Chapter 1

A Healthy Society

> The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.
>
> *Closing the Gap in a Generation*
> Commission on the Social Determinants of Health[1]

Buying Smokes for my Patients

Maxine just turned twenty, but walks like she's ninety-one. I suppose that's because she's closer to death than most ninety-one-year olds. You'd walk slowly, too, if that's what lay ahead. While she's been on the street since she was thirteen, hooked on IV cocaine and morphine for nearly as long, she has only had HIV for two years, three at the most. For some reason she, like many of the growing number of people infected with HIV in Saskatoon, is a rapid progresser. This means that, rather than taking years for her infection to progress to the immune suppression of AIDS, it happened very quickly. There are a few theories out there: different genetic capacity to respond, unique strains of the virus, or just poor underlying health. The truth is, we don't quite know why. What we do know is that she's in really bad shape — what many doctors would call, in back rooms and unprofessional asides, a train wreck.

When I first met Maxine, she came in with florid thrush, a rip-roaring pneumonia, and a prescription for prophylactic antibiotics she never intended to fill. I instantly recalled the hospital in Mozambique where caring for young men and women who arrive emaciated and scared, fast approaching the end of their lives, is a daily occurrence. Maxine's is the worst case of AIDS I've seen walking a Canadian street. I told her she was sick

enough to go into the hospital, but she had just been discharged for the umpteenth time. She wouldn't say much, just told me she wanted antibiotics and nutritional supplements. The last thing she wanted was to go back into the hospital.

Three months later, the word on the street is that Maxine wants help. She's getting weaker and sicker, and finally recognizes she's in trouble. She comes into the clinic and falls asleep on the exam table. She is deathly thin, and under my stethoscope her lungs sound like a rubber boot being pulled from the mud. I call the Infectious Disease service and Internal Medicine at Royal University Hospital. They know her well; she's done this before. She gets sick enough to need some help, she is admitted, she gets a bit better, hates the hospital, misses the drugs, and bolts. Reluctantly, they agree to give her another try.

That was a Friday, and I was out of town for the weekend. When I arrive to see her on Monday morning the internal medicine team is about to discharge her. Her CD4 count, a measure of the immune cells that defend against infection, is four. It should be at least 400. The HIV viral load tells us how active the virus is in her system. More than 100,000 is considered too much; hers is three million. However, her pneumonia has improved, she's not ready for the antiretroviral medications that must be taken every day without fail in order to avoid increasing resistance, and the normal functions of an acute ward have been reached. She doesn't make it easy to help her, either. She swears at the nurses, refuses to take pills or have blood work. When the security guard assigned to keep her in line takes her for walks, she bums cigarettes, hides them in her gown and smokes them on the ward. She takes as much time and attention as the rest of the patients on her ward combined, and the nurses and medical staff are exasperated.

Despite her misbehaviour, she tells me she wants to stay. I visit twice a day, sitting on the edge of her bed and talking with her about the future. She says she wants to get on methadone and off the streets. She wants to take the antiretroviral medications to get her immune system working again. She is refusing to leave the hospital. The idea that, as health care providers, we might have security guards escort this young girl who is dying of AIDS to the street is against all we stand for.

So we don't. After a long discussion with the medical team, we agree to try a little longer. Give her a week and see how she does. Because, despite the frustrations of bed shortages, extra workload, and chances that

are cachectically slim, we know these are the moments that define us as a profession. Even when the odds are long, we cannot walk away from someone who is so clearly suffering. So we'll try for another week. Get the methadone doc to see her, get psychiatry involved, and social work, and nutrition, and anyone else we can think of, make our boundaries clear and try once more.

We know the hospital is no place for Maxine. But the system has no better place. Most drug rehab programs won't take people on methadone; none of them will take someone who needs to start it. The waiting list to get started can be several months and requires people with numerous social and economic barriers to jump through multiple hoops that seem designed to keep them out. So in the gap between wanting to kick the drugs and having the personal and social capacity to do so, they're dumped back on the streets to start from scratch.

On the second or third night of this experiment in patience, I go up to see Maxine. The nurses are frustrated; she's still sneaking smokes into her room. She constantly demands that security take her for walks. She fights meds and blood work. But she's still there. She's taking her methadone. She tells me again she wants to stay, she wants to get better. The nurses think that maybe if she had her own cigarettes they could help her set a schedule and stay out of trouble. Maybe if they print her off more of the crossword puzzles she likes she'll stay busy. In many ways she is older than her 20 years. In others she's truly a child.

The next morning I go in to see her. I've got a couple of books of crossword puzzles and a pack of Player's Light. I never thought I'd buy a pack of smokes for a patient, but in this case "first do no harm" takes a back seat to the immediate fight for her life.

I go up to her room to deliver my gifts and talk to her some more. She's gone. The night before she got frustrated, left the hospital, scored some drugs, shot up and showed up in emergency in bad shape. The line was crossed and she is not welcome in the hospital any more. She can come to see me at the clinic the next week — we'll always see her — but the glimmer of hope is significantly dulled.

The last time I saw her, just before I stopped working at the clinic she trusts, she was repeatedly wearing out her welcome at the brief detox centre. I told her I hoped she'd at least come in and take her medications and see the other doctors there. She said goodbye, and thank you, and gave me a heartbreakingly innocent hug.

The cigarettes stayed in my freezer for a long time. I thought the next time I was invited to a sweat lodge ceremony, I'd bring them as my offering of tobacco and say a prayer for Maxine. It turned out I didn't get the chance — at least not while she was still alive. A few weeks after I left the clinic to work in rural Saskatchewan, she was hit by a car, shattering her pelvis. While in hospital she contracted pneumonia again, and this time she couldn't recover from it. She died just before her twenty-second birthday.

It's easy to get distracted by the pathology of Maxine's story, to think that it's a story of viral invasion, of fractured bones and infected lungs. These physical details, however, are distractions from the real disease. They are symptoms of what Dr. Stu Skinner, a Saskatoon infectious disease physician who specializes in HIV, refers to as the "End Stage of Poverty."

Maxine's life was hard from the beginning. She grew up in an environment of poverty, dysfunction, and abuse. Her mother had spent most of her own childhood in a residential school; she hadn't seen what it was like to be a parent and wasn't very good at it. Maxine never knew her father. Instead, she knew the attentions of various boyfriends and extended family members who abused her physically, sexually, and emotionally throughout her childhood. She had a baby before she reached Grade 9 and never returned to finish high school. In many ways she never got a chance to be a child, and at the same time never matured to be an adult.

Such a broken life, such an inherently tragic existence, provokes serious questions about our society: questions about the prevention and treatment of disease, about poverty and services for vulnerable people, about education, and about justice. What often escapes our attention when considering the tragic story of one individual is how intimately it is connected to all of us, to the collective decision-making process that is electoral politics. It is politics that decides whether young women like Maxine live or die. Ultimately, our political choices are to blame for the large number of people that slip through the cracks.

There is strong evidence that our current political choices aren't working for everyone. In Canada and around the world, the health of the poorest people is far worse than the health of the richest, and new evidence suggests we all suffer as a result. In order to address the fundamental unfairness of the situation, we need to rethink not just how we do health care, but how we make decisions as a society.

Economic growth and advances in health care have increased the life span, health status, and quality of life of people all over the world. Yet there

are many people, in poorer countries and within wealthy nations, who do not experience the benefits of this progress. Canada is one of the wealthiest nations on the planet, but the gap between the rich and the poor is widening, and rates of child poverty and homelessness are on the rise. Despite Canada's self-image as a welcoming and equal nation, Aboriginal peoples, immigrants, and women continue to suffer more illness than the rest of the population. The cost of post-secondary education has risen to levels that are unaffordable for many. Epidemics of drug abuse, diabetes, obesity, HIV/AIDS, and other diseases closely related to poverty result in lost lives and wounded communities. Meanwhile, human actions are harming the wider environment that supports us; this, in turn, harms humans. These problems are fundamentally political, but those who raise objections to the current state of affairs, who suggest that there must be a different way of organizing ourselves that will be to the benefit of all, are dismissed as naïve and ignorant of economic realities.

None of this is news. Most people are well aware of the situation, and many are moved to action. The overall response, however, is fragmented, confused, and ineffective. The question before us all is, how can we move beyond this impasse? How can we organize ourselves to make wise decisions for the benefit of all?

Politics and public discourse, the field that should be responding to such pressing societal concerns, flounders instead from crisis to crisis. Parties and public figures bounce around the political and social spectrum in reaction to events or public opinion. The key issues of the day are decided more by the news cycle than any rational understanding of priorities. Ideas are presented by extreme opposite views in debate rather than in a search for common ground. Political reporting is dominated by scandal to the exclusion of substance, and, as a result, we are unable to focus on real issues. The agenda of governments seems to be either hidden or absent. From day to day the top stories change from an international conflict to a far-off natural disaster, from the rising or falling loonie to a record lottery jackpot, with no discernible pattern of progress or failure. In this fragmented experience of history and the present, all of us have a hard time recognizing what is really happening, what a government has done, or what it ought to do.

The problem is not a failure to understand the extent of our difficulties; it is the lack of a focus, of an organizing principle for change. An undeclared objective will not be realized; we must state our goals clearly if we wish to succeed in reaching them. In the absence of a societal project that

advances the wellbeing of all, it is only natural that different groups will use politics cynically for their own gains, and that people will find it difficult to decipher the mixed and ever-changing signals. Without clear common goals, we have increasing polarity and discord. If we are to make anything of this mess, we must find something we agree on and work toward it. We need a clear objective that will inspire people from diverse circumstances to work together for a greater good.

What I propose is that people have already chosen that focus. It is simply a matter of recognizing, understanding, articulating, and acting upon it. The focus is health: the health of individuals, the health of communities, the health of democratic institutions.

People care about health. It's part of our assumed common ground, a truly shared value that transcends class, colour, and political ideology. Our conversations are replete with references to health. If you ask expectant parents if they're having a boy or a girl, the answer is inevitably, "We don't care, as long as it's healthy." When neighbours and friends are ill, we go out of our way to help them. If people fall on hard times, a common encouragement is, "At least you have your health." We speak of healthy relationships, healthy attitudes, healthy economies, and healthy appetites. We toast one another's health. These familiar expressions reflect our unconscious preoccupation with our common vulnerabilities, hopes, and fears: we know, deeply, that health — physical, mental, and social — is a necessary condition for the full enjoyment of life.

This focus on health is reflected in public life as well as private, particularly in the heated political debates around health care and health spending. Health care and health are very different things, but health care is the policy area most obviously linked to health, and the attention given to it is an identifiable surrogate for this deeper preoccupation. With rare exceptions, health care is the number one issue of importance in Canadian polling, an unusual constant in the tumultuous sea of public opinion. Accordingly, health care spending takes up the largest portion of provincial budgets. There have been many who have complained about this, saying that an inordinate focus on health takes away from other important areas such as education, justice, and infrastructure spending. In a way they're right — our focus on health care at the expense of other important aspects of public life is disproportionate. But the problem is not that we care too much about health, it's that we are doing so in an incomplete and reactive fashion. Our approach tends to be palliative rather than preventative; we

focus too much on what to do when our health fails, not on how to make sure the conditions are in place for more people to thrive, to stay healthy. If we truly want a healthy society, we need to build a political movement with health as its focus.

So Urban it's Rural

To explore the idea of health as a focus for public discourse, I'll start with an example, one that for me hits very close to home. I live in Saskatoon, a city of nearly a quarter million people on the Canadian prairie. My house is in a neighbourhood called Riversdale, a few blocks west of the South Saskatchewan River. Riversdale is one of five core neighbourhoods that make up this area of Saskatoon, often referred to simply as the west side. Some people are surprised that a place the size of Saskatoon should have an inner-city, but it certainly does, with all its the accompanying charms and difficulties. My neighbours keep an eye on the house when I'm away, and in summer they share fresh carrots and zucchini from their gardens. Strangers lean over the hedge to chat when I'm out raking leaves. People say "Hi, Doc" when we pass on the street. I often say it's so urban it's rural.

While its isolation amid the city's donut development (with peripheral suburbs and big box stores pulling social and economic activity away from the city centre) has conferred upon it some small town charms, its problems are decidedly urban. These neighbourhoods have the lowest per-capita income in the city. They have a reputation for petty and violent crime, and are the city's active marketplace for illicit drugs and prostitution. They also face a significant deficit in services, including frequent shortages of quality housing, access to good nutrition (there has been no real grocery store in the area for years), health services, and more. As a result, the health of the people who live in these neighbourhoods is the worst in the city.

Typical of the way in which these communities have been treated is the story of Station 20 West. In the spring of 2007 the government of Saskatchewan dedicated $8 million dollars to this innovative project, a collaboration between community groups in the core neighbourhoods, with the goal of addressing service gaps and creating economic opportunities. Community-based organizations such as CHEP (the Child Hunger and Education Project), and QUINT (a housing co-operative based in the five core neighbourhoods) joined with the Saskatoon Community Clinic, the University of Saskatchewan, and the Saskatoon Health Region to design

this unique response. The name, Station 20 West, played off its location literally just on the wrong side of the tracks crossing 20th Street, the core's main drag. It was billed as the Engine of Urban Renewal and consisted of a wide variety of services and community development initiatives in one convenient location.

Station 20 West was to be located next to 56 new affordable housing units and a branch of the public library, and was to include a dental outreach clinic, a community health clinic, a student-run after-hours clinic, offices for the aforementioned community-based organizations and others (including Heifer International and the Elizabeth Fry Society), a university outreach education centre, and a member-owned co-operative grocery store called the Good Food Junction. These were all to be housed in a building that would set a standard for environmentally responsible development with the highest level of LEED (Leadership in Energy and Environmental Design) certification.

At least that was the plan. In November 2007, the New Democratic Party (NDP) government was defeated in a provincial election and replaced by the Saskatchewan Party. In March 2008, the new government informed Station 20 West board members that the dedicated funds were being rescinded. Just months before starting construction, the project's future seemed extremely dim.

The new government's ill-considered decision to withdraw the funding for Station 20 West shocked the people of Saskatoon, triggering a firestorm of criticism of the decision and a groundswell of support for the project. In April 2008, in one of the largest demonstrations in Saskatchewan in decades, over 2,500 people from across the city took to the streets to proclaim their support for Station 20 West. Despite this show of support, funding was not reinstated, and the organizers had to start from scratch. Fundraising continues for a scaled-down version, without many of the earlier components. Over three years later, the much-needed services Station 20 West would have introduced are still largely unavailable.

At the time of this decision, I was working as a family physician at the clinic that was meant to relocate to Station 20 West. While working on the west side as a student, a resident in Family Medicine, and later as a practicing family doctor, I became quite excited about the potential of this project and was deeply disappointed by the cancellation of funds.

Clinical work in underserved areas offers many joys: the sense of community, the easy humour and relaxed attitude of many of the patients, and

for me a sense of purpose, as I am often able to connect with people in real need and offer them meaningful support. The frustrations are many as well. Every day, whether I'm working in Northern Saskatchewan, rural Mozambique, or in my neighbourhood, I see patients whose problems are not merely physical, but political. They stem from a lack of safe or appropriate housing, a lack of education, or from simply not having enough money to access the basic necessities of life. People don't get sick when they come into the clinic or show up at the hospital; their problems can't be solved there, either. They get sick in their real lives, at home, at school, at work, and at play. Station 20 West was a project designed to meaningfully address the factors that play such an important role in determining longevity, illness, and quality of life: the determinants of health.

Healthy, Wealthy, and Why

The notion that health and illness are determined by life circumstances is not new, and in recent years it has become a staple of health theory and teaching. In one of the first lectures of medical school, students are asked what the greatest factors are in deciding whether someone will be healthy or ill. Lifestyle choices — like the so-called holy trinity[2] of diet, exercise, and smoking cessation — are a common response. Others will talk about access to health services, while others reference genetics or culture. After this discussion, the students are shown the list of health determinants from the Canadian Institute for Health Information. In order of impact, the factors that make the biggest difference in people's health are: 1. income status; 2. education; 3. social support networks; 4. employment and working conditions; 5. early childhood development; 6. physical environment; 7. personal health practices and coping skills; 8. biological and genetic factors; 9. health services; 10. gender; 11. culture, and 12. mass media technology (i.e., television viewing and physical inactivity).[3]

Invariably, this list is met with a degree of surprise. As aspiring doctors, the students think they are getting into the business of making people healthy. Then they see that the services offered by the health professions barely crack the top ten factors.

The lesson to be drawn from the list of determinants, and the one that is stressed to students, is that the most important factors that determine people's health are social, and the most effective solutions are political. Health services — the response to ill health — have much less effect on

ultimate health outcomes than social determinants such as income and education, housing and nutrition. Gender, culture, and biology, the more immutable of the determinants, also figure near the bottom. What the students learn is that, while they can indeed have the power to heal, they cannot act alone. The response to illness is not limited to one profession or sector: it must be societal.

The question, then, is where does it make the most sense to focus our political efforts? In other words, which determinants of health are most directly affected by public policy? The social determinants of health are income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety net, health services, Aboriginal status, gender, race, and disability.[4] As you can see, these are all areas where public policy can change a person's situation or experience to either improve or worsen health. When we address inadequate housing, when we stop gender discrimination and racism, when we ensure people have access to work that is safe and fair and that our children receive the care and attention they need to grow, then we can dramatically improve health outcomes. So what's holding us back?

An Unhealthy Imbalance

The list of social determinants rings true to me and to others who work with the people of Saskatoon's west side. The majority of our patients are First Nations or Métis. They face challenges in accessing education for themselves, and child care and education for their children. Unemployment, poverty, and dependence on an inadequate social safety net are endemic, in particular for women. Housing is expensive, and often crowded or unsafe. Health care services are limited, and difficult to access. Violence, racism, sexual exploitation, and substance abuse are only a few of the many symptoms of ongoing poverty and social exclusion. The list goes on, and the result is ill health.

The effects of the social determinants on health are readily apparent to those who live and work in underserved communities. They are also supported by studies such as "Health Disparity by Neighbourhood Income,"[5] a 2006 paper published in the Canadian Journal of Public Health. This study compared the health of the six lowest-income neighbourhoods in Saskatoon (according to Statistics Canada) with the same health indicators in

the rest of the city. The findings were startling. People in the core are four times more likely to have diabetes, four to seven times more likely to get a sexually transmitted illness, and fifteen times more likely to have Hepatitis C. Those in the core also experience significantly higher rates of injury, mental illness, and coronary artery disease.

When the six poorest neighbourhoods were compared with the city's six most affluent neighbourhoods, the contrast was greater still. If you live in the core, you are fifteen times more likely to contract a sexually transmitted infection, fifteen times more likely to attempt suicide, thirty-five times more likely to get Hepatitis C, and thirteen times more likely to have type 2 diabetes than if you live in the suburbs. Children in the core are half as likely to have received their vaccinations. With all these increased risks, a core neighbourhood resident is 2.5 times more likely to die in any given year. The infant mortality rate is three times higher in the lowest-income neighbourhoods than in the more affluent neighbourhoods.

To get a sense of income ratios, the average annual family income in the six core neighbourhoods was approximately $30,000 per year, in the rest of Saskatoon it was over $60,000, and in the wealthiest neighbourhoods it was just under $100,000. Forty-four per cent of families in the core live below the low income cut-off line, compared with less than four per cent in the high-income neighbourhoods. People from the wealthier neighbourhoods are more than five times as likely to have gone past grade nine or to have current employment.

This landmark study demonstrates clearly the huge disparities in health in Saskatoon and the clear correlation to the social determinants.

Saskatchewan has a reputation for seeking equality, in particular with regard to health. It was the first province to institute what would eventually become Medicare, a national health insurance program designed to ensure that all Canadians would receive health care based on need rather than ability to pay. It is also a reasonably well-off province in one of the wealthiest and supposedly most advanced countries in the world. The discordance between perception and reality represented by this drastic imbalance in health has been a shocking embarrassment for Saskatchewan. It is, paradoxically, not particularly surprising. We know, and have known for a long time, that poverty is the greatest contributor to ill health. What is new about this study is the way in which it shows, in simple and clear data, just how significant that effect is in Saskatchewan. And the implications are clear, although politically inconvenient: one, poverty and inequality kill;

two, governments that stand idly by are complicit in every avoidable illness and premature death.

Waking up Democracy

This embarrassment and shock could serve as a wake-up call. It could help to refocus our political discourse on the real work of a democracy. Our job, as people who govern themselves, is to strive to do so in a way that is fair and good, that allows all to participate fully and enjoy wisely the good things given to us by providence. A functioning democracy is one in which the government, to the best of its ability, carries out the will of the people and takes seriously its responsibility to serve the best interests of all citizens. This democratic governance requires a number of things, key among them being that people be sufficiently informed to articulate their real needs, sufficiently empowered to present them as demands that can't be ignored, and sufficiently organized to see the process through to fruition. Put another way, a democratic society requires a shared notion of what is good and a willingness to find a way to reach it. That is not to say that in the presence of such a shared notion everyone would agree and work together in harmony. Democracy is the messy, argumentative, painstaking art of navigating a common course among conflicting priorities; were it not, we could be sure it was because all voices were not being heard. Having some shared framework, some set of guiding principles to steer the course, can allow these conflicting priorities to be weighed by all in terms of what is best for all.

I mentioned earlier the importance we give, in private and in public, to human health. The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[6] Each of us wants health for ourselves and our family. The role of government in a democracy is to work with the people to produce what they want and need. What better goal for a society than to ensure that all people enjoy true health — a state of complete physical, mental, and social wellbeing? And what better measure of the success of a government, and the society it represents, than the health of the people?

If we as a society address the social determinants of health — economy, education, the environment, and more — people will live fuller, healthier lives. This much is clear. If we are transparent in our intentions, decisive in our actions, and honest in our evaluation of the results, we will also foster a

common purpose that deepens community, builds solidarity, and rejuvenates democracy. In short, we will have found a means to move beyond our fragmented, haphazard approach to governance to one that works.

Yet there will be those who object to such an approach. Change is hard, especially if there is a cost associated. If people don't feel they will benefit, they will be resistant. Any reasonable approach to building a healthy society, especially one informed by social accountability or social justice, means that improving conditions among the poorest in our society must be a top priority. The foundation of a healthy society must be built among those who find themselves at the bottom. This is where addressing the determinants of health will have the greatest impact.

There are many people who see the world through compassionate eyes, who understand social justice, and act altruistically to improve the world. However, many of us don't see the world that way; perhaps we don't enjoy the luxury of doing so. We look first to the needs of our family, to a little more enjoyment of our own existence. We operate out of rational self-interest, and support the politicians who reflect our world-view, who offer us a little more money in our pockets, or protection from the forces that threaten our peace and security. What we fail to recognize is that it is in the best interests of everyone, even those at the top, to improve the health of all.

Helping Some Helps Us All

Addressing the social determinants of health doesn't just help those most in need; it helps everyone, regardless of social position. This is why the concept is so important: everyone benefits. This approach can be used to reach across divisions of class, race, geography, or political affiliation.

The poverty and ill health of some affect us all. Poverty is a drag on the economy. When people live in poverty they are unable to participate fully in public life and the marketplace, and are unable to contribute to the common account through taxes. They are also more likely to require health services, fall into the prison system, or require social assistance. People who do not have decent housing or access to education are less able to participate in the economy as customers, workers, or innovators. As their health suffers, the costs are borne by taxpayers. Our jails are not filled with hardened criminals (at least not when they go in); the vast majority of crimes against property and people stem from poverty. Our

safety, prosperity, and satisfaction with society are decreased by gross inequality.

In *The Spirit Level: Why More Equal Societies Almost Always Do Better,*[7] epidemiologists Richard Wilkinson and Kate Pickett present compelling evidence that the degree to which resources are unequally distributed has a significant impact on the health of everyone. Countries that are more equal, such as Japan or the Scandinavian nations, have much better health outcomes overall than less-equal countries such as the United States or Britain. While the ill effects of inequality are greater for those at the bottom of the social ladder, the impact is not limited to the poorest few. Health outcomes follow a gradient of wealth: people with low income have worse health than the middle class, whose health is not as good as that of higher-earning professionals, and so on up the social and economic ladder. But even the wealthiest people in an unequal society are less healthy than they would be in a more equal society. Whether it is the stress of constant competition and jockeying for position, the threat of personal ruin, or the burden of a large, marginalized population on public services and the social fabric, there is something about the experience of living in a society with a vast gap between rich and poor that damages everyone's health, resulting in more mental and physical illness, shorter life spans, greater levels of obesity, and higher infant mortality for everyone. Less equal societies suffer more of the social problems that lead to negative health effects, experiencing higher levels of violence, imprisonment, illiteracy, and teen pregnancy.

Life in a more egalitarian country, on the other hand, benefits the health of everyone, from the least advantaged to the most successful. The editors of the *British Medical Journal* grasped the significance of these findings: "The big idea is that what matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly that wealth is distributed. The more equally wealth is distributed the better the health of that society."[8]

Any serious attempt to address health disparities must therefore involve a plan to address not just poverty, but wealth disparity as well. This is not an easy idea to sell, especially not in countries that have a strong systemic commitment to inequality. One need only recall the "Joe the Plumber" incident during the 2008 US presidential election, in which the mere suggestion of spreading the wealth of society more equally caused a huge uproar. This shows the degree of influence held by those interested in maintaining the current level of inequality. But if the cause of ill health is, as the Clos-

ing the Gap report asserts, the inequitable distribution of power, money, and resources,[9] then any serious attempt to address health inequities must involve a plan to distribute resources more fairly.

The UN declaration of human rights states:

> Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[10]

When hearing stories of people living in poverty, the response is often that they are poor because of their own bad choices. People who succeed in life are those with the drive, determination, and skills to get ahead; they are people who make wise decisions. Looking back at Maxine, there's no denying that she didn't make the wisest of decisions. The question is, could she have done differently?

To choose well, one needs to have had the chance — through good role models, through childhood development, through access to the basic necessities of life — to have developed some real wisdom. Maxine didn't choose the life she was born into, and that life didn't equip her to make better choices than she did. In fact — through poverty, abuse, lack of education, discrimination, and social exclusion — it worked against her at every step. It's hard to imagine anyone succeeding in her circumstances. While there's no way to make a system that can force people to make wise choices, we can work toward one where more people have the opportunity to do so. By making the social determinants of health a primary driver of public policy, we can develop a society where more people have the chance to succeed and to live better lives as a result.

Providing everyone the opportunity to improve their lives, to escape poverty and experience the fullness of health, is not just the right thing to do, but also the smart thing to do. It is a delightful coincidence that our future wellbeing depends not on our selfishness but our generosity, our sense of justice. The growing gap between rich and poor impoverishes us all, diminishing the quality of life for rich and poor alike. We in Canada consider ourselves a developed country, but to allow the gap between rich and poor to grow is to become less developed.

The dream of a truly healthy society offers us a shared goal with the power to reach across the differences that separate us. It allows us to connect with our neighbours in recognition of our common vulnerability and our common desire to live full and healthy lives. By systematically addressing the determinants of health, and continually measuring our success, we can do both what is right and what is smart. We can chart a path of meaningful progress. We can improve the health of people and of the political system at the same time.