchers say that inequity and chronic disease connect through the social and economic factors that affect health. Like the layers of an onion, these factors overlap, link and build on each other in complex ways.

The first layer looks at the physical effects of inequity. It says that social and economic inequities lead to poverty and deprive people of the material things they need to be healthy. The logic goes like this:

- Governments don't spend enough money on social and economic support programs.

- This leads to social and economic inequities. These include lack access to education, recreation and transportation; unhealthy child development; unemployment; crime; violence; and reduced access to basic needs such as food, clean water, shelter and clothing.

These inequities lead to poverty and exclusion, cutting people off from their communities and society as a whole.

- Inequities have physical effects that make people more likely to get sick.

- Inequities also have effects on behaviour. For example, people facing inequity and exclusion are more likely to smoke, abuse alcohol and drugs, eat poorly and not exercise.

- These factors all lead to increased levels of chronic disease.

The second layer looks at the social and psychological effects of inequities and how these lead to chronic disease. It builds on the first layer and says that:

- Social and economic inequities deprive people of the resources they need to be healthy. They have less control over their life and work.

- This deprivation has psychological effects. It leads to chronic stress as well as other mental health problems including depression, anxiety, uncertainty, insecurity, and a lack of connection.

- Stress has a bad effect on health and makes us more likely to get a wide range of illnesses.

- People living in poverty endure high levels of stress that never let up. Over a lifetime, this stress builds up and leads to health problems.

- Vulnerable groups who are strongly affected by poverty and other inequities are particularly stressed and have poorer health. These groups include Aboriginal peoples, visible minorities, single mothers, children and youth.

- The psychological effects of inequities cut people off from their family, friends and community. People who are socially isolated tend to be less healthy and more likely to die early than those who have strong social relation ships. For example, lack of social support from family, friends, and communities is linked to higher rates of cardiovascular disease, premature death, depression and chronic disability.

The third layer takes a broad view of the root causes of inequities and exclusion. It links inequities to underlying political, economic, cultural and historical pressures. It says:

- A lack of resources to lead a healthy life, and the physical and mental effects of this lack, are **risk factors** for a broad range of chronic diseases. But risk factors are **not** root causes of chronic disease.

- The **root causes** of chronic disease are inequities that arise from broad social and economic structures and policies. Inequities such as poverty, racism and social and economic exclusion are the root causes that lead to risk factors like stress and physical and mental suffering. These risk factors then lead to ill health and chronic disease.

- We must look at broad social and economic structures in order to understand the root causes of inequities in health status. These structures include the market economy, globalization, and the welfare state.

These layers of inequity impact most strongly on vulnerable groups, **but inequity affects everyone, not just people who are poor and excluded.** Research tells us that **the more equal the spread of wealth, the healthier the society.**

For example, many studies show that your health is related to the social and economic well-being of the neighbourhood, community and region where you live. This factor is more important than how well off you are compared to others in your community or whether you are part of a vulnerable group. People who are poor tend to have the worst health outcomes in a community. But even if you are not poor, if you live in a poor community your health outcomes will tend to be worse than those of others who live in a community where incomes are higher.

What does all this mean?

This research tells us that there are strong, complex and very real links between inequity and chronic disease.

Inequity — through poverty and exclusion — has more impact on health than the choices people make in their daily life.

This tells us that in order to reduce the incidence of chronic disease, we're going to have to do more than focus on lifestyle changes and risk factors. We're going to have to find ways to address the inequities that are their root causes.

For example, we've seen that people living on low-incomes are more likely to get chronic diseases and are more likely to die from them than people with higher incomes. We've also seen that people living on low incomes are more likely to smoke, eat unhealthy foods and get little exercise.

But these risky behaviours explain only a small part (25% to 30%) of the difference in death rates between high- and low-income groups. This means that if people who are poor had the same rates of smoking, physical activity and healthy eating as people who are rich, the low-income group would still have higher rates of chronic disease. Despite this, most health promotion efforts have been aimed at trying to change these behaviours. These programs have been more successful with high-income groups than with low-income groups that have fewer options and less control over their lives. This has resulted in **more** inequity — that is, the wealthy get healthier and the health gap between the rich and poor widens.

This is because lifestyle programs cannot undo the deeper influences of poverty and social exclusion on health. Changing individual behaviour does not change the social and economic conditions that led to the behaviour and may lead to the same behaviour in the next generation.

What's the link with Atlantic Canada?

The provinces of Atlantic Canada have more social, economic and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

Atlantic Canada has lower incomes, higher rates of unemployment and a smaller share of the national wealth than the rest of Canada. It also has higher rates of smoking, obesity and physical inactivity (which are risk factors for chronic disease) and poorer levels of health than the rest of Canada.

Even though overall, the Atlantic region has high levels of inequity and high levels of chronic disease, the relationship isn't simple or straightforward. There are differences among the four provinces, and there are differences within different regions of the same province. For example, if you live in Prince Edward Island or Newfoundland and Labrador, you're likely to have a much higher level of mental health than if you live in Nova Scotia or New Brunswick.

Disadvantaged, low-income areas of all four provinces consistently show worse levels of chronic disease, disability and early death, but some of the urban centres in the same provinces have rates that are closer to the Canadian average. For example, if you live in Labrador, you'll have a lower life expectancy than if you live in St. John's. If you live in northern New Brunswick or Cape Breton, your health is likely to be worse than if you live in Saint John or Halifax.

Turning the Tides: Strategies

What can we do?

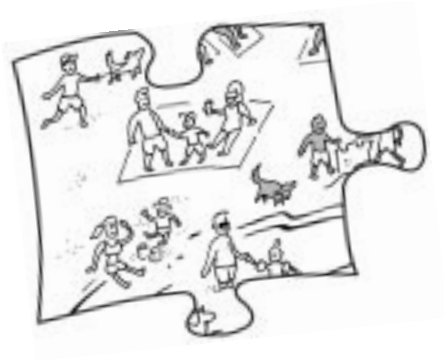
Social and economic factors that lead to chronic disease can be changed. Strategies addressing the root causes of inequities will be most effective in reducing the levels of chronic disease. Strategies that focus on preventing or managing a particular disease have not been very effective in reaching vulnerable groups. Prevention strategies for communicable diseases, non-communicable diseases and mental illnesses need to work toward relieving the underlying social and economic causes.

Like the diseases they cause, the social and economic factors leading to inequity are chronic — they are long-standing and not easily or quickly resolved. But public policies can change social and economic conditions. For example, youth now have the highest level of mental distress in the population, while seniors have the lowest. Twenty years ago, youth had the lowest level, while seniors had the highest.

What happened to cause this switch? On the one hand, youth unemployment rates have risen, income has declined, and young people face the financial stress of higher student debt and rising tuition costs. At the same time, seniors' incomes have benefited from government policies around pension plans and taxation. Could this shift in mental health status reflect a growing age-related economic inequity in Canada? Did public policies work to change these conditions?

Chronic disease patterns a are cause for concern in Atlantic Canada. Strategies must be based on an understanding of regional inequities, social and economic risk factors, and chronic disease patterns in the region. They must be specific to local economic, social and cultural conditions. And the groups most affected must be involved.

Over the years, all levels of government have tried to reduce inequity and poverty through policy. These policies and programs have achieved improvements in some areas, for some people. However, they have not changed the underlying social and economic inequities, and so have not altered chronic disease patterns.



The problem may be that there is no plan that looks at all these factors together. And that only a few programs have health as their aim. As one example, health care reform does not include looking at reducing poverty and inequity. Atlantic Canada needs coordinated, complete population health strategies that address all the social determinants of health and the way they are linked. Workable strategies could be based on these recommendations:

1. Social and economic factors that create health are crucial. New population health strategies must reflect an understanding of these factors.

2. New population health strategies must be based on common values and set up with a central vision.

3. New population health strategies must be designed to reach across different levels of government, different government departments, and all parts of the community — businesses, community groups, organizations, etc.

4. New population health strategies must strengthen assessment, data collection, research and evaluation in order to see if we are making progress on equity.

5. New population health strategies must give extra help to vulnerable groups and regions of greatest need. They must be designed with care to avoid further exclusion and discrimination.

The Atlantic region has social strengths that can help inspire healthy policy changes. Research on civic and volunteer work has shown that social support networks are stronger in Atlantic Canada than in other parts of Canada. The strength of these family, social and community supports is an asset that may help soften the impact of other factors.

For example, we need to look closely at the "Newfoundland advantage." Despite higher levels of unemployment and lower levels of income and schooling, residents of Newfoundland and Labrador have much better mental health than other Canadians; they report the lowest levels of stress and the highest levels of psychological well being in the country. They also have the lowest rate of new cancer cases, asthma, allergies, back problems, sexually transmitted diseases (STDs) and suicide (despite high levels of suicide in Labrador).

Why is this? Are high levels of social support and family connectedness enough to protect Newfoundlanders from the impacts of inequity and chronic disease? Understanding the roots of the "Newfoundland advantage" could offer a more complete and positive view of health.

How can we change things?

We **all** have an important role to play in helping change social and economic conditions.

In our paid and volunteer work, we can be aware of the links between inequity and chronic disease. By working to reduce poverty and inequity, we will be working to reduce chronic disease.

We can acknowledge that equity and social inclusion are necessary for everyone's health and well–being.

We can add our voice to the policy process.

We can commit ourselves, and our organizations, to supporting population health principles aimed at:

- achieving a fair and just society
- looking for approaches than can be kept up over the long term
- ensuring that everyone has an equal chance to be healthy
- looking at the whole picture
- working together with other organizations and communities
- approaching issues from many directions, using many strategies
- empowering communities and citizens to participate in improving our health

By following the Atlantic Canadian traditions of cooperation, fairness and compassion, we can work to reduce inequity. This will lead to more inclusive and healthier communities.

What the Research Tells Us: Definitions, Links and Strategies

Setting the Stage: Definitions

1. Social and economic exclusion happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society, and to feel that they are valued and respected members of their community.

2. Inequity occurs when things are unfair or unjust. For example, the gap between the rich and poor, lack of access to housing and education, and low levels of social support.

3. A chronic disease is an illness or condition that continues over a long period of time. It cannot be cured easily or quickly, if at all.

Making the Links: Key Messages

4. Research shows that there are strong, complex and real links between inequity and chronic disease.

5. Physical, psychological, social and economic factors all combine to make individuals and communities healthy (or unhealthy).

6. Inequity makes people vulnerable — groups of people facing inequity have much higher rates of chronic disease than other, less vulnerable groups.

7. Inequity affects everyone, not just people who are poor and excluded. Research tells us that the more equal the spread of wealth, the healthier the society.

8. Inequity — through poverty and exclusion — has more impact on health than the choices people make in their daily life.

9. The provinces of Atlantic Canada have more social, economic and health inequities than the other Canadian provinces. They also have higher rates of chronic disease.

Turning the Tide: Strategies

10. Social and economic factors that lead to chronic disease can be changed. Strategies addressing the root causes of inequities will be most effective in reducing the levels of chronic disease.

11. Like the diseases they cause, the social and economic factors leading to inequity are chronic—they are long-standing and not easily or quickly resolved. But public policies can change social and economic conditions.

12. Chronic disease patterns are a cause for concern in Atlantic Canada. Strategies must be based on an understanding of regional inequities, social and economic risk factors, and chronic disease patterns in the region. They must be specific to local economic, social and cultural conditions. And the groups most affected must be involved.

13. The Atlantic region has social strengths that can help inspire healthy policy changes. By following the Atlantic Canadian traditions of cooperation, fairness and compassion, we can work to reduce inequity. This will lead to more inclusive and healthier communities.

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Linking Inequity to Social and Economic Exclusion

Leaving people out creates inequity.

Inequity happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community. This is known as social and economic exclusion.

What is the effect of leaving people out?

People who are left out have to do without — they may do without work, education, and/or proper food and shelter. They may do without health care. They may do without respect and feeling valued.

Doing without in this way has effects on us — on our income, our health and the health of our children. It affects our ability to learn, our self-esteem, our ability to cope and, sometimes, even our very survival.

Social and economic inequities contribute to high levels of chronic disease.

Why are people left out?

People don't choose exclusion. Most often, the way society is set up leaves people out. Our own social and economic systems create barriers within government, communities and private businesses. Even our culture and customs create barriers. For example, a lack of low-cost public transportation or low-cost housing become physical barriers. A lack of jobs or decent wages become economic barriers. High tuition fees and crowded classrooms become educational barriers. A lack of legal rights becomes a political barrier. Sexism and racism become social barriers.

Barriers keep people from taking part in society — they become excluded. Changing systems and processes so people can overcome these barriers is complex, but possible. This is not a matter of returning people who are excluded to society. Rather, we must break down the barriers within society so everyone can be included.

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How does this relate to racism and discrimination?

Poverty, inequity and exclusion are related to discrimination. Discrimination happens when one individual or group excludes other individuals or groups.

Discrimination can be based on race, colour, sex, ability, mental health and so on. People can be racist, but so can systems (like justice, education or the media). Cultures, too, can be racist. Living with racism leaves people without hope, and keeps them from fully taking part in society.

Poverty is related to racism. Poverty rates are almost twice as high in racial groups across the country than in non-racial groups.

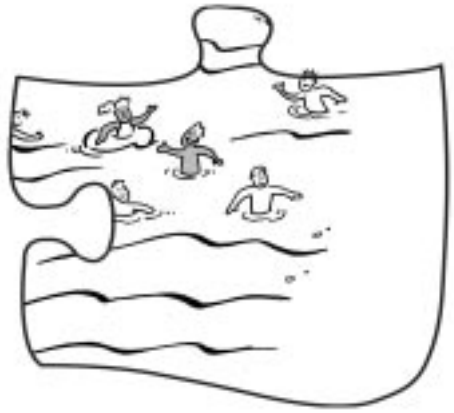
People with mental illness experience discrimination and exclusion. They are often afraid to seek help, or are shunned by others because of their mental illness.

People receiving Social Assistance or Employment Insurance (EI) also face discrimination. Some people believe that users of these services do so by choice, not need, and so treat them differently.

People who live with discrimination due to their race, ethnic background or sexual orientation suffer poor physical and mental health. Living with discrimination creates stress, depression, low self-esteem and anger. It also adds to poverty and makes it harder to access education and other supports and services needed for good health.

Making the links

- Poverty, inequity and exclusion are related to discrimination.
- To make sure everyone is included, society must change. We must work toward equity, inclusion and reducing poverty.
- To be successful, this work must get to the root of the exclusion and inequity. Often, there are many factors to consider.
- Integrating social and economic inclusion into the population health framework may be helpful. With government support, this may help communities develop specific local strategies based on local needs.



Linking Inequity and Chronic Disease to Vulnerable Groups

Some groups of people experience inequity more often than others. These groups are more at risk of living in poverty and of being excluded. A greater number of risk factors for all forms of chronic diseases occur in these groups.

What groups are vulnerable to chronic diseases and inequity?

Vulnerable groups include:

- children
- women — particularly single mothers, low-income single women and unattached senior women
- low-income families
- people in rural areas
- aboriginal peoples
- African-Canadians and other visible minorities
- people with disabilities
- people who are gay, lesbian or bisexual
- recent immigrants

As well as having higher rates of poverty, vulnerable groups tend to be more isolated, lack social supports, and have higher rates of smoking, inactivity and poor diet.

People in vulnerable groups tend to have low education levels, making it harder for them to move out of poverty. Poverty and these other related factors mean that daily life is a struggle — a stressful and depressing way to live.

Being trapped by poverty also means these groups are more likely to work in non-standard jobs, have several different jobs, or work longer hours just to make ends meet. They may work in unsafe or unhealthy workplaces. Over time, living under these conditions often results in chronic disease.

Making the links

- Reducing inequity must begin by truly understanding the vulnerable groups who are excluded. Those most affected must be involved in the work.

- Strategies to reduce inequities in vulnerable groups are needed, including increasing social and economic inclusion.

- To do this, we must look for the reasons for these disparities. As well, we must consider the special needs of vulnerable groups or we may make things worse by creating more separation and exclusion.

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Linking Inequity to Everyone

Why does inequity affect everyone?

Inequity, including poverty, affects us all, not just people who are poor or excluded. There are three key reasons why.

1. Global changes may affect everyone's health.
2. Where you live matters, even if you are not part of a vulnerable group.
3. The more equal the spread of wealth the healthier the society.

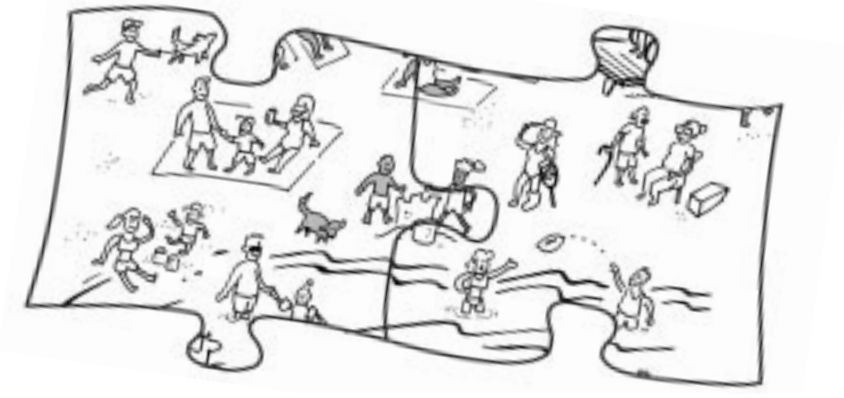
1. Global changes that may affect everyone's health.

In the past 25 years there has been a rise in free trade, competition, and globalization. This changes the way businesses operate. It reduces wages and incomes, increases working hours and also affects the environment. Knowledge and information are more and more important in this "new economy."

Natural resources, manufacturing, equipment and labour (the "old economy") seem to be less important. This causes increased inequity between people with different education levels and between those with different health outcomes. Energy and other natural resources are being overused. This has caused fish stocks, forests, farmland, water, and air quality to decline, which can affect health. There has also been a shift from small family farms to large agribusinesses. We also rely more and more on processed foods. These changes may affect the nutritional value of the food we eat.

More women are in the paid work force. This means increasing stress for women, who still continue to do most of the in-home caregiving and housework.

Finally, government cutbacks affect the well-being of families and access to health services and social supports.



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2. Where you live matters, even if you are not part of a vulnerable group.

The physical and social elements of neighbourhoods affect the health of the people that live there. Even after removing the effects of low income and other risk factors, outcomes for health and well-being are still linked to the neighbourhoods where we live.

Most studies also show that health is related to the social and economic well-being of the community and/or the region where we live. This factor is more important than how well off you are compared to others in your community. People who are poor tend to have the worst health outcomes in a community. But even if a person is not poor, but lives in a poor community, their health outcomes will tend to be worse than others who live in a community where incomes are higher.

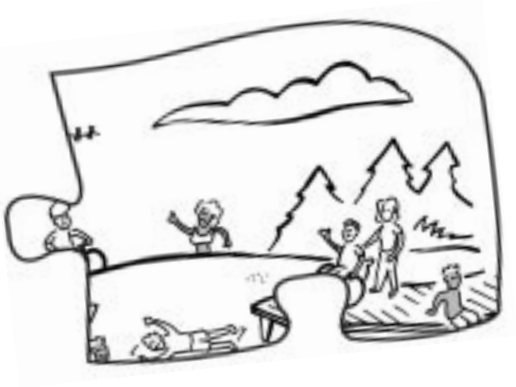
This implies that there may be factors in certain communities that affect health. These could include social and economic factors, such as poverty, differences in income, exclusion because of race, or the lack of support networks. It could also include physical factors, like air and water quality and poor housing.

3. The more equal the spread of wealth the healthier the society.

Income distribution is about the spread between income levels — for example, the income gap between the rich and poor, between men and women or between communities in Atlantic Canada. The smaller the gap between groups, the more evenly income is distributed.

Differences in income mean inequities in economic status, which affect health. Also, income distribution is more important to health than overall income levels. Wealthy countries with large income gaps between the rich and poor have lower health levels than poorer countries with smaller income gaps.

Societies with smaller gaps between the rich and poor have lower rates of unemployment, good education, high standards of living, and people who live longer. They also spend less on health care each year, and more on social supports.



Making the links

- Inequity, including poverty, affects us all, not just people who are poor or excluded.
- Consider the specific conditions in neighbourhoods, communities and regions to get to the root of inequity and poor health. Not doing so can actually make things worse.
- The gap between the rich and poor in Canada is widening. The real incomes of the wealthiest have increased, while the real incomes of the poor and middle class have fallen. This is true across the country, within Atlantic Canada and in each province in Atlantic Canada. We must work to change this.

The Determinants of Health

The 12 Factors That Affect Our Health

Income and Social Status: The more money you have, the more likely you are to be healthy. This is the single most important determinant of health. You are most likely to be healthy if you live in a place where there isn't a big gap between the rich and poor.

Social Support Networks: You are healthier and feel more in control of your life when you know you can count on friends and family for help in solving problems and handling hard times.

Education: The more education you have, the healthier you are likely to be. More education means you can get a better job with better pay and have more control over your life.

Employment / Working Conditions: You are healthier and live longer when you have more control over your work and less stress on the job.

Social Environments: You are more likely to be healthy when you live in a community, region, province or country that sticks together and works to find ways to help and support one another.

Physical Environments: The quality of the air, water, food and soil has an impact on your health. So do factors like housing, indoor air quality, workplace safety, and the way communities and transportation systems are designed.

Personal Health Practices and Coping Skills: The things you do to take care of yourself and the skills you use to deal with stress affect your health. Programs and policies that make it easier for you to make healthy choices and develop skills for coping with life's challenges are important influences on health.

Healthy Child Development: Things that you experience before birth and in early childhood affect your health, well-being, coping skills and competence throughout your life. A healthy start is important for a healthy adulthood.

Biology and Genetic Endowment: The biology of your body is a basic determinant of health. Each of us has a personal physical and genetic make-up that can make us more or less likely to develop particular diseases or health problems.

Health Services: Health services play a fairly small part in your state of health. Services that contribute most to health are those that help us to stay healthy or to regain our health after we've been sick or injured.

Gender: Whether you are male or female can affect your health. For example, women are more likely to face sexual or physical violence, low income and lone parenthood. Men are more likely to die young, from heart disease, injuries, cancer or suicide.

Culture: Culture can affect your health. You are less likely to be healthy if your culture is different from that of mainstream society, if you feel that your language and culture are not valued, or if you can't get health care and services that are appropriate for your culture.

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Frequently Asked Questions About Inequity and Health

Is being poor bad for your health?

Yes, it is.
Compared to Canadians in the highest-income households, Canadians in the lowest-income households:

- are four times more likely to report fair or poor health
- are twice as likely to have a long-term activity limitation
- have almost eight fewer years of life expectancy
- have significantly more disability

For example, Canadian men in the lowest 5% of incomes were twice as likely to die before age 70 than men in the top 5%.

Unemployed people tend to have poorer health, more depression and lower life expectancy than those who are employed.

The more education you have, the more likely you are to be both well off financially and healthy. The more education you have the less likely you are to be obese.

Poor neighbourhoods are often located in toxic, industrial areas where environmental factors such as exposure to toxins and lack of clean air and pure water also lead to disease.

Does stress affect health?

Yes, it affects health in several ways.

One way is through the body's response to stress. The body responds to stress by releasing hormones. This is what most of us know as the 'fight or flight' response. These hormones raise your heart rate, increase your blood pressure and cause more blood to flow to your muscles. When these responses continue over time, they lead to illnesses like heart failure and stroke, or make you more likely to get sick by weakening your immune system.

Stress also leads to more alcohol and tobacco use, substance abuse and poor diet. These lead to poor health directly — by damaging body organs. They also affect health indirectly — by making you more susceptible to illness. For example, 21% of women and 27% of men reporting very **low** levels of stress are smokers. But 45% of women and 46% of men who report **high** stress levels are smokers.

Can stress at work affect my health?

Work-related stress is linked to high blood pressure and heart disease. There is an especially strong link when the worker has low levels of responsibility, lack of control, time pressures and/or work overload, and gets no support from superiors. In other words, when he or she has the kind of jobs disadvantaged people often get.

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In an American study, male workers with the highest levels of job strain were found to have four times the risk of heart attack as those with the lowest levels of strain.

What's the difference between risk factors and root causes?

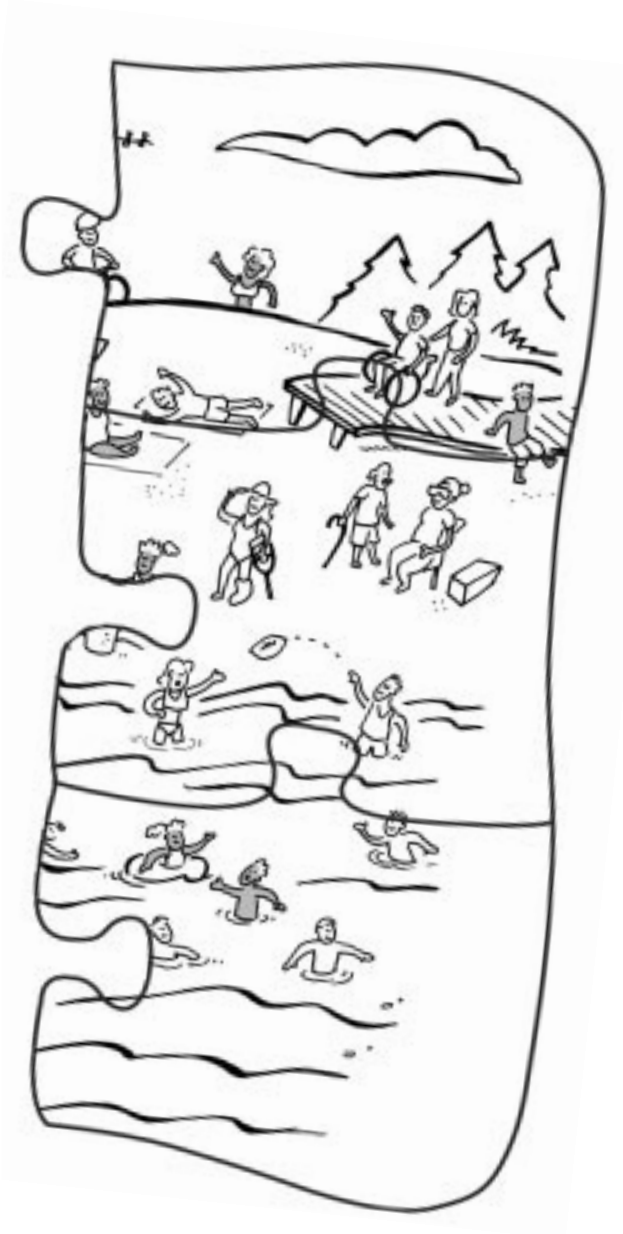
Risk factors are the behaviours and conditions that make it more likely that you will get a chronic disease. For example, smoking, obesity and a lack of physical activity are risk factors for chronic disease.

Root causes of chronic disease are inequities that arise from broad social and economic structures and policies. Inequities such as poverty, racism, and social and economic exclusion are the root causes that lead to risk factors for chronic disease.

For example, poor diet is considered a **risk factor** for chronic disease. It causes physical and mental suffering and leads to poor health. Children's food programs are one way to address this risk factor. They relieve the children's suffering, give them healthy food and stop them from being hungry for a time.

These programs serve a useful purpose, but they do not address the **root causes** of child hunger.

What is causing these children to be hungry? Why do they need a food program? The root causes of child hunger are political and economic policies. To eliminate child hunger, we need to look at those policies and find out which ones are causing the poverty, exclusion and inequity that are leading to child hunger. Then we need to work to change them.



The Most Common Chronic Diseases in Atlantic Canada

Non-Communicable Diseases

The most common *non-communicable* chronic diseases in Atlantic Canada are:

- cardiovascular disease
- cancer
- diabetes
- respiratory illnesses

Cardiovascular disease — which includes heart attacks and strokes — is the major cause of death in the Atlantic provinces and accounts for 37% of all deaths. If you have a heart attack or stroke in the Atlantic region, you are more likely to die from it than are people in the rest of Canada. As of 1996, the highest rate of death from cardiovascular disease in Canada for men was in Prince Edward Island. For women, the highest death rate was in Newfoundland and Labrador.

Cancer is the second-highest cause of death in Atlantic Canada. Nova Scotia has the highest death rates from cancer in Canada.

All four Atlantic provinces have a higher rate of diabetes than the Canadian average. Across Canada, 4.2% of people age 12 and older have diabetes. In Newfoundland and Labrador the number is 5.8%, in Nova Scotia, 5.2%, in New Brunswick, 5.1% and in Prince Edward Island, 5.0%.

Prince Edward Island and Nova Scotia have higher than average rates of respiratory diseases.

There are differences in rates of chronic diseases within provinces, too. In Nova Scotia, Cape Breton has much higher rates of all chronic diseases than the rest of the province. In New Brunswick, northerners have much worse rates of cancer deaths, lung cancer and high blood pressure than residents of southern New Brunswick. In Prince Edward Island, the death rate due to stroke is higher in urban areas than in rural areas of the province. Newfoundland and Labrador has the lowest cancer incidence in the country, but Labrador has the highest rate of lung cancer deaths in the Atlantic region.

Communicable Chronic Diseases

The relationship between inequity and chronic disease is particularly easy to see in the case of the two most common communicable chronic diseases in Atlantic Canada — hepatitis C and HIV/AIDS.

Rates of HIV/AIDS infection have declined in the general population over the last five years, but they are rising among vulnerable populations. These include people living in poverty, the unemployed, minority groups, people with little education, Aboriginal peoples (particularly Aboriginal women and people under age 30), prisoners and people on the street.

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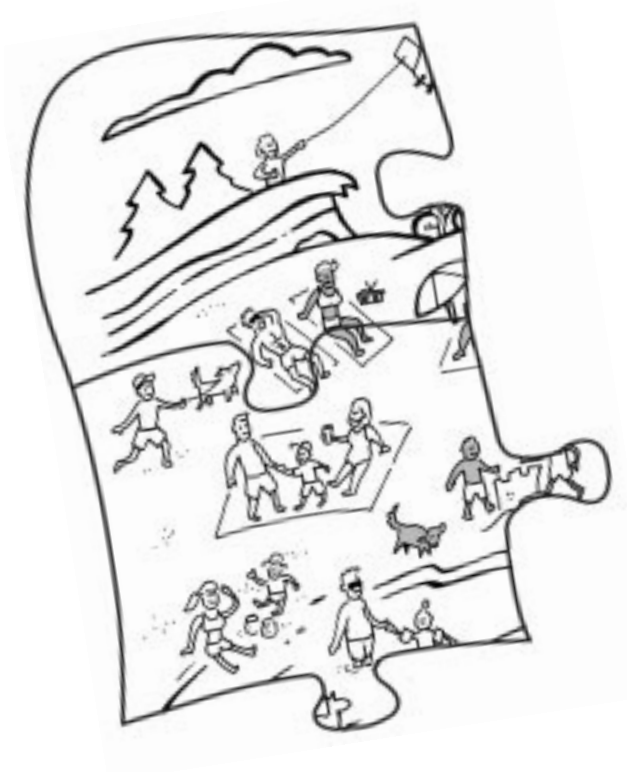
Intravenous drug use (IDU) and sexual contact account for 80% of HIV infections in Canada, with most new cases appearing among injection drug users. It is estimated that about 90% of injection drug users are infected with hepatitis C. Most injection drug users have not finished high school, are poor and live on the margins of society.

Poverty, low education levels, physical and emotional abuse, despair and hopelessness are often cited as underlying causes leading to the high-risk behaviour associated with communicable diseases such as hepatitis C and HIV/AIDS.

However, despite a high level of social and economic inequities, the rate of positive HIV test reports is lower for all four Atlantic provinces than for Canada as a whole. So is the death rate due to AIDS: 4 per 100,000 people in Canada; 2.0 per 100,00 in Nova Scotia; 1.9 in New Brunswick; 1.4 in Newfoundland and Labrador; and 1.0 in Prince Edward Island.



Mental Illness

There is a distinct split in the mental health status among the four Atlantic provinces, with Newfoundland and Labrador and Prince Edward Island having higher levels of mental health than the Canadian average, and Nova Scotia and New Brunswick having lower levels.

Newfoundland and Labrador and Prince Edward Island report high levels of mental well-being and low levels of chronic stress. In 2001, high stress was 40% less common among residents of Newfoundland and Labrador than among other Canadians. In Prince Edward Island, chronic stress levels were 23% lower than the national average.

Residents of Newfoundland and Labrador are 30% more likely than other Canadians to report high levels of psychological well-being. Prince Edward Island has a rate of psychological well-being 17% higher than the national rate. In contrast, both Nova Scotia and New Brunswick have lower levels of psychological well-being than other Canadians.

Across Canada, 7.1% of the population is considered to be likely to become depressed. This rate of risk for depression is lower in Newfoundland and Labrador (4.7%) and in Prince Edward Island (5.8%). The rate is higher in both Nova Scotia (8.7%) and New Brunswick (7.7%). The regions with the highest risk of depression in Atlantic Canada are in Nova Scotia — Colchester, Cumberland and East Hants counties (11.6%) and Cape Breton (9.8%) — and in New Brunswick — the Moncton region (10.7%).

Newfoundland and Labrador, Prince Edward Island and Nova Scotia all have suicide rates lower than the Canadian average of 12.9 per 100,000 people, but these rates conceal some differences within provinces. Newfoundland and Labrador's low provincial average of 7.3 per 100,000 conceals a very high rate of suicide in Labrador (19.2 per 100,000) where Aboriginal peoples make up 28.7% of the population. Prince Edward Island's suicide rate of 11.0 per 100,000 hides an urban rural split – the rate is higher in urban Charlottetown and Summerside (14.1) than in the rural areas of the province (8.3). At 11.6 per 100,000, Nova Scotia's suicide rate is also lower than the national average.

New Brunswick's rate of 13.4 per 100,00 is higher than the national average, and it, too, masks an urban-rural difference. However, in New Brunswick, in contrast to Prince Edward Island, the rates are higher in rural areas than in urban – Saint John (9.2), Fredericton (10.6) and Moncton (12.3) are all below the national average, while the Edmundston area in the western part of the province (24.9%) and the Campbellton area in northern New Brunswick (22.8%) have the highest rates of suicide in the Atlantic region.

What does all this mean?

There is no single health profile in Atlantic Canada, but there are some trends that can be teased out of the data.

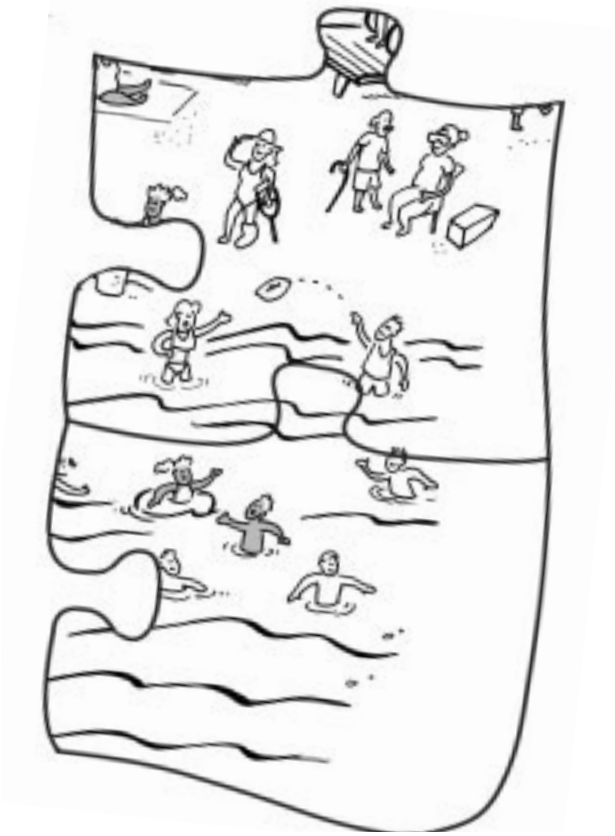
- Cape Breton, with high rates of unemployment and low incomes, has far more chronic illness, disability, and premature deaths than Halifax.

- There is a clear north-south divide in New Brunswick, with far better health status in the urban centres of Saint John, Fredericton and Moncton, than in the Campbellton and Edmundston areas.

- In Newfoundland and Labrador, Labrador has much higher rates of suicide, lung cancer death and premature death than the rest of the province, requiring sensitivity to the social, cultural and health needs of the large Aboriginal population.

- In many areas – like mental health and self-rated health – Newfoundland and Labrador and Prince Edward Island do much better than Nova Scotia and New Brunswick. The reasons for this are not clear and need to be looked at carefully.

These trends have their roots in social and economic inequities, in the regions' growing urban-rural split, in cultural differences and in social processes that can help or worsen the conditions of people's lives. We need to understand these underlying causes and relationships if we are to develop policies that will improve the health and well-being of people in Atlantic Canada.



Setting the Stage: Definitions

Health is a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease. (WHO)

Health is created and lived by people within the settings of their everyday life: where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all members. (Ottawa Charter for Health Promotion)

Determinants of health are the range of social, economic and environmental factors that affect health. Health Canada has identified 12 determinants of health: income and social status; social support networks; education; employment and working conditions; social environments; physical environment; healthy child development; personal health practices and coping skills; biology and genetic endowment; health services; gender; and culture.

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. To do this, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.

Inequity occurs when things are unfair, or unjust. There can be inequities because of gender, race, income, resources and other social and economic factors.

Health inequities occur when some people — because they have more money, higher status, more education, etc. — have a better chance of being healthy.

Health equity means that everyone has an equal chance to be healthy.

Social and economic exclusion happens when people don't have — and can't get — the education, jobs, decent housing, health care and other things they need to live comfortably, to take part in society and to feel that they are valued and respected members of their community.

Chronic diseases are illnesses or conditions that continue over a long period of time and cannot be cured easily or quickly, if they can be cured at all.

Chronic diseases can be physical or mental. They can be non-communicable (this means you can't catch the disease from someone else) or communicable (this means you can catch it from someone else).

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Photocopy Masters for 2 Action Sheets

Action Sheets		
#1	Recommendations for Population Health Strategies	2 sheets (3 pages)
#2	Suggestions for Governments and Community Health Boards	1 sheet (2 pages)

The growing gaps in health status between people in different groups is a serious and a major concern for the government. We cannot accept that the rich get healthier and the poor get sicker. Not in our country, nor in the world.

Ingvar Carlsson, former Prime Minister of Sweden, 1995

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Recommendations for Population Health Strategies

Reducing social and economic inequities to reduce chronic disease is a complex problem. It needs complex solutions that must be part of a plan. The solutions are possible if people and governments work together towards a common goal: to create a physically, mentally, socially and economically healthy society. In other words we need the political will to make this happen.

The research paper that was the basis for this Kit — *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper* — makes five key recommendations for action in population health.

1. Social and economic factors that create health are crucial. New population health strategies must reflect an understanding of these factors.

Choose carefully where to invest public and private resources with equity in mind. This will have the greatest impact on reducing health inequities and improving public health.

Choose strategies that build on the strengths of Atlantic Canada. Choose strategies that focus on assets, strengths, health, well-being and quality of life, not disease.

Address the root causes of inequity and chronic disease instead of focusing on individual behaviours. Working on single diseases in isolation ignores their roots — the social and economic factors that cause them. Create a complete plan that takes action on the three disease areas: communicable, non-communicable and mental health. Changing policies and programs by reducing inequity will have effects far beyond the Atlantic region.

2. New population health strategies must be based on common values and set up with a central vision.

Use the principles of population health to guide social and economic strategies. These principles include:

- ensuring that everyone has an equal chance to be healthy
- looking for approaches than can be kept up over the long term
- achieving a fair and just society
- looking at the whole picture
- working together with other organizations and communities
- approaching issues from many directions, using many strategies
- empowering communities and citizens to participate in improving our health by finding ways to give them a voice that matters

On a positive note, Atlantic Canadians put a high value on social justice, equity and fairness. This region has a rich tradition of compassion and working together that is carried through in projects developed today.

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Planning for Health

A good example of sound planning can be found in Sweden. All levels of government policy are coordinated with the clear goal of improving public health. Sweden's new national public health policy is:

- coordinated by a central body
- built around the social determinants of health not health outcomes
- focused on wellness versus disease
- working to gain broad, popular support

3. New population health strategies must be designed to reach many levels of government and different government departments. As well, they must involve many sectors, such as non-profits, volunteers, business and labour groups.

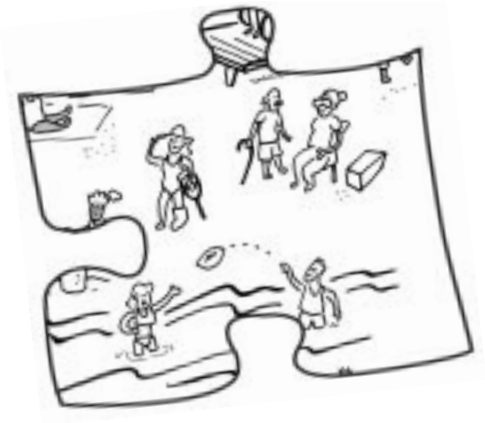
All policy decisions at all levels should be guided by a set of common values. Working together will strengthen efforts, avoid duplication, lead to long-term strategies and coordinate action. Federal and provincial governments need to coordinate population health, social justice and healthy community strategies. They must be accountable for periods longer than four years.

Collaboration and coordination between all policy departments will be needed to reduce inequity. The health sector should play an influencing, but not a leading role. Consider actions that raise incomes, increase access, improve social supports and decrease stress. Change economic and social policies that result in poor health outcomes. Look to change systems that affect inequity instead of trying to "smooth off the rough edges."

4. New population health strategies must strengthen assessment, data collection, research and evaluation in order to see if we are making progress on equity.

Collect data that links health indicators with measures of equity and inequity — socio-economic status, race and so on. Expand health indicators to include the full range of social and economic determinants of health.

Encourage participatory, action, and qualitative research. Involve the community in setting indicators and research topics. Develop an Atlantic Canada research strategy to avoid duplication, gather and coordinate knowledge and focus on cooperation among research groups.



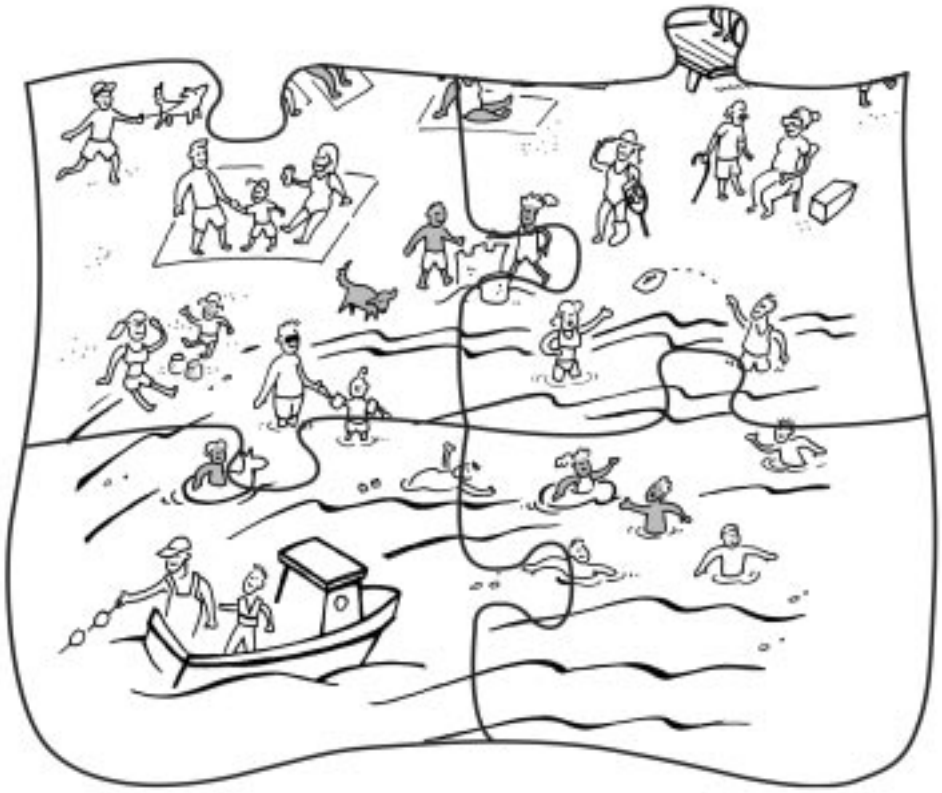
Evaluate success and provide long-term support for successful initiatives. Find ways to turn knowledge into policy. Equity issues must be central to core measures of progress. Currently, measures are based on economic growth, production and income. They rarely look at income distribution or income sharing. Income gaps can be measured by quintiles and using the GINI coefficient. Monitor also the gender wage gap and the status of vulnerable and marginalized groups. Encourage Statistics Canada to provide equity data more frequently.

5. New population health strategies must give extra help to vulnerable groups and regions of greatest need. They must be designed with care to avoid further exclusion and discrimination.

Vulnerable groups need special interventions, but these must be carried out carefully. Policies and programs must respect their wisdom, value them and avoid seeing them as "problems." Develop capacity so that these vulnerable groups, regions and communities can define their own needs and solutions which government can then support.

Target interventions in regions of greatest need, where inequities are causing poor health outcomes. This research has identified areas of greatest need, including: Cape Breton, northern New Brunswick, Labrador, rural areas, and African-Canadian and Aboriginal communities.

Look deeply to design strategies specific to each area and community. Simplistic connections between income and health are not always accurate. For example, Labrador has relatively high income levels but low life expectancy. Newfoundland has low average incomes and high unemployment, but also has low stress levels and good mental health outcomes. Study the way social and economic factors work together to affect inequity and health. Use what you learn to design specific policy interventions.



Suggestions for Governments and Community Health Boards

The research paper that was the basis for this Kit — *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper* — suggests several ways for governments and community health boards to act to reduce inequity and chronic disease.

The Federal Government

Expand the circle of people working on health issues to include other fields — for example, economics, environment, development, and labour. Work together and study the role of social and economic factors in health and well-being.

Create background papers that, in the long run, will lead to major policy papers. Examples of such papers include the United Kingdom's *Independent Inquiry into Inequalities in Health,* and Minnesota's *A Call to Action: Advancing Health for all Through Social and Economic Change.* Include broad areas outside of health, such as housing, economic policy, agriculture, and so on.

Identify and research policies and processes for coordinated plans developed in other places — for example, Minnesota, the United Kingdom, and Sweden.

Research the effect that systems and structures have on air, water, food, labour and other foundations of inequity and health. Look at how changes to employment insurance, pensions, and transfers have impacted on health.

Create a way for different sectors to work together. How do they influence and affect each other?

Shift the research focus from illness to health and well-being.

Provincial Governments

Analyze the impact of local policies and power structures on health and on social and economic inclusion. What are the health effects of reducing social assistance rates? Of a lack of social housing? Of rent control?

Identify and examine policies meant to help people move out of poverty, meet their basic needs and increase their standards of living. Compare resources spent on housing, education, wages and benefits, and zoning with their effects on health. Be specific about critical issues. For example, how much affordable housing is needed? What will it cost?

Know your communities. What areas have strengths to build on? Where are things working well? Where are there vulnerable groups and inequities? Create health and socio-economic profiles of these areas. Why are some successful? What are the root causes of problems? Consider the environment, income, work, education, local assets, social supports and so on. How do these factors influence health and inclusion?

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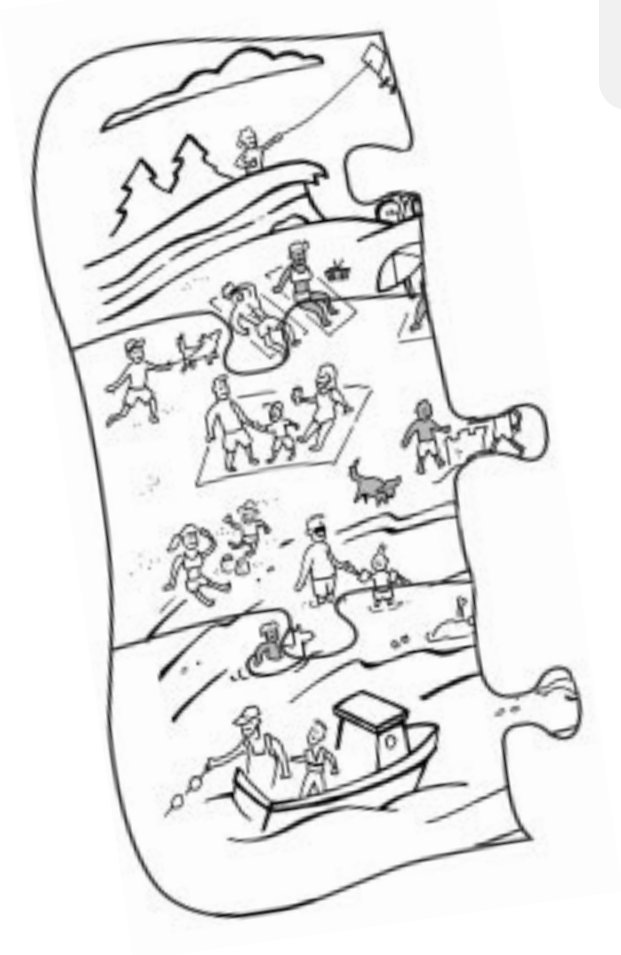
Identify past and present programs that worked. Support these and encourage others. Build the capacity of people and structures to name and work on population health issues. This is one way to enable people to work together with you.

Municipal Governments

Study the health effects of your policies and programs — library user fees, parks and recreation services, public transportation fares.

Bring leaders from different municipal departments together to work on health issues. There may be ways to use existing resources to quickly take action to improve population health. Involve the community every step of the way.



Municipal Action Through Cooperation

A low-income San Francisco neighbourhood worked together with local government to take action on inequities. Their key health issues were chemicals and indoor mould, a lack of access to affordable/healthy food and high rates of violence.

Together, they took action by:

- providing a shuttle bus to take people to the grocery store (the local transit authority)
- printing a guide to local recreation services (the Parks Department)
- improving key services — lighting, community gardens, school yards (the city)
- researching the lack of healthy food and acting on the results — community meetings, fresh food in stores, and farmer's markets (a local youth group)

Community Health Boards

Create local target areas for pilot projects. Examples are U.S. Health Action Zones and Environmental Justice Neighborhoods in San Francisco.

Develop tools and ways to work with vulnerable groups to improve health.

Do rapid health impact assessments (HIAs) on issues important to the community. For example, would carpet-free public housing improve health? How does a proposed zoning issue affect health?

Bring the community together to identify needs, assets, resources and ways to take action on health.

Evaluate programs to see if they can be used in other areas.

Photocopy Masters for 5 Statistics Sheets

Statistics Sheets		
#1	Chronic Disease Statistics for New Brunswick	1 sheet (2 pages)
#2	Chronic Disease Statistics for Newfoundland and Labrador	1 sheet (2 pages)
#3	Chronic Disease Statistics for Nova Scotia	1 sheet (2 pages)
#4	Chronic Disease Statistics for Prince Edward Island	1 sheet (2 pages)
#5	Economic Facts and Chronic Disease Statistics for the Atlantic Region	1 sheet (2 pages)

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Chronic Disease Statistics for New Brunswick

Death Rates and Causes

- New Brunswick has the second highest rate of lung cancer deaths for men in the country.
- New Brunswick has higher-than-average mortality rates from cancer and coronary heart disease.
- Although heart attack rates have declined, New Brunswick's mortality rate for males is still about 6% above the national average.
- The highest cancer death rates in the province are in the northern New Brunswick communities of Campbellton and Miramichi.
- Areas with the highest lung cancer deaths in the province are Campbellton and Edmundston in western New Brunswick.
- Suicide is the leading cause of death among those aged 25 to 29, and it appears to be rising among males aged 34 to 49.

Chronic Diseases

- In New Brunswick 5.1% of the population aged 12 and over have diabetes.
- The province's incidence rate for male lung cancer is 32% higher than the national average.
- New Brunswick men have the second highest incidence of cancers in the country. New Brunswick women have the third highest rate.
- Prostate cancer incidence was approximately 30% higher in 1996 than in 1990 and 19% higher than the national average.
- Disability-free life expectancy is two years lower than the national average.
- Campbellton has the highest blood pressure rates in New Brunswick and the second highest rate of lung cancer in Atlantic Canada.
- The Fredericton area has the second highest rate of breast cancer in the region.
- New Brunswick and Nova Scotia have the most injection drug users in the Atlantic region. Approximately half of the users share needles and engage in unsafe sexual activity.
- In 1999, estimates of unreported and reported cases of hepatitis C included 1,430 cases in New Brunswick.

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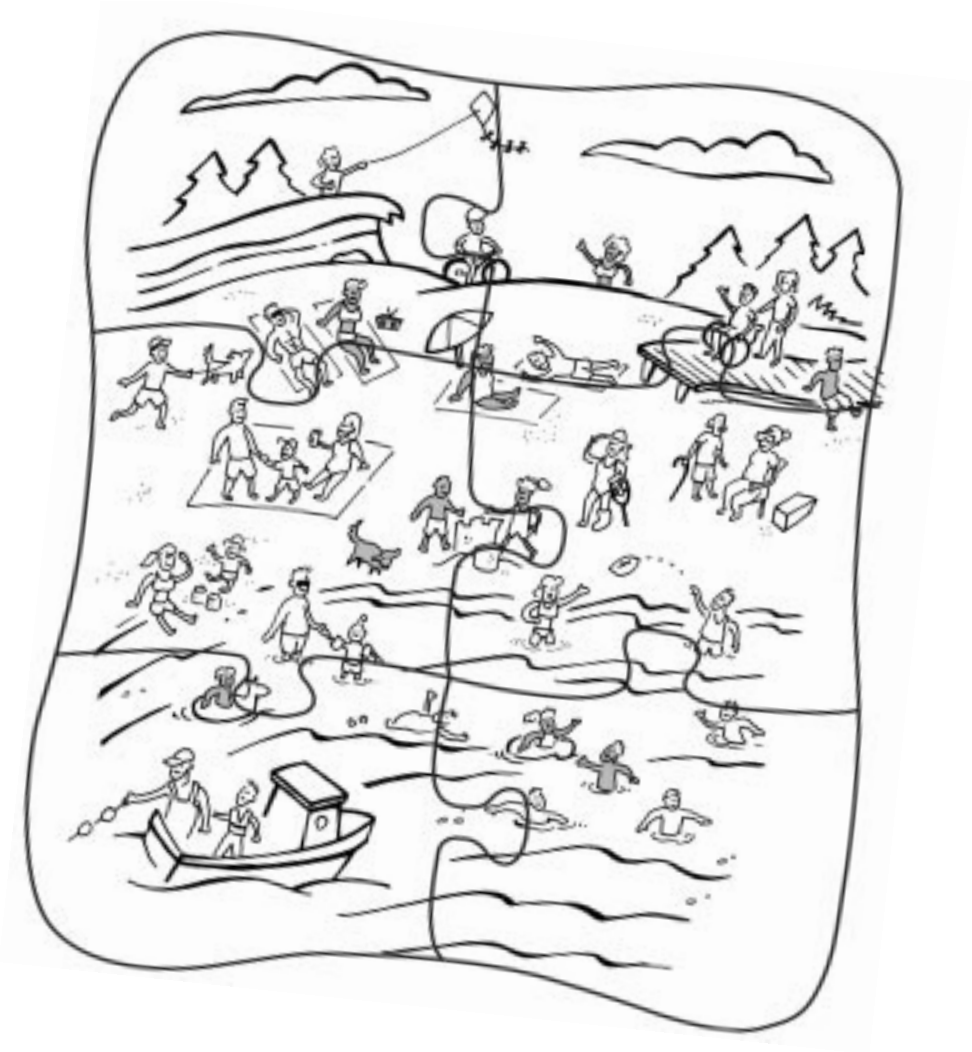
Chronic Mental Illness

- New Brunswick residents are at a greater risk for depression than other Canadians.
- New Brunswick reports a higher suicide rate than the Canadian average.

Child Poverty Rate

- New Brunswick has a child poverty rate of 10.2%, which is lower than the national average of 12.5%.



Compiled by: Eleanor Cameron, Health Policy and Communications Branch, Atlantic Regional Office, Health Canada
Source: R. Colman and K. Hayward, *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.* Population and Public Health Branch, Atlantic Regional Office, Health Canada, 2003.

Chronic Disease Statistics for Newfoundland and Labrador

Death Rates and Causes

- Newfoundland and Labrador has the highest age-standardized death rate for cardiovascular (heart) disease in women.
- The province has the highest death rates in the country for heart attacks, strokes, and colorectal cancer.
- Labrador has, by far, the highest age-standardized rate of deaths from all causes in Atlantic Canada — 30% higher than the Canadian rate.
- The second highest overall death rate in Atlantic Canada is in eastern Newfoundland.
- Eastern Newfoundland has very high cancer death rates.
- Labrador has the highest rate of lung cancer deaths in the Atlantic region.
- Breast cancer deaths are highest in western Newfoundland.
- Deaths from prostate cancer in the province doubled between 1979 and 1999.
- The highest respiratory disease death rate in Atlantic Canada is in Labrador at more than double the national average.

Chronic Diseases

- In 1996, Newfoundland and Labrador had higher-than-average rates of coronary heart disease and stroke.
- Rates of heart disease in eastern and northern Newfoundland are more than 50% above the national average.
- In Newfoundland and Labrador 5.8% of the population aged 12 and over have diabetes.
- The highest diabetes regional rates are recorded in central Newfoundland.
- Newfoundland and Labrador has the lowest cancer incidence in the country but higher-than-average cancer mortality rates.
- Lung cancer rates are lower overall than in Nova Scotia and Prince Edward Island, however, the rate of men dying from lung cancer is more than double that of women.
- Prostate cancer incidence (and deaths) in the province doubled between 1979 and 1999.
- In 1999, estimates of unreported and reported cases of hepatitis C included 537 cases in Newfoundland and Labrador.

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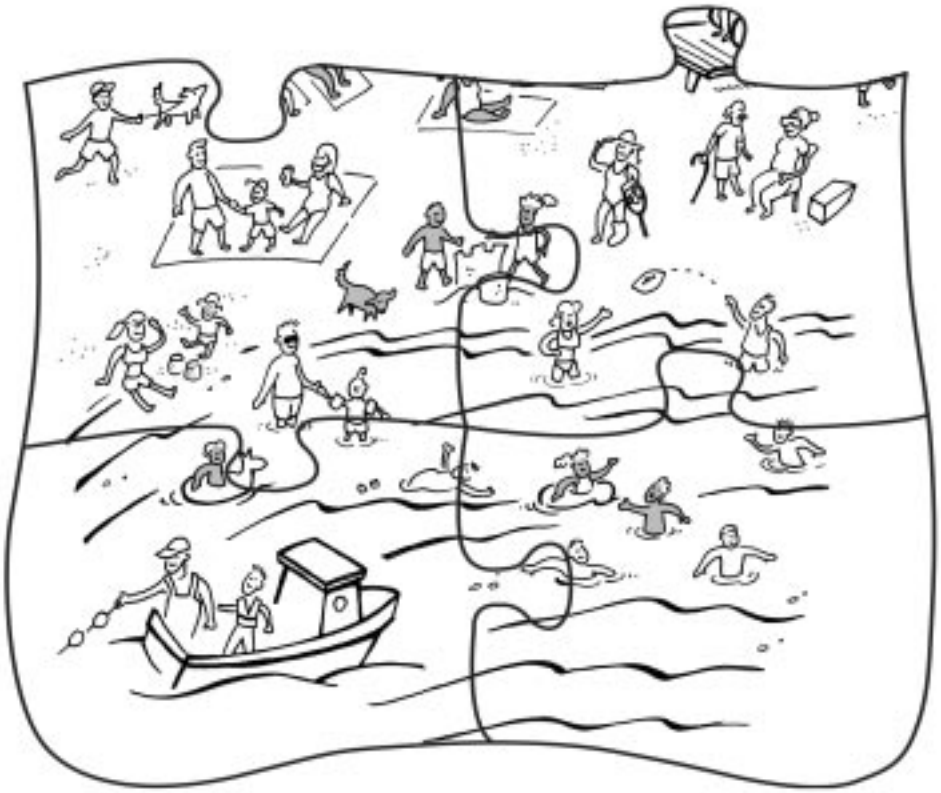
Chronic Mental Illness

- Residents of Newfoundland and Labrador have significantly higher levels of mental health than other Canadians. They consistently report the lowest stress levels and the highest levels of psychological well-being in the country.

- Newfoundland and Labrador has the lowest suicide rate in Canada at half the national average. However, youth suicide rates have been rising, especially among Aboriginal youth in Labrador.

Child Poverty Rate

- Newfoundland and Labrador has the highest rate of child poverty in the country — nearly three times the rate of Prince Edward Island.



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Source: R. Colman and K. Hayward, *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.* Population and Public Health Branch, Atlantic Regional Office, Health Canada, 2003.

Chronic Disease Statistics for Nova Scotia

Death Rates and Causes

- Some 5,800 Nova Scotians die from four types of chronic disease every year: cardiovascular (heart) diseases, cancer, chronic obstructive pulmonary (lung) diseases, and diabetes.
- Nova Scotia has the highest rate of death from cancer (including breast cancer and prostate cancer) and from respiratory disease, as well as the highest rates of arthritis and rheumatism.
- The province has the second highest rates of circulatory and lung cancer deaths in Canada.
- Cape Breton has the highest age-standardized death rate in the three Maritime provinces, and the highest death rate from circulatory disease and heart disease in the Maritimes.
- Of the 21 Atlantic health regions, Cape Breton has the highest death rates from cancer, from lung cancer and from bronchitis, emphysema, and asthma.

Chronic Diseases

- Chronic diseases account for 60% of the total medical costs in Nova Scotia, more than $1 billion each year.
- Nova Scotia has the lowest disability-free life expectancy in the country — three years less than the Canadian average.
- Among the four Atlantic provinces, Nova Scotia has the poorest overall health profile and the highest rate of disability.
- Nova Scotia has higher-than-average rates of respiratory ailments.
- In Nova Scotia 5.2% of the population aged 12 and over have diabetes.
- The province has the second highest rate of diabetes in Canada.
- The highest prevalence of diabetes among all Aboriginal peoples is found in Nova Scotia.
- Cape Breton has the highest rate of high blood pressure in Atlantic Canada which is 72% higher than the Canadian rate.
- The second highest diabetes rate in Atlantic Canada is in the regions of Colchester, Cumberland, and East Hants.

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- The highest rates of breast cancer in Atlantic Canada are in the regions of Pictou, Guysborough, and Antigonish, Nova Scotia.

- Nova Scotia and New Brunswick have the most injection drug users in the Atlantic region. Approximately half of the users share needles and engage in unsafe sexual activity.

- In 1999, estimates of unreported and reported cases of hepatitis C included 4,000 cases in Nova Scotia.

Chronic Mental Illness

- Nova Scotians are at a greater risk for depression than other Canadians.

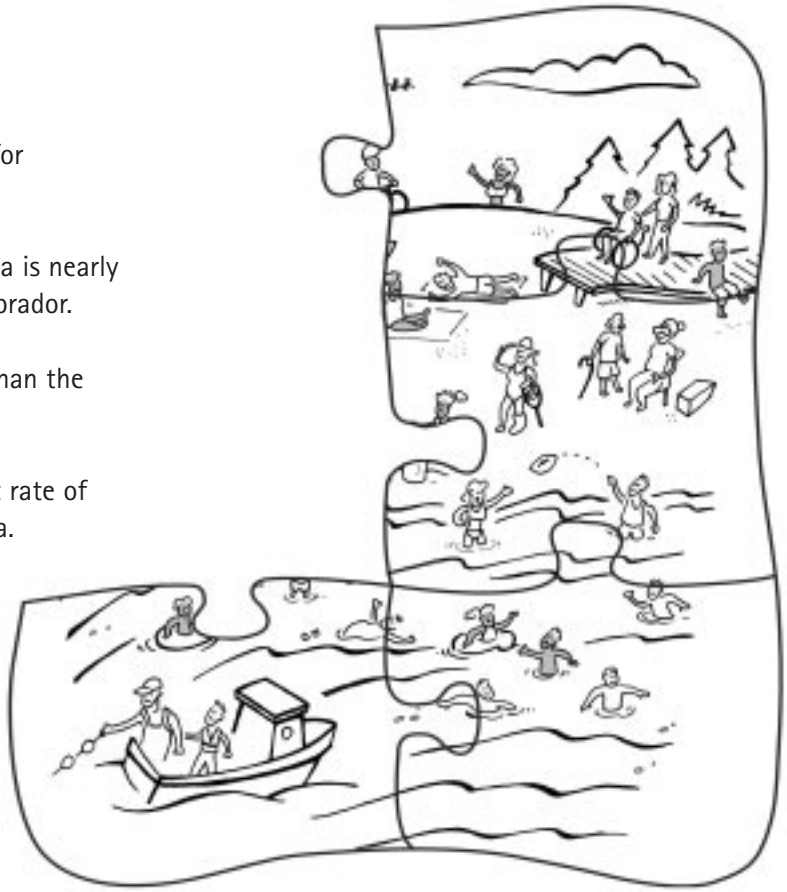
- The rate of depression in Nova Scotia is nearly twice that of Newfoundland and Labrador.

- Nova Scotia's suicide rate is lower than the Canadian average.

- The province has the second highest rate of psychiatric hospitalization in Canada.

Child Poverty Rate

- Nova Scotia had the highest drop in child poverty since 1997 — down from 18.1% to 11.4%.



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Source: R. Colman and K. Hayward, *The Tides of Change. Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.* Population and Public Health Branch, Atlantic Regional Office, Health Canada, 2003.

Chronic Disease Statistics for Prince Edward Island

Death Rates and Causes

- Lung cancer and heart attacks are the leading causes of death in Prince Edward Island.
- Island males have the highest age-standardized death rate for cardiovascular (heart) disease in Canada.
- While the rate of cancer deaths for both men and women is lower in Prince Edward Island than in the other Atlantic provinces, it is still higher than the national average.
- The Prince Edward Island breast cancer death rate in 1999 was higher than the national average.
- Over the previous 20 years, the breast cancer death rate for Island women has risen, while the rate for Canada has been slowly declining.
- The lowest death rates in the Atlantic region are in rural Prince Edward Island.
- The highest rate of cerebrovascular (stroke) deaths in the Maritimes is in Charlottetown and Summerside.
- The death rate due to strokes is much higher in urban areas of Prince Edward Island than in rural areas.
- The second highest rates of death from respiratory (lung) disease are in Charlottetown and Summerside.

Chronic Diseases

- Diabetes rates have risen over the past three years across all age groups.
- In Prince Edward Island, 5% of the population aged 12 and over have diabetes.
- Prince Edward Island has higher-than-average rates of respiratory ailments.
- Asthma and arthritis rates are higher than the national average.
- In 1999, estimates of unreported and reported cases of hepatitis C included 403 cases in Prince Edward Island.

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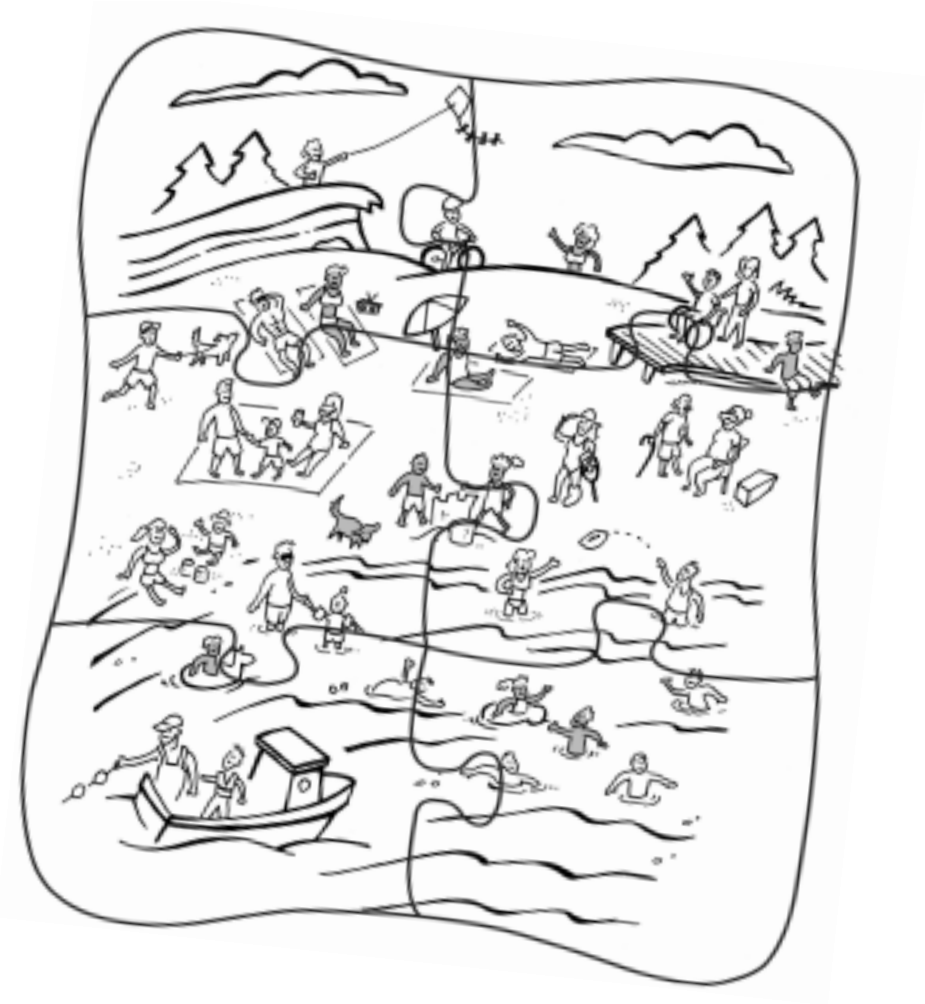
Chronic Mental Illness

- Residents of Prince Edward Island have a high level of mental health, with chronic stress levels 23% lower than national levels and a rate of psychological well-being 17% higher than the national rate.

- Prince Edward Island also has a lower rate of suicide than the Canadian average.

Child Poverty Rate

- In 2000, Prince Edward Island reported a child povery rate of 6.6%, making it the lowest in the country.



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Economic Facts and Chronic Disease Statistics for The Atlantic Region

Economic Facts

- The Atlantic provinces are poorer than the rest of Canada which may contribute to the elevated levels of some chronic diseases in the region.
- In all four Atlantic provinces, the ratio of female lone-parent families compared to total census families increased between 1996 and 2001. These families are much more likely to live in poverty.
- The wealth gap between rich and poor provinces has widened in the last 20 years with the Atlantic region having a smaller share of the national wealth.
- A higher percentage of Atlantic households have negative wealth (or debts that exceed assets) than in any other region.
- Nova Scotia registers the greatest difference between urban and rural incomes in Canada, while the other three Atlantic provinces record the smallest disparities.

Demographic Profile

- All three Maritime provinces have a higher percentage of senior residents than the national average. By contrast, the population of Newfoundland and Labrador is younger than the national average.
- The urban-rural mix in Atlantic Canada is dramatically different from that in the rest of the country which is a reality that may also affect health outcomes. In Canada, 20% of the population lives in rural areas. In the Atlantic region, these numbers are much higher: The rural population is 55% in Prince Edward Island, 50% in New Brunswick, 44% in Nova Scotia and 42% in Newfoundland and Labrador.
- Atlantic Canada has seen the loss or decline of several key industries associated with the "old economy" such as mining, steel making, logging and fishing. As a result, the region is in the midst of major social shifts that are likely to affect health in significant ways.

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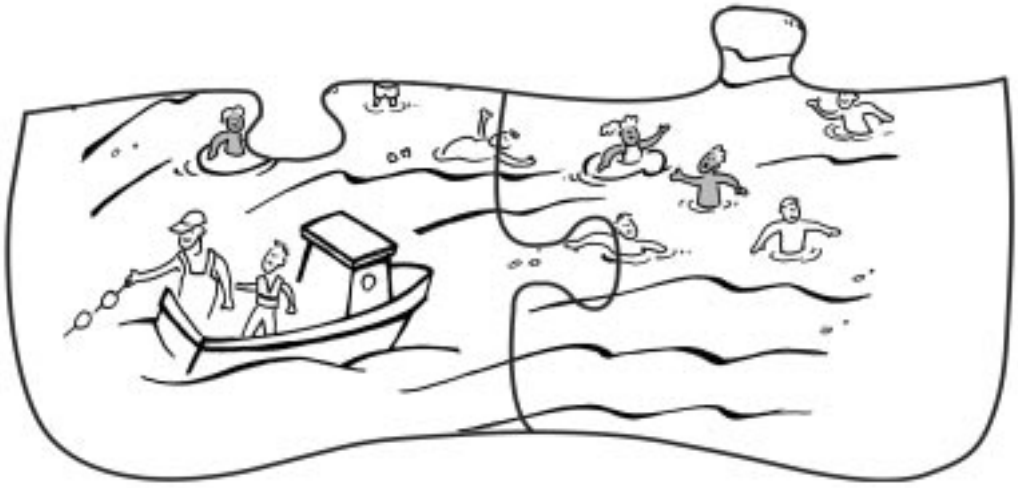
Canada

Death Rates and Causes

- Cardiovascular disease is responsible for 37% of all deaths in the Atlantic region.
- The Atlantic provinces have a higher death rate for cardiovascular disease than the rest of Canada.
- Cancer is the chronic disease with the second highest death rate in Atlantic Canada.
- The death rate due to AIDS is markedly lower in the Atlantic region than in Canada as a whole.

Chronic Diseases

- There is no single health profile in Atlantic Canada. For example, in terms of mental health and self-rated health, Newfoundland and Labrador and Prince Edward Island are much better off than Nova Scotia and New Brunswick.
- Atlantic Canadians have higher rates of diabetes than the Canadian average of 4.1%.
- The most prevalent communicable chronic disease in Atlantic Canada is hepatitis C, followed by HIV/AIDS, both of which can lead to other forms of chronic disease. Communicable diseases are almost entirely preventable.
- The rate of positive HIV test reports is considerably lower in all four Atlantic provinces than in Canada as a whole, although estimates of unreported cases remain high.



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