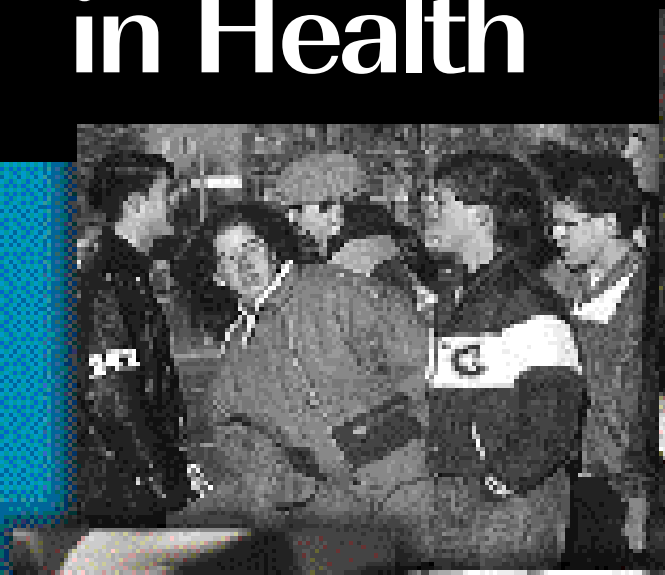
RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

Direction de la santé publique

1998 Annual Report on the Health of the Population

Social Inequalities in Health



DIRECTION DE LA SANTÉ PUBLIQUE

Garder notre monde en santé

1998 Annual Report on
the Health of the Population

Social Inequalities in Health

A publication of the
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I would first and foremost like to draw special attention to the work of our team members who devoted themselves to compiling the thematic files. Not all of these files were included in the final version, but they all helped to guide our way through the process. Very special thanks must go to the project team for its support throughout the process: from defining the contents of the report to revising the various versions of the text. The list of these persons can be found in appendix 3.
Finally, thanks to all who were more or less closely involved in making this project a reality.

Richard Lessard, M.D.
Director of Public Health

Summary

This annual report is the first ever published by the Montreal-Centre Department of Public Health. It is concerned with the population's state of health, seen from the angle of social inequalities in health and well-being. Far from growing less serious, current disparities are having a negative impact on the health of the population.

We thus find that residents of Montreal's low-income neighbourhoods can expect to live 5 years less than their counterparts in high-income areas. Nor is this just a matter of subtracting a few years at the end of a long healthy life, but often from a life in reduced circumstances; for social inequalities in health are observed at all stages of life:

- Infant mortality is 8 in 1,000 in low-income areas vs 5 in 1,000 in high-income areas.
- The proportion of low-weight newborns is twice as high among poorly educated women.
- The fertility rate among adolescents in low-income areas is 6 times higher than that among those in wealthy areas.
- Psychological distress and suicide, on the rise all over Montreal, strikes harder in underprivileged areas.
- AIDS is the leading cause of death among men in the 22-to-44 age bracket in Montreal and 77% of the cases reported in Quebec occur in Montreal. Moreover, the rate of HIV infection is 10 times higher among street youth than in the general population.
- Lung cancer has replaced breast cancer as the leading cause of death in women, and it strikes harder among the poor. What is more, the proportion of young women who smoke has more than doubled over recent years.
- The underprivileged live one year short of the normal life expectancy for a 65-year old and the elderly poor live one more year of disability than their wealthy counterparts.

The Island of Montreal counts 500,000 residents living under the threshold of poverty, and more than half of these live in the municipality of Montreal alone. From 1989 to 1996 the number of welfare recipients increased by 100,000. Unless something is done to counter this trend, we will probably continue to see social inequalities in health persist and worsen in the years to come.

Representing a quarter of Quebec's population, the Montreal region with its enormous potential can once again offer its residents a better quality of life. Our network has an important role to play in dealing with Montreal's serious social inequalities in health. But the real solution depends on the social and economic environment. All decision-makers in all the different sectors of society (community, municipal, school, union, economic, political) who play a role in social and economic development are urged to join in the fight against social inequalities in health.

Forward

"Canada's capital of poverty", this is the rather unflattering title Montreal has earned because of its large number of poor citizens: 500,000 out of 1.8 million inhabitants and close to 23% of families living under the low-income threshold. When we know that poverty is often associated with poorer health, this situation must be recognized as a critical public-health issue.

All the more so because, here as elsewhere, we have been witnessing over the past ten years a radical change in values. Forces are at work worldwide to increase the effectiveness of interventions as well as to make individuals, families, and communities assume greater personal responsibility for their health. Concurrent with these trends, the political choices being made in education, health, and income security affect thousands of families and hundreds of thousands of people, including the poorest.

Moreover, the network of health and social services (also nicknamed system of consequences because it serves as a spillway and bandaid for a number of social problems) is in full mutation. These transformations are inevitably a source of anxiety.

The Montreal-Centre Department of Public Health is not indifferent to that anxiety. As a member of the network of health and social services, the Department feels it is its immediate responsibility to point out the actions to be taken. As spelled out in the *Act Respecting Health Services and Social Services...* (art. 373.1): *The public health director shall be responsible for informing the population on its general state of health and on the major health problems, the groups most at risk, the principal risk factors, the interventions he considers the most effective, monitoring the evolution thereof and conducting studies or research required for that purpose*.

It is to fulfill this mandate that we are publishing this first annual report on the state of the health of the population. We wish to inform but even more urgently to alert all key players as well as our partners in the health and social services network. *The Policy on Health and Well-being*, with its list of specific objectives to be achieved by 2002, already stakes out the areas where the needs are most crucial. This achievement is worthy of praise: We are one of the rare Western societies to have such a priceless tool at its disposal. As it both carves out a position and constructs a framework for action, *The Policy on Health and Well-being* proposes a platform for specific intervention.

In the following pages, we will evaluate the current situation in our region in light of the above-mentioned objectives and from the angle of the links between health and poverty. In actual fact, today's socioeconomic context dictates our leading questions: What influence do living conditions, social environment and, more particularly, social inequalities have on health and well-being?

It can never be repeated too often that the responsibility to fight against social inequalities is one we all share, starting with our official network, the regional board to which we belong, and including all our partners in health and social services. This responsibility also concerns citizens, communities, organizations, decision-makers, and our governments. It is this question of life and health which we will be examining throughout this report.

Director of Public Health

Richard Lessard, M.D.

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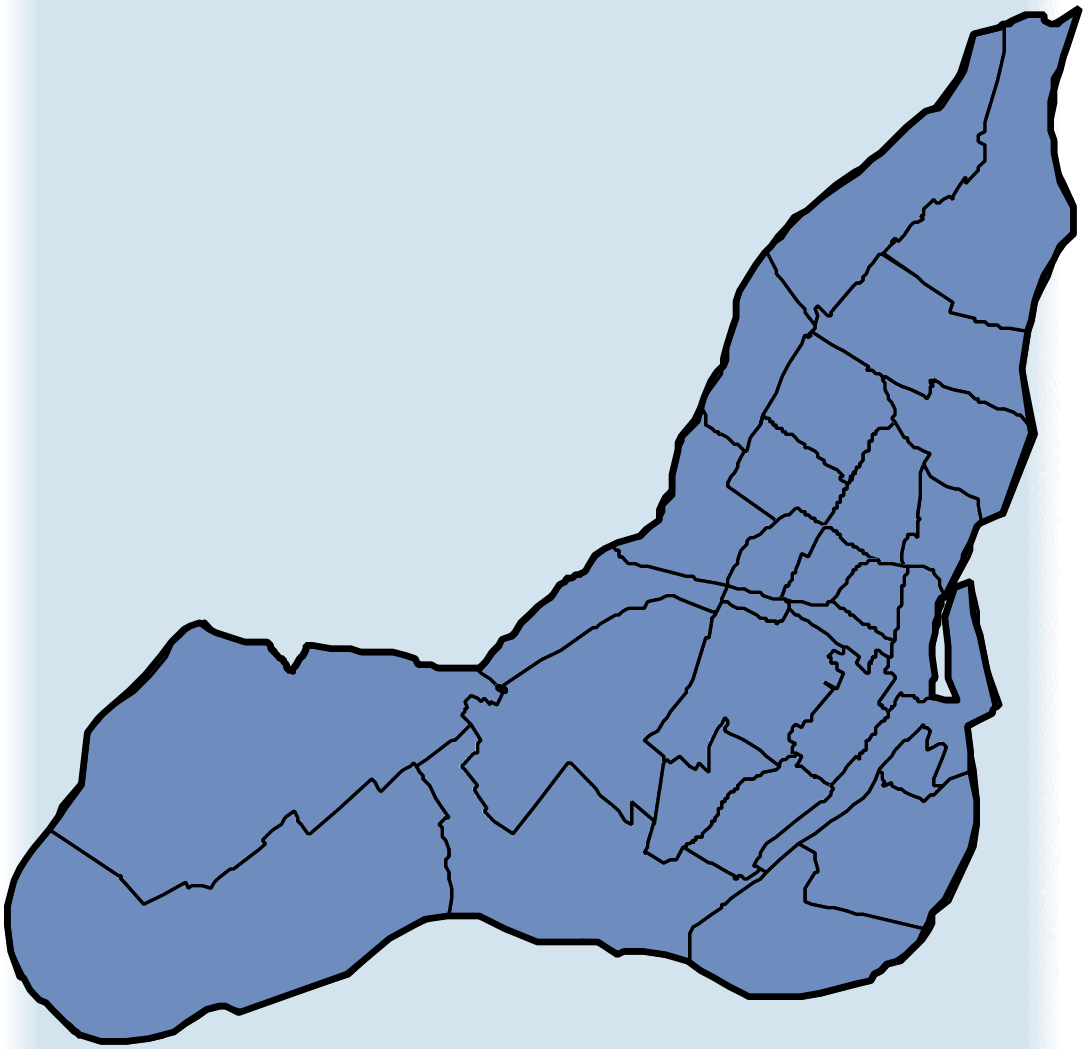
CLSC districts in Montreal-Centre



1. Ahuntsic
2. Bordeaux/Cartierville
3. des Faubourgs
4. Côte-des-Neiges
5. Hochelaga-Maisonneuve
6. J.-Octave-Roussin
7. Lac Saint-Louis
8. LaSalle
9. Mercier-Est/Anjou
10. Métro
11. Montréal-Nord
12. Notre-Dame-de-Grâce/ Montréal-Ouest
13. Olivier-Guimond
14. Parc Extension
15. la Petite Patrie
16. Pierrefonds
17. du Plateau Mont-Royal
18. Pointe-St-Charles
19. René-Cassin
20. Rivière-des-Praires
21. de Rosemont
22. Saint-Henri
23. Saint-Laurent
24. Saint-Léonard
25. Saint-Louis du Parc
26. Saint-Michel
27. Verdun/Côte St-Paul
28. du Vieux La Chine
29. Villeray

Instrument Panel for Health Issues on the Island of Montreal

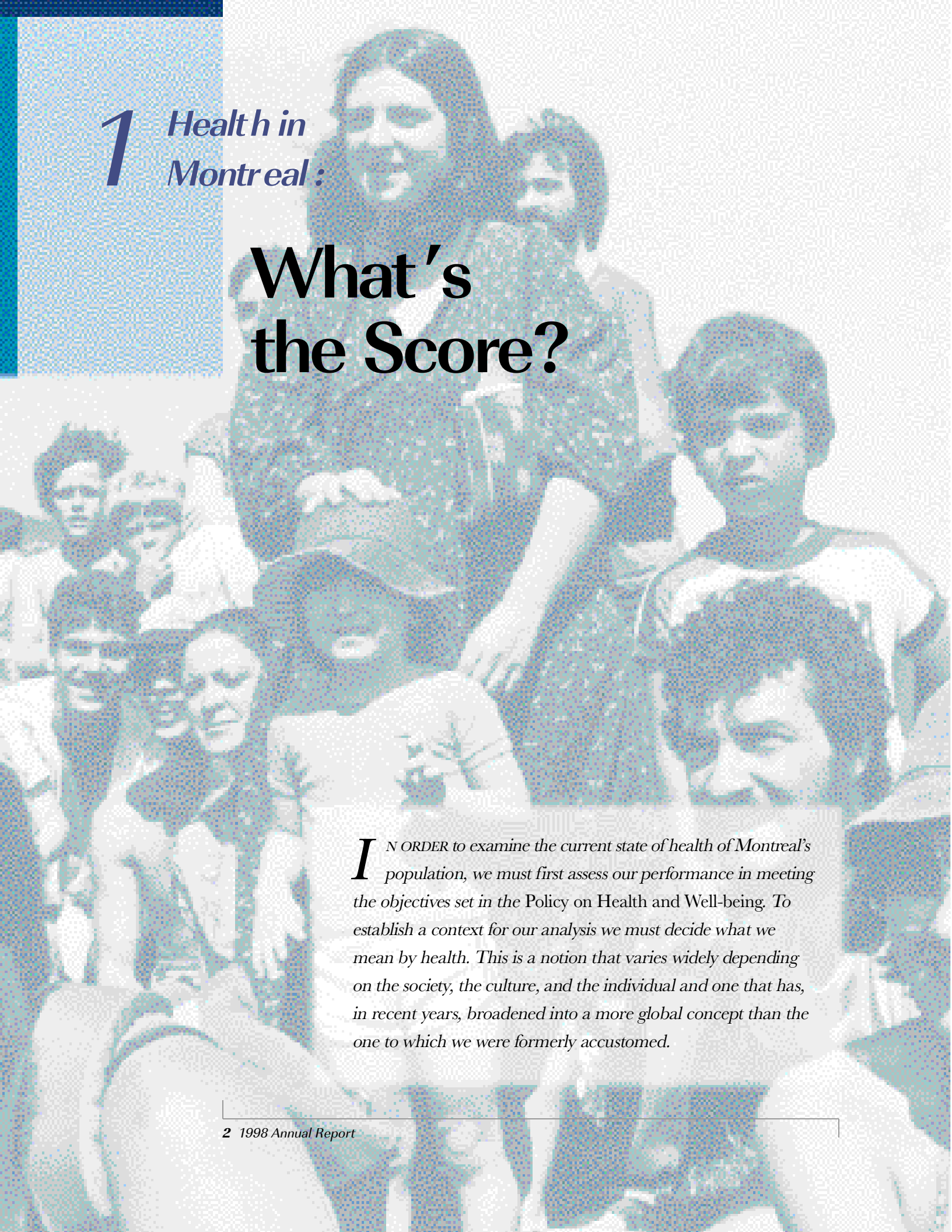
Our report covers Montreal-Centre, meaning the whole Island with its 29 municipalities and, of course, the City of Montreal. However, to simplify our task, we use Montreal to refer to the whole Island.

The report is organized around some forty indicators illustrating the links between poverty and health and producing a sort of instrument panel for the health of Montrealers. The data presented are often those derived from the 1991 census, because 1996 data were not yet available. Other more specific data are to be found in the appendices.

We will first of all take stock of our current situation in terms of the objectives set by The Policy on Health and Well-being; we will then explain from an overall perspective how socioeconomic inequalities can pose a threat to health. In the following sections, we will point to the specific issues raised by poverty in the four stages of life: early childhood, youth, adulthood, and old age. Finally, in section 7, we start to reflect on the contribution a public-health organization such as ours can and must make to the community in the fight against poverty and its consequences.

1 Health in Montreal:

What's the Score?



IN ORDER to examine the current state of health of Montreal's population, we must first assess our performance in meeting the objectives set in the Policy on Health and Well-being. *To establish a context for our analysis we must decide what we mean by health. This is a notion that varies widely depending on the society, the culture, and the individual and one that has, in recent years, broadened into a more global concept than the one to which we were formerly accustomed.*

What Is Health ?

Everyone has his or her own conception of health, and each era, each culture takes its own approach to health. In common parlance, we equate the absence of sickness and infirmity with health and, therefore, make a strong association between health and health care. Yet, it has been over 50 years since the World Health Organization redefined health as a *"complete state of physical, mental, and social well-being,"* thus as something positive, with links to self-fulfillment and quality of life.

"Health is above all the resources and energy for dail y living."

More recently, a whole school of popular thought—often inspired by oriental traditions associating health with energy— has developed a more dynamic perception of health. New definitions proposed by contemporary health specialists follow the same trend. Thus, according to the *Act Respecting Health Services and Social Services*, health is *"the physical, mental and social capacity of persons to act in their com - munity and to carry out the roles they intend to assume in a manner which is acceptable to themselves and to the groups to which they belong."*

The capacity to act and to accomplish goals seems less an absolute than a starting point, a resource for daily life, the energy to realize one's aspirations and influence one's environment. Seen in this light, health takes on a social dimension, that of harmonious well-being in one's environment.

Our annual report discusses health from a global and dynamic perspective. But a limitation must be noted: there is no absolute measurement of a population's health. So, we will use existing indicators based on data about sickness and death. Though they reflect the negative side of reality, they do convey very concrete information.

As a datum, health varies widely from one individual to another as well as from one collectivity to another. This is explained by what we call the determinants of health and well-being. At conception, we each receive a health potential encoded in our biological constitution and the genes transmitted by our parents will condition our whole human development. This is the biological determinant. Once this heritage and the ineluctable phenomenon of age are taken into account, other disparities in health can be largely explained by environmental determinants linked to the

physical and social surroundings in which we live from cradle to grave. Education, employment, income, family and social fabric, distribution of wealth: all these factors play a role. We realize that socioeconomic status and state of health are closely linked: this link can be observed in data on a population's rates of hospitalization, disability, health problems, and mortality.

There are of course the other determinants such as lifestyles and behaviours (smoking, eating habits, etc.). Even though these are modifiable factors and are often targeted by prevention programmes, we also know that they are largely conditioned by socioeconomic factors. Finally, the last determinants are the health services themselves, and these vary in their level and organization according to community and country.

The 19 Objectives to be Achieved by 2002

In 1992, Quebec drew up a *Policy on Health and Well-being* which set 19 objectives to be achieved by 2002 in five sectors: social adjustment, physical health, public-health protection, mental health, and social integration. The minister of Health and Social Services then asked the Regional Board to mold these objectives in light of the needs and conditions specific to our Montreal reality.

Four priorities for our region

Four priorities were thus identified for our region:

- Early childhood
- Optimal development of youth
- Prevention of violence against women
- Reduction of morbidity and mortality due to breast cancer

These choices underline the importance we accord to problems involving social adjustment, especially among the underprivileged. These same priorities now figure as guidelines in the plan to consolidate the network of health and social services.

Is it realistic to believe that these 19 objectives can be achieved? This is what we will evaluate in the following pages. We will also try to see if the phenomena in question are more prevalent in Montreal than in the rest of Quebec, and if they are more prevalent among low-income groups (see table, p. 8-9).

Social adjustment: cause for concern

Social adjustment covers violence and the abuse and neglect of children, behaviour problems in children and youth, delinquency, conjugal violence, homelessness, as well as abuse of alcohol, medication, and drugs.

Though only spotty, the data available to quantify these phenomena lead us to make the following statements:

- Three of the objectives—reducing delinquency and conjugal violence as well as increasing the number of persons never having consumed illegal drugs—will probably not be achieved.
- Sexual abuse, violence, and neglect involving children as well as delinquency and conjugal violence seem more prevalent in Montreal. As to the disparities linked to socioeconomic status, data show that drug use is more widespread among low-income groups.

Physical health: the poorest at an obvious disadvantage

We studied the six objectives linked to physical health: perinatality (premature and low-weight births, birth defects), heart disease, lung and breast cancer, accidental injuries, back problems, arthritis and rheumatism, and respiratory diseases.

For four of these objectives—death from heart disease, death from lung or breast cancer, death due to injuries, back pain—there is every reason to believe that they will be achieved and even surpassed. In contrast, thresholds for perinatality and respiratory diseases will probably not be attained. Compared with Quebec as a whole, the situation is similar or slightly more promising in Montreal. Finally, low-income groups stand out as the most disadvantaged with regard to perinatality, circulatory diseases, lung cancer, accidental injuries, and respiratory diseases.

Public health: sharp disparities persist

In the field of public-health protection, the main goals are to reduce the incidence of AIDS and sexually transmissible diseases. We note that the incidence of these diseases is more pronounced in Montreal and among low-income groups. The objective will probably be met as concerns most sexually transmissible diseases. But, in the case of AIDS, we would be prudent not to take the decline in reported cases since 1994 as a retreat of the disease: it might only be the temporary effect of new treatments which delay the appearance of AIDS in subjects infected with the virus. Prevention is still the only avenue possible towards any real reduction of HIV infection.

We also want to eliminate or reduce certain diseases that can be avoided through vaccination. This objective might be achieved: already, in 1996 there are no cases of diphtheria, tetanus nor polio and very few cases of measles, rubella, and mumps. Objectives for the reduction of whooping cough and Haemophilus influenzae will probably be met. And though there is a lower incidence of these diseases in Montreal, they are noticeably more prevalent among low-income groups.

As for the objective of improving dental health, it will be achieved neither among the 6-to-12 age group nor among those 35 to 44. The problem is not more serious in Montreal, but there are obvious disparities based on income bracket.

Mental health: mounting psychological distress

The *Policy* sets two objectives which will not be met: reduce mental health problems and reduce suicides and attempts at suicide. Recent years have revealed quite the opposite trend, psychological distress and suicides are on the rise, revealing the same disparities associated with income. Though Montrealers seem less prone to suicide, their psychological distress is just as widespread as in the rest of Quebec.

Social integration: try harder

The task here is, on the one hand, to remove obstacles to the social integration of seniors and, on the other, to weed out situations which handicap people with disabilities. Even though limited, the current data available lead us to think that objectives in this area will not be met and that the problem is not more serious in Montreal. Here also we observe socioeconomic disparities.

What is the probability objectives will be achieved?

The prospects for physical health and public-health protection are satisfactory, but they are much less so for social adjustment, mental health, and social integration. We also note that the population of Montreal suffers more from problems of social adjustment, AIDS, and STDs than the rest of Quebec and that, on the flip side, it fares better in the area of physical health. Finally, no noticeable trend differentiates Montreal from the rest of Quebec in the areas of mental health and social integration.

Income-related disparities were not measured for all the objectives (for lack of data), but it is clear that impoverished groups are harder hit, especially in the areas of physical health, public health, and mental health. Though several objectives are well on the way to being met, their achievement will not eliminate health-related social inequalities.
In our view, the reduction of these disparities should itself be an objective, in order to improve the health and well-being of the whole population.

To sum up, this follow-up on the *Policy*'s objectives confirms both the judicious choice of regional priorities and the need to pursue the efforts undertaken in recent years. We see it as imperative that the agendas of local, regional, and national authorities should feature the goal of reducing the social inequalities affecting the health and well-being of Montrealers.

Let us now move on to the analysis of an important question:
Is the socioeconomic situation of Montreal also a public-health issue?

Objectives for 2002 as set by the Policy on Health and Well-being

Social adjustment

1. Reduce the cases of sexual abuse, violence, and neglect involving children and counteract the consequences of these problems
2. Reduce the most serious behaviour problems among children and teenagers
3. Reduce the prevalence and severity of delinquency
4. Reduce the cases of domestic violence against women
5. Prevent homelessness and, particularly in Montreal and Quebec City, counteract its consequences and promote the social reintegration of the homeless
6. Reduce by 15% the consumption of alcohol and by 10% the use of psychotropic drugs among the elderly and recipients of last-resort services
   Increase the number of persons who will never use illegal drugs

Physical health

7. Reduce premature births to less than 5%
   Reduce the incidence of low birth weight to less than 4%
   Reduce the incidence of congenital or genetic defects
8. Reduce deaths attributed to cardiovascular disease by 30%
9. Stabilize the death rate from lung cancer
   Reduce the number of deaths from breast cancer by 15%
10. Reduce by 20% fatalities and injuries caused by accidents that occur on the roads, at home, at work, and during sports and recreational activities
11. Reduce the prevalence of back pain by 10%
    Shorten the total days of disability linked to arthritis and rheumatism
12. Reduce deaths from respiratory disease by 10%

Public health

13. Reduce the incidence of AIDS and STDs and their complications
    Stabilize infections resistant to standard antibiotics
14. Eliminate measles, German measles, diphtheria, tetanus, mumps, and poliomyelitis
    Reduce whooping cough and Haemophilus influenzae (type B)
15. Reduce by 50% the average number of decayed, missing, or filled teeth in 6-to-12 year olds
    Lower the rate of missing teeth in 35-to-44 year olds to less than 5%

Mental health

16. Reduce mental health problems
17. Reduce the number of suicides and attempted suicides by 15%

Social integration

18. Remove obstacles to the social integration of the elderly
19. Reduce circumstances that handicap disabled people, irrespective of the origin and nature of their disabilities

Probability of achie ving objective as indicated by current trends	Problem more prevalent in Montreal	Problem more prevalent among lowest-income groups
nd	yes	nd
nd	nd	nd
no	yes	nd
no	yes	nd
nd	yes	yes
yes nd no	no no no	no yes yes
no no nd	no no nd	yes yes nd
yes	no	yes
yes probably	no no	yes no
yes	no	yes
yes yes	no no	nd nd
no	no	yes
yes	yes	yes
yes (in general)	no	yes
no no	no no	yes yes
no	no	yes
no	no	yes
nd	no	nd
no	no	nd

nd: no data

2 The Socioeconomic Situation in Montreal :

A Question of Public Health

THE LEVEL OF HEALTH and well-being enjoyed by Montrealers is among the best in the world and, on the whole, compares favourably with that of other Quebecers and Canadians. A glance at figure 1 is enough to confirm this fact.

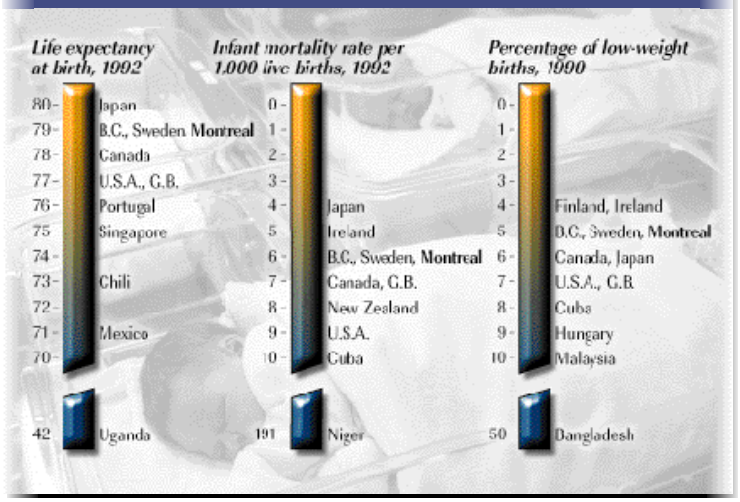
However, as elsewhere in Quebec as well as in Canada, health inequalities persist between men and women, between socio-economic groups, and between different districts. In some cases these gaps are growing even wider. These social inequalities in health are of concern to us in the Department of Public Health: Do we not face the risk of a widening gap and a decline in the health of all Montrealers? This is the concern guiding the analysis of the health and well-being of Montrealers presented in this section under two headings: social inequalities in health and poverty in Montreal.

Social Inequalities in Health

How can the level of a population's health and well-being be measured? There is no direct, nor single, nor perfect measurement enabling us to assess the health and well-being of a population in its three dimensions: physical, mental, and social. However, we do have at our disposal measurable but indirect indicators which reveal partial facets of the phenomenon in question. Moreover, there do exist two currently accepted measurements — perception of one's health and one's life expectancy at birth — which we will use to draw a picture of the global health prospects for the population of Montreal.

fig. 1

Life expectancy, infant mortality and low-weight births, Montreal and various countries



B.C.: *British Columbia*
U.S.A.: *United States of America*
G.B.: *Great Britain*

Montrealers perceive themselves as healthy

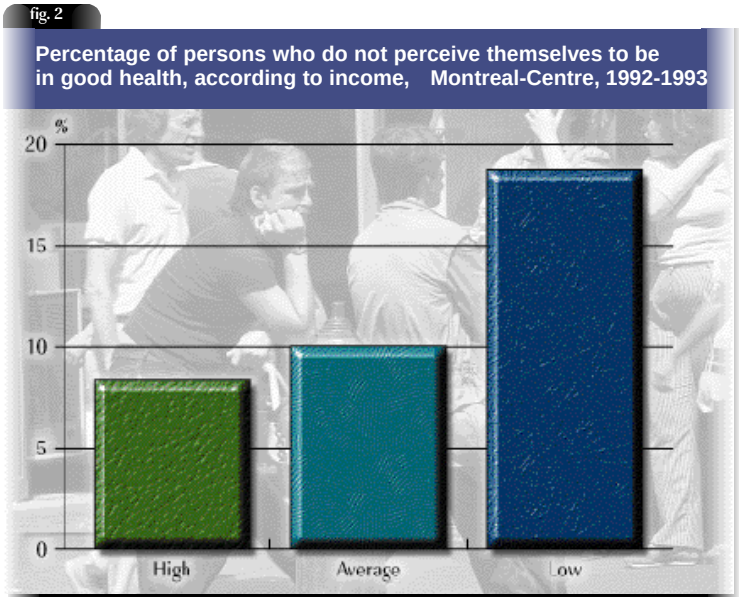
It is relatively easy to gather information on how people perceive their state of health. In surveying the population, only one question is needed: *"Compared to other persons of your age, would you say that your health is in general excellent, very good, good, average or poor?"*

The answer faithfully reflects the sense of well-being or vitality a person feels in his or her environment. It has also been demonstrated that perception of state of health coincides closely with the facts as measured by more objective indicators.

In terms of socioeconomic status, twice as many low-income subjects (as compared with high-income earners) feel they are not in good health. Other socioeconomic variables — such as low

fig. 2

Percentage of persons who do not perceive themselves to be in good health, according to income, Montreal-Centre, 1992-1993



schooling, unsatisfactory social life, or weak social support — are also associated with the lowest perceptions of personal health.

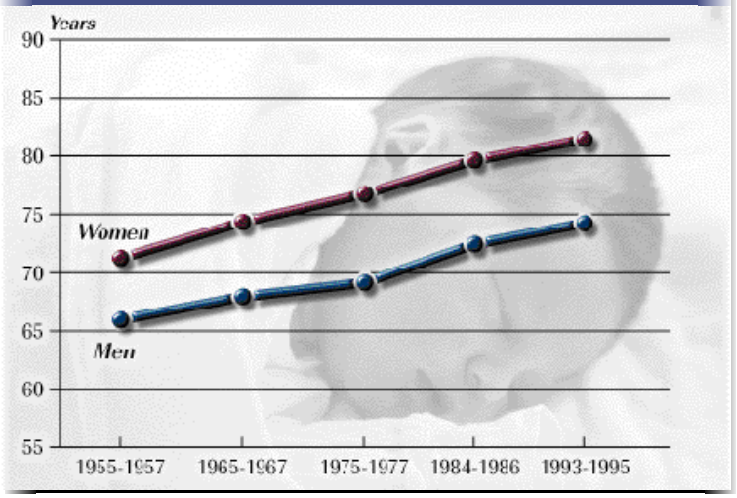
However, it appears that Montrealers are, in general, rather satisfied with their state of health: almost 9 out of 10 say they are in relatively good, very good or excellent health.

Life expectancy : 50 years of steady progress

This measurement, like the preceding one, is a composite. It gains by being more objective but fails to take any account of the psychosocial aspects of health. Life expectancy at birth for a given period is calculated based on deaths by age group during the course of that same period. The higher the death rate, the lower the life expectancy — indicating poorer health conditions.

fig. 3

Life expectancy at birth according to gender, Montreal-Centre, 1955-1957 to 1993-1995



From as far back as we can measure in Montreal, life expectancy at birth has been climbing steadily. It has increased by 10 years since the 50s and is today estimated at 81 for female Montrealers and 74 for male Montrealers. In our developed countries, men do not live as long as women. This lower life expectancy has three main causes: accidents and violence, heart disease, and lung cancer.

The rising trend in life expectancy at birth goes back to the last century. In 1831, the average longevity among Canadians was only 39. This spectacular progress can be attributed in large part to improvements in public hygiene, working conditions, income, and education. Medical science, with the giant strides made in the first half of the century, has also contributed to this trend. We need only think of vaccines, antibiotics, obstetric and perinatal care — especially their role in reversing the tide of infant mortality and mortality from infectious diseases.

But inequalities persist

The issue of social inequalities in health was not born yesterday. In Great Britain as early as two centuries ago the first health statisticians were classifying deaths by cause and occupation. The expression "healthy district" was synonymous with "rich district" in the XIXth century and English statistics reveal that an inverse relationship between social class and mortality has existed since 1911. Then, in 1980, the Black report showed that the higher one climbs on the social scale, the greater the regression of premature death.

Today, studies proliferate and one constant remains: despite the global reduction of mortality, despite medical progress, despite policies of universal access and free health and social services in many industrialized countries, the poor are less healthy and die younger than the rich. And Montreal is no exception.

In both men and women, life expectancy at birth declines with income. The gap is most obvious in men: almost 7 years separate the low-income from the high-income group.

Again and again, the same observation

This relationship between health and income is observed for most of the 140 health indicators in a study recently conducted by the Department[1]. Along with the gap between low and high income, we generally also note a gradation effect: an individual situated at any point on an income scale is likely to be less healthy than any of those above and more healthy than any of those below that particular point.

[1] Some of these indicators are presented in the appendix. The Montreal-Centre Department of Public Health also has a web site providing fuller information on this study. (http://www.santepub-mtl.qc.ca).

For example, our study reveals that the low-income group outstrips the highest-income group for indicators of several negative trends, among which only 6 of the most striking are presented in the table below:

Adolescent fertility (15-19)	+ 589 %
Suicide	+ 111 %
Death from lung cancer	+ 62 %
Low birth weight	+ 47 %
Death from heart pathologies	+ 31 %
Hospitalizations	+ 31 %

After the broad strokes of the perception of health and life expectancy at birth, this eloquent table adds another detail to the global picture of social inequalities in health in Montreal. These questions will be developed in greater detail as they apply to the different stages of life.

Growing Poverty in Montreal

As a public health organization, our primary concern is the health of the population. But without wanting to play the economist, we do want to recall that, beyond health and social services, the determinants of a population's health are socioeconomic in nature: a strong economy, stable and meaningful jobs, decent salaries, and a good level of education.

Over recent years, Montreal has seen shut-downs, massive layoffs, job losses (6.3% from 1990 to 1994 and 3.4% from 1994 to 1996), all this coupled with the exodus of the upper middle class to the suburbs. On the other hand, many of the newcomers who keep Montreal's population hovering, on the average, around 1.8 million, struggle along in precarious economic circumstances. In light of the data presented above on the social inequalities in health, it can hardly be surprising that we, as public health officials, are concerned about what is going on.

We have no intention of mounting a debate about the socioeconomic context, but we do want to highlight its impact on health. This we will do by examining five social phenomena: Montrealers living

below the low-income threshold; welfare recipients; the unemployed; workers in precarious situations; refugees; and newcomers.

More than a simple question of income

In assessing levels of poverty, we will sometimes use data on the low-income threshold and at other times data on welfare. The attention paid to the income indicator should, however, not mask the fact that poverty is a complex, multifaceted phenomenon, a set of cumulatively interactive material and social shortfalls: low schooling, poor housing, poor working conditions, economic inactivity, exclusion from the decision-making process — which, pushed to the extreme, lead to social exclusion.

What impact does poverty have on healt h?

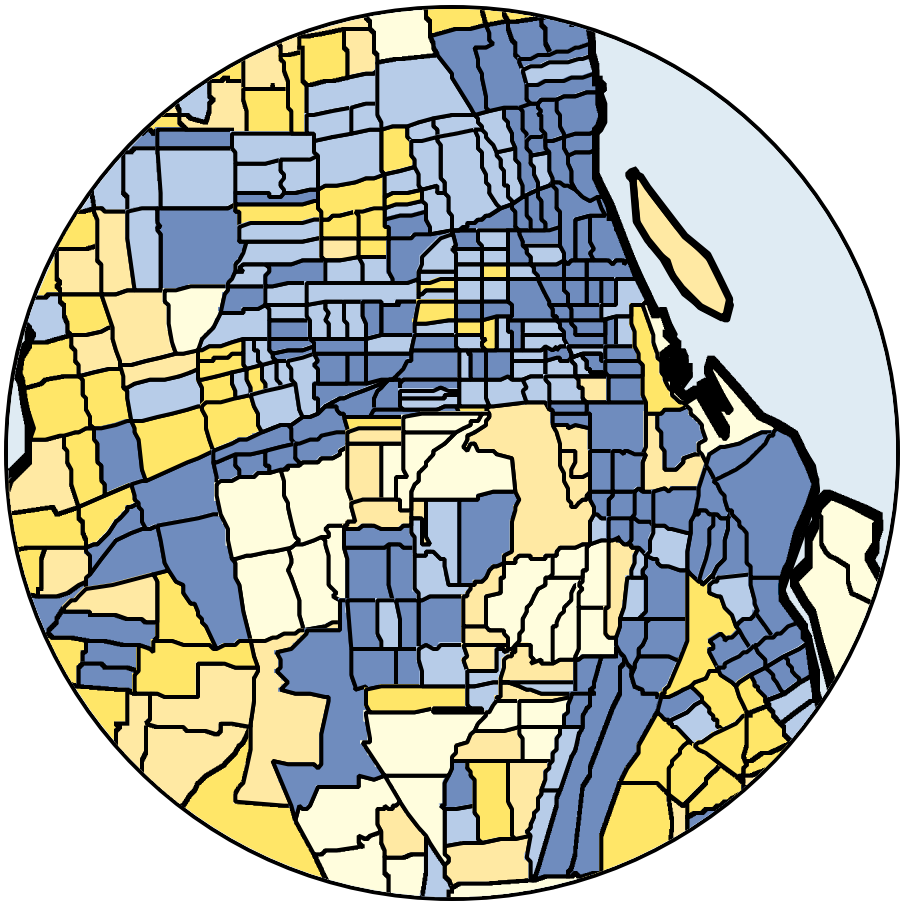
While it provides no definitive answers, current research does offer some interesting avenues of approach to the links between health and poverty. Low income does not seem to be the direct cause of poor health; no more than the occasional lack of basic necessities such as food, clothing, housing, medical care or the influence of lifestyles are the sole causes of poor health. What happens is that people living in these conditions begin to feel socially worthless and lose any sense of control over their lives. The stress of seeing themselves stuck in the position of "hewer of wood and drawer of water" with no hope of one day breaking free makes people more vulnerable and fragile and, thus, exposes them to physical and mental health problems.

A half million Montrealers living below the low-income threshold

Montreal leads Quebec in the percentage of people living below the low-income threshold. From 1985 to 1990, this proportion declined slightly (from 29% to 28%), but it still counts close to half a million people, whereas this proportion has dropped from 22% to 19% in Quebec as a whole. In both cases, the percentages include more women than men. We estimate that the increase observed for Quebec since 1990 also applies to Montreal.

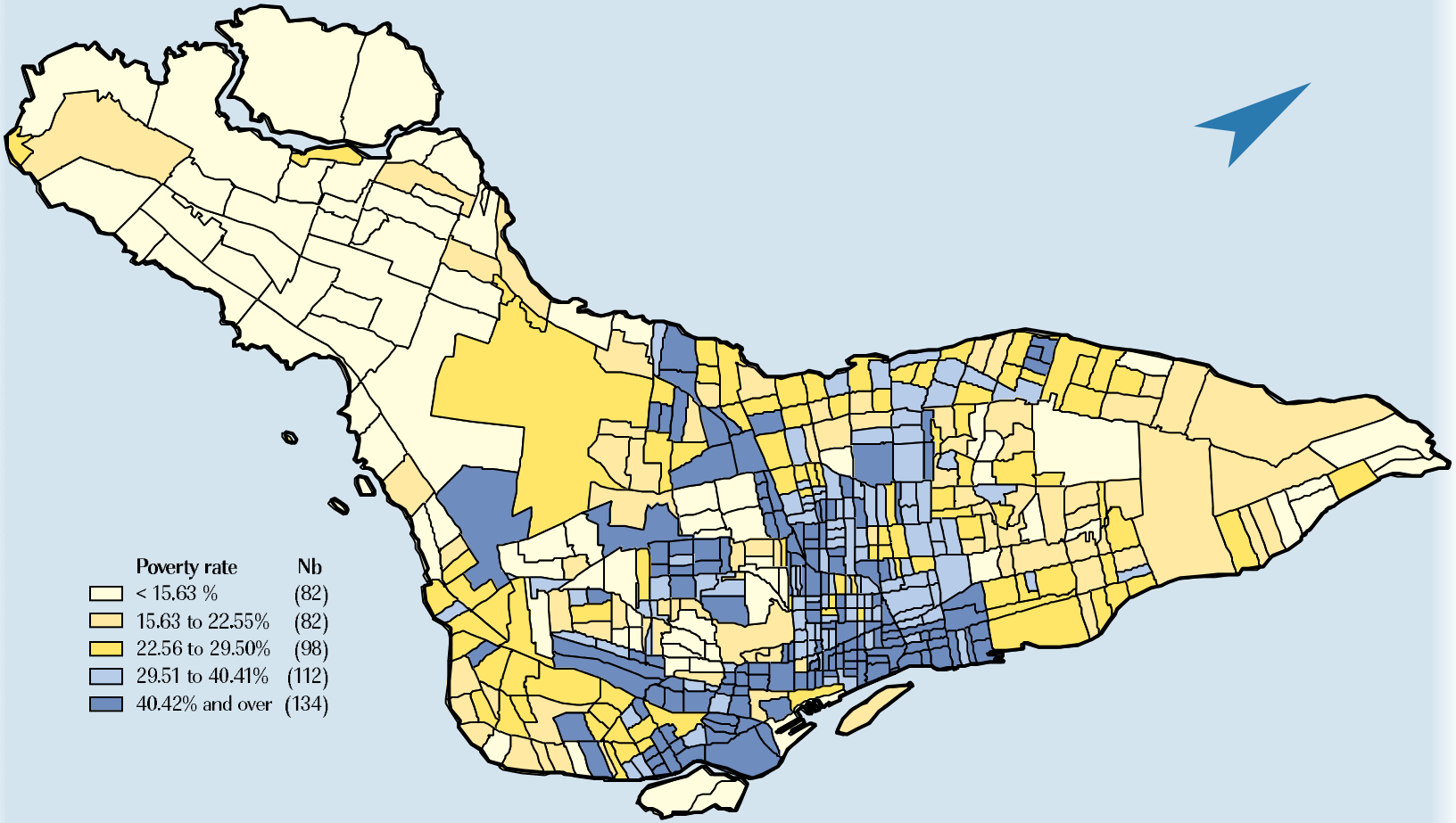
But Montreal also has another face: an unequalled concentration of wealth. Some municipalities stand out with the highest incomes per household in Canada. Others, in contrast, post a rate of low-income earners strikingly higher than the Canadian average. This is the case for the municipality of Montreal itself which counts roughly 330,000 residents living below the low-income threshold or about two-thirds of the region's inhabitants who fall into that category.

The map of the Island of Montreal depicting census districts[2] by the percentage of people living below the low-income threshold shows why some speak of two Montreals. It illustrates the concentration of poverty in the Island's south-central and eastern sectors.



[2] Territorial units of 2,000 to 8,000 persons.

Percentage of people living below the low-income threshold by census district, Montreal-Centre, 1990

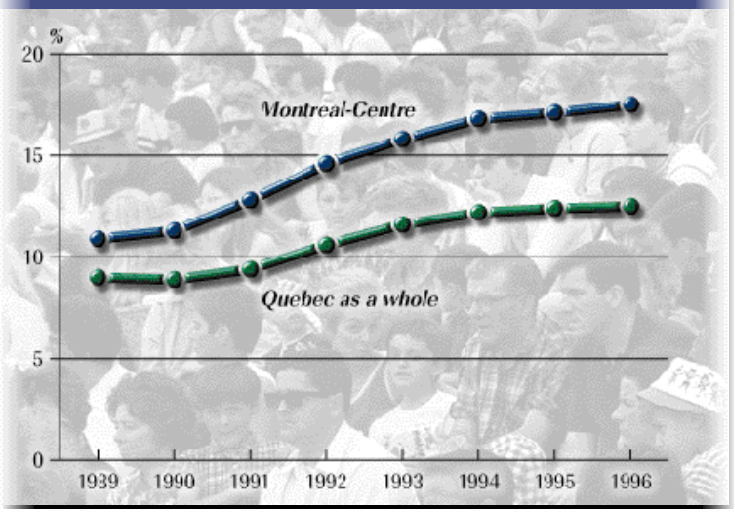


100,000 added to social assistance rolls in 7 years

Montreal ranks third in Quebec as regards the proportion of people living on social assistance. We know that, since 1989, the number of welfare recipients has been increasing all over Quebec and even faster in Montreal where, from 1989 to 1996, it has climbed from 11% to 18%. No matter what the causes (fewer jobs, harder access to employment insurance, and shorter periods of benefits), the fact remains that more Montrealers depend on state welfare: Montrealers have no doubt grown poorer from 1991 to 1996. In 1995, for example, more than 30% of the residents of the Island's five central CLSC districts depended on social assistance.

fig. 4

Percentage of welfare recipients, Montreal-Centre and Quebec as a whole, 1989 to 1996

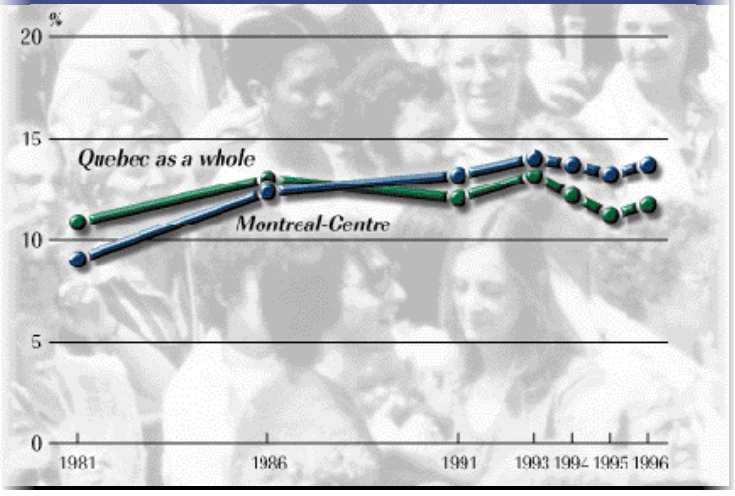


Unemployed and working poor

From 1991 to 1996, Montreal's annual rate of unemployment has never dropped below 13% (steadily higher than that for Quebec as a whole), whereas in the 80s Montreal was outperforming the rest of Quebec. This reversal is a stark reflection of the city's decline over recent years. In 1997, the declining trend in unemployment for Quebec as a whole seems to coincide with a slight increase in jobs, but only hindsight will tell whether this heralds true economic recovery. When we add to these rates the long-term unemployed who no longer seek jobs; welfare recipients; and part-time workers, we end up with a figure representing one Quebecer in five.

fig. 5

Percentage of unemployed, Montreal-Centre and Quebec as a whole, 1981 to 1996



In some regional municipalities with a high proportion of 15-and-over jobless, we have already observed a higher frequency of illnesses and social problems coupled with poor academic performance as well as high rates of drop out, delinquency, and alcoholism. A good job procures not only a decent income but is also, in itself, a factor of social worth which facilitates social integration. This increases the sense of control over one's destiny and relieves stress: two important concepts in understanding the impact of poverty on health. Finally, though the unemployment rate represents only a portion of those excluded from the job market, it does give a picture of the employment situation.

Having a job is not always a bulwark against poverty. Today, with job instability, many workers — unable to earn a living wage from their unstable and poorly paid part-time jobs — are poor. According to some observers, the current modest economic recovery makes no room for job creation. Yet this is what Montreal would truly need; for a stable job often remains the solution to poverty, as we shall see below.

Percentage of population living below the low-income threshold according to participation in the job market, 1991

	Number	% below the threshold of poverty
Employed	806,695	14.9 %
Unemployed	122,425	40.6 %
Inactive	522,005	41.6 %

Recent immigrants: a Montreal feature

The large number of refugees and recent immigrants living in precarious economic circumstances is also a Montreal feature. Statistics from the *ministère de la Sécurité de revenu* bears witness to this fact: in the spring of 1996, 60% of children on social assistance were living in families whose adult members had been born outside Canada. These newcomers are generally in good health and very eager to improve their situation and that of their children. For most of them, this poverty is circumstantial: after a few years, these new Montrealers usually do very well. However, if the economic situation does not

improve, these newcomers might stay on social assistance longer or get stuck in underpaid jobs that make a waste of their qualifications.

Why Make an Issue of Poverty?

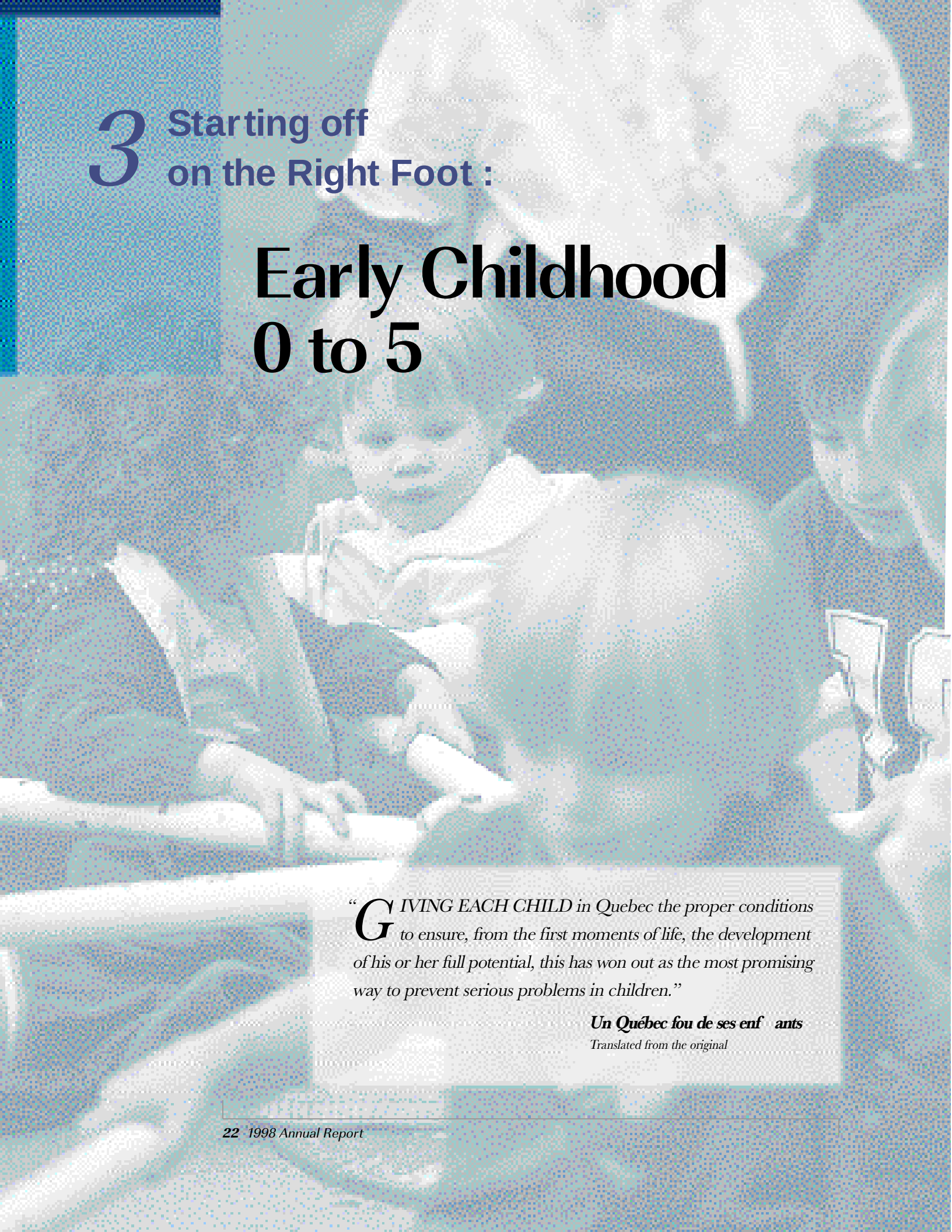
In Montreal, these half a million men and women living below the low-income threshold — equal to the population of a region the size of Mauricie-Bois-Francs — are in poorer health than their more fortunate fellow citizens. This is a constant, across time and throughout the developed world: the poorest die earlier and are in poorer health than the rich.

After years of the welfare state, with universal and free access to medical and hospital care and the establishment of systems of social protection to improve health and well-being, we observe that inequalities persist. This constitutes a major challenge for decision-makers, because lightening the load of health and social problems among the most underprivileged might prove the best strategy, both here and abroad, to improve the health of the population as a whole.

We believe that the situation is not irreversible. It is not preordained. Montreal does have certain trump cards: it is a big city, a major economic and cosmopolitan centre in the heart of a region containing almost half the population of Quebec; it is well equipped in resources and infrastructures (including several universities); and its population is well educated. Montreal can also count on other types of dynamic forces, notably several hundreds of local community groups which are close to grassroots needs.

For anyone interested in public health, social inequalities in health must be a major concern. But we now know that the solution is not to invest more in the health system or in new technologies. These inequalities must rather be met head on; and well-targeted actions must be undertaken to ensure that they will not become worse.

In sections 3 to 6, we move on to examine the health of Montreal's population at four different stages of life: early childhood, youth, adulthood, and old age.



3 Starting off on the Right Foot :

Early Childhood 0 to 5

"GIVING EACH CHILD in Quebec the proper conditions to ensure, from the first moments of life, the development of his or her full potential, this has won out as the most promising way to prevent serious problems in children."

Un Québec fou de ses enf ants

Translated from the original

The vast majority of children in Montreal do enjoy the conditions needed for their healthy development. However, they are not all born equal.

In this context, our main concern is for young children and their families who live in underprivileged and very precarious conditions. This means overcrowded or insalubrious housing, lack of food, disturbed family relations, unhealthy lifestyles, lack of social support, and absence of recreational facilities. Among the many factors explaining such a situation, we would single out the fragility of family ties in our society, but all of them present a threat to the development of young children.

We are well aware that poverty and its procession of privations all too often leave scars that will stay with these children throughout their lives, scars that they will perhaps transmit to their own children. We must nonetheless refrain from concluding that all children of poor families will necessarily be stunted by these privations. As the *Policy on Health and Well-being* is careful to underline, *"...most poor families manage to offer their children a good home life,"* pointing out that: *"in conditions of equal poverty, the [children] least at risk are those where the environment offers the best social support."*

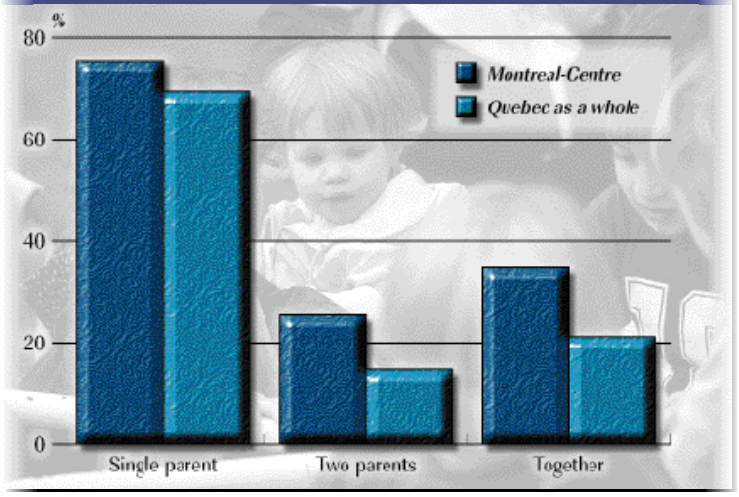
When economic and political conditions dictate restrictions, what priority should be chosen? Without hesitation: underprivileged infants and their families go to the head of the line. Fortunately, whether on the local, regional, or provincial level, there is a consensus on this priority and on the need to act early in supporting families with young children and in creating more favourable environments for their development.

A Quarter of Young Children on Social Assistance

How many poor children are there in Montreal? Two indicators, the proportion of young children living below the low-income threshold and the proportion living on social assistance, give us some idea of the hardships of poor families with young children and the levels of poverty among these families.

fig. 6

Percentaage of children under 6 living below the low-income threshold according to type of family, Montreal-Centre and Quebec as a whole, 1990



The phenomenon of poverty among children is more marked in Montreal: more than one child in three (roughly 43,000) for Montreal against one child in five for the whole of Quebec. In single-parent families this proportion climbs to three children in four. This last statistic is worthy of note, since Montreal counts many more children under 6 living in single-parent families (19% to 12%).

What is more, recent years have seen families with young children become even poorer: children under 6 living on welfare jumped from 20% in 1990 to 27% in 1996.

Influence of Poverty on Health

When a family is trapped in extreme poverty, its young children may be affected in a number of ways: lack of stimulation and socialization, abuse, neglect, family violence, absence of the father; nutritional deficits; tooth decay; deterioration of physical environment (due notably to parents' smoking); contagious diseases preventable by vaccination; injuries, burns, poisonings. This is compounded by the fact that, in these milieus, services for young children are often poorly coordinated and organized[1]. These preventable problems may touch all children but they are more frequent and more serious among the poorest.

To illustrate these inequalities, we have selected three indicators whose evolution is easy to track over time: infant mortality, low birth weight, and hospitalizations. In addition, we will later open a window on psychosocial problems with a look at the abuse and neglect of children.

[1] *L'état de situation pour la région de Montréal — Partenaires pour la santé et le bien-être des tout-petits,* I996. Direction de la santé publique de Montréal-Centre.

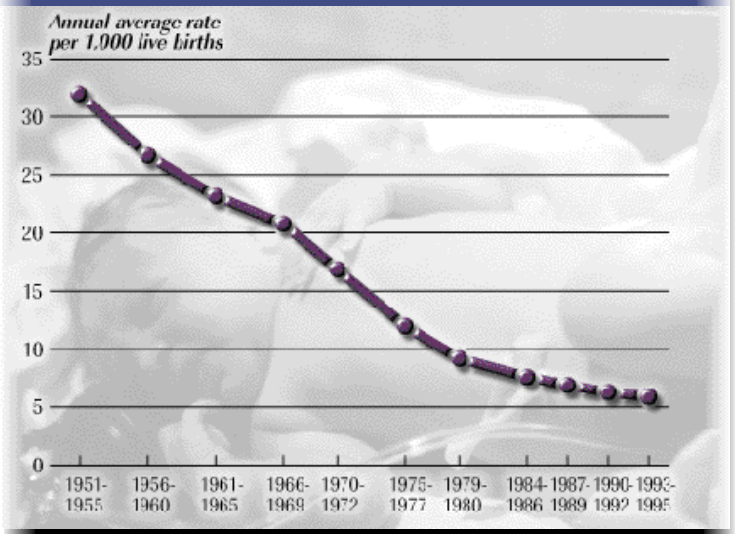
Infant mortality : excellent results

Even in countries with accessible health services, the mortality of infants under one often remains tied to parents' poverty and lack of schooling.

Over the last 40 years in Quebec, the mortality for children under one has constantly declined. In the early 50s, it was not unusual to lose a child at birth or in its first year: infant mortality dropped from 32 in 1,000 to 6 in 1,000 in 1993-1995.

fig. 7

Infant mortality rate, Montreal-Centre, 1951-1955 to 1993-1995



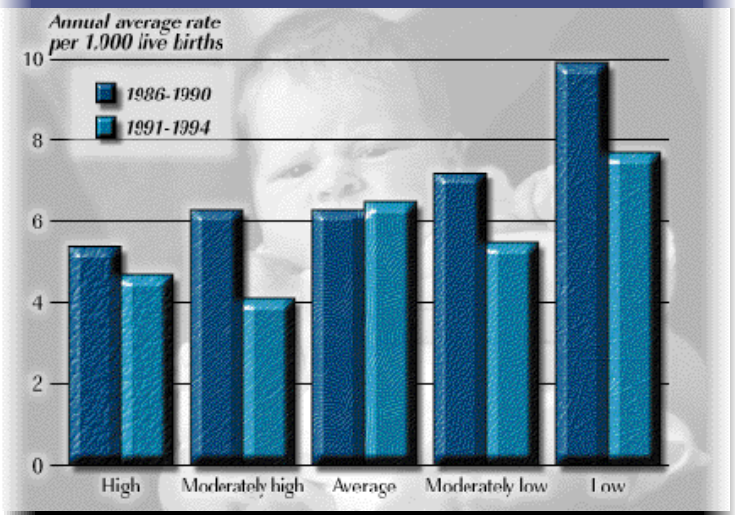
As is the case for Quebec, Canada, the Scandinavian countries, and a few European countries, Montreal today posts one of the lowest infant mortality rates in the world, ahead of the United States (9 in 1,000), France (8 in 1,000), and the United Kingdom (7 in 1,000), but behind Japan (4 in 1,000).

But inequalities persist

However, these figures mask stark inequalities. In our region, infant mortality follows a trend which is inversely related to income: it gradually increases as we move from high-income to low-income zones. In 1986-1990, with 10 deaths per 1,000 births, the low-income zones registered almost double the rate of higher income zones.

fig. 8

Infant mortality rate according to income, Montreal-Centre, 1986-1990 to 1991-1994



In 1991-1994 the situation did, however, seem to improve and the gap narrowed: the rate dropped below 8 per 1,000 for the low-income zones and stayed around 5 for high-income zones — an unacceptable and correctable difference. This improvement can doubtless be explained by the 10 years of hard work devoted to programmes in prevention and perinatal care aimed at underprivileged clients.

We know it is possible to improve things. Close to 50% of deaths in the first year of life can be attributed to perinatal problems — complications during pregnancy or delivery affecting the fœtus, premature birth and low birth weight — all problems for which there are preventive measures.

Low birth weight: a priority target

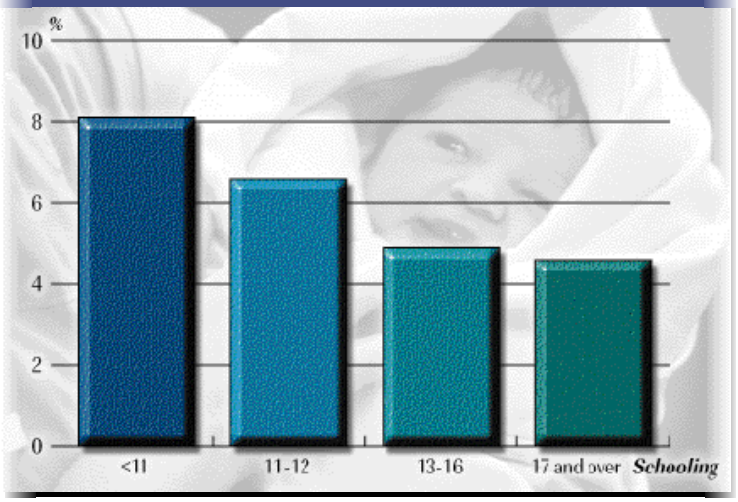
As a rule, more than 9 newborns out of 10 weigh at least 2.5 kilos. Babies with a low birth weight run greater risks of mortality, sickness, and developmental problems. In more than one case in two, low birth weight and premature birth (37 weeks) go hand in hand. And since we know how to prevent these two problems, we must stress prevention, especially with mothers under 18 and those over 35 who, as we know, are more at risk.

In Montreal as in the rest of Quebec, decline in the low-birth-weight rate seems to have stalled around 6%, whereas the Maritimes, the West, and Ontario had already pushed their rate below the *Policy's* 4% target 10 years ago. Reducing the number of low-weight births must thus remain a priority, especially since this target is not being attained as forecast.

Inequalities can be reduced

fig. 9

Percentage of low-weight bir ths according to mother's level of education, Montreal-Centre, 1993-1995



Another noteworthy variable is the mother's level of education: the higher this level, the lower the proportion of low-weight births. For mothers with 11 years of schooling and less, the rate is double that for those with 17 years and up. A low level of education plays the same role as low income: it defines the socio-economic level of the birth family.

In underprivileged areas, the already higher risk of having low-weight babies is amplified by the fertility rate of their adolescent members, which is six times higher than that among the wealthier. Aside from age, two of the other known risk factors are the mother's inadequate diet and body weight (less than 45 kilos) and her smoking habit. These are modifiable factors and should be targeted for prevention during pregnancy, even though they may be hard to change, given the mother's living conditions.

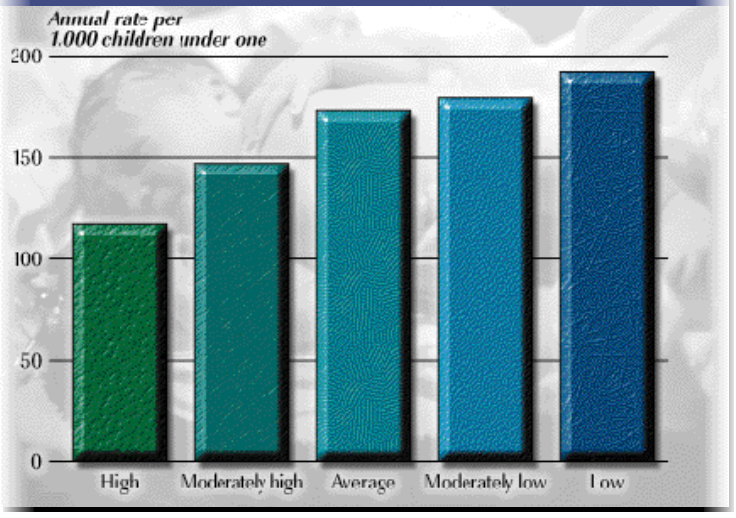
There are things we can do: create environments more favourable to the birth and development of healthy children. Based on current experience, we can count on the effectiveness of programmes such as *Naître égaux — Grandir en santé*. Launched in 1989, this programme is designed to help families living in extreme poverty. It has had a demonstrably positive impact on such things as the weight of newborns, the proportion of births brought to term, and the reduction of perinatal deaths. The programme's strategy is built on an intersectorial network of local resources (community organizations, day-care facilities, CLSCs, Centres Travail Québec, Department of Public Health). Partners from these various bodies have come together to develop a common plan of action tailored to the families' needs, and they have achieved remarkable results: improvement of living conditions (especially nutrition), support for the parent, development of the child, comprehensive and personalized

follow-up, and guidance toward a variety of community groups. The Regional Board, along with a team from our Department, ensures the implementation of these projects in 8 CLSC districts classified as underprivileged. As advocated in the *Québec Priorities in Public Health: 1997-2002*, we hope that, by the year 2002, this programme will have reached at least 50% of poorly educated pregnant women living in extreme poverty.

Preventable causes of hospitalization

fig. 10

Rate of hospitalization among children under one according to income, Montreal-Centre, 1993-1995



The higher frequency of hospitalization among the underprivileged also reflects inequalities in health: there are 65% more hospitalizations among children under one and 55% more among those 1 to 4.

Respiratory diseases rank as the leading cause of hospitalization: 4 out of 10. As the link between these statistics and smoking has already been proven, we conclude that persuading family members to stop smoking would be a first step in avoiding some of these hospitalizations.

Injuries represent a non-negligible 6% of hospitalizations; of this figure, falls in the home account for more than half the hospitalizations among children under one and for more than a third among those 1 to 5. An increased risk is observed in underprivileged sectors in the case of burns from hot liquids, hot objects, corrosive substances, or steam and in the case of falls from play equipment in parks.

Once again, we see that prevention is possible: creating safer environments and advocating safety would surely help reduce the higher frequency of hospitalization among underprivileged infants.

Violence and Neglect: Giving Children a Voice

Abused and neglected infants are, in the truest sense, forlorn. Defenseless and voiceless, totally dependent on their family milieu, they are powerless to go and seek comfort from outside resources.

Though they spare no stratum of society, violence against and neglect of children often go together with poverty and a weak social network. Parents in such reduced circumstances experience many forms of stress: lack of money is amplified by problems such as emotional distress and drug addiction. Social isolation also appears to be common.

"Starting life without the security of a loving and caring family, being the innocent victim of rage and frustration, being cold or hungry, being never or rarely cuddled, starting off on the wrong foot in life is both tragic and unacceptable."
Cal Gutkin M.D.

The tip of the iceberg

For the present, no one yet knows the true scope of these situations, but we surmise that the cases reported to the Youth Protection Department are only the tip of the iceberg.

We are not talking about marginal cases: in 1995, the Youth Protection Office evaluated 1,505 cases for children under 6 and in 50% of these cases the conclusion was that the child's safety was in jeopardy. Neglect is *the* leading motive for reporting a case, whereas there are proportionally fewer of the more sensationalized cases of sexual abuse.

- 1,172 cases of neglect. . . . . 78 %
- 163 cases of physical abuse . . . . . 11 %
- 131 cases of sexual abuse. . . . . 9 %
- 33 cases of abandonment
- 6 cases of behaviour problems

In force since 1979, the *Youth Protection Act* has put in place a good system of notification. Wishing to add better measures of prevention, the government, in 1990, published broad orientations favouring strategies that would combine protective and global upstream measures. The Department of Public Health is contributing to these programmes.

Orientations: A Stitch in Time...

In the current context of impoverishment and drained resources, the number-one priority is underprivileged children, because they have no voice. This is why we advocate taking strong action based on four orientations:

- Applying strategies at the community, family, and individual level
- Supporting families in difficulty and keeping in close contact with them
- Supporting community energy and initiatives (parent, family centres...)
- Revalorizing parenting, helping develop the parent-child bond, and helping parents to feel more competent

To achieve these objectives, efforts must be made on two levels: promotion and support of all those involved at neighbourhood and regional levels, and promotion of public policies. Partnership and cooperation are the key to prevention especially in underprivileged areas and especially between hospitals, CLSCs, and attending physicians. All the forces of the social milieu must join in the pursuit of these objectives — community groups, schools, day-care facilities, municipalities, Regional Health Board, income security agencies, the police, public safety agencies, and the families themselves.

Finally, at the state level, there must be policies giving priority to young children and families living in poverty, whether this has to do with transfer programmes (family and income policies) or policies (employment and housing) to help families escape from chronic poverty and favour their integration.

4 A Time to Learn :

Youth 6 to 24

Like most of those working with youth[1], we note that the majority of them are in good health. Youth see themselves as such despite the often difficult context in which they live. They describe themselves as having strong wills, resistance to stress, and a strong capacity to adapt and learn. According to the expression coined by the report, ***Un Québec fou de ses enfants*** *, youth embody "a tremendous power of actuality."[3]*

But, just as with its infants, Montreal's youth do not all face the future on equal terms. Many are experiencing the harsh reality of poverty[2]: lack of money, failure or drop out, precarious jobs, isolation, solitude, loss of self-esteem. They are poor and it shows. All the existing social services notwithstanding, they cannot manage to meet their basic needs; they see themselves in a dead-end, at school, on the job market, in the network. They have no future. If something is not done for them, the consequences on the individual and social level may be serious.

1 "Youth" designates children of school age (6 to 11) as well as adolescents (12 to 17) and young adults (18 to 24), all groups with their own specific characteristics.

2 See *Dites à tout le monde qu'on existe,* Avis sur la pauvreté des jeunes, Conseil permanent de la jeunesse.

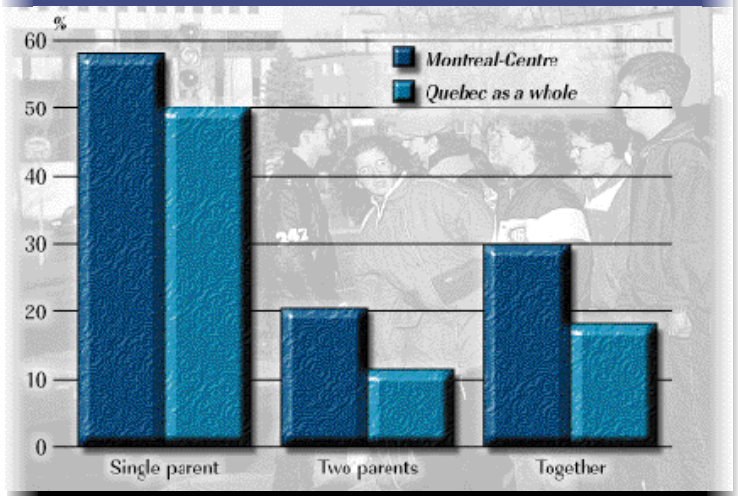
3 Translation of "une formidable force du présent".

Greater Numbers of Disadvantaged Youth

There are relatively more youth living below the low-income threshold in Montreal than in Quebec as a whole: more than 128,000 (about 30%) in Montreal against 18% in Quebec as a whole. In single-parent families, close to 60% of 6-to-17 year olds live below the low-income threshold, as compared with 20% in families with both parents.

fig. 11

Percentage of youth 6 to 17 living below the low-income threshold according to type of family, Montreal-Centre and Quebec as a whole, 1990



The most recent data for Montreal date from 1990: there is a slight drop in the proportion from 1985 to 1990, but as the trend has been rising in Quebec as a whole since 1991, chances are it is also rising in Montreal.

More and more youth depend on social assistance: from 1991 to 1996, the proportion of children and adolescents living on social assistance has practically doubled, climbing from about 10% to 20%. We are troubled by the situation of these youth who are among the poorest of the poor.

Harder and harder to find a job

We are concerned about job-seeking youth who find no work, whether they are dropouts or graduates, because there is an observed link between employment and better health.

How many youth are in this situation? It is hard to know, as not all follow the same academic path. We do however know that, in 1991, more than 50% of youth in the 20- to-24 age bracket had not attended school for at least 9 months and were thus available for work. Though the employment rate gives only a partial view of the situation of youth who have no job and are no longer engaged in studies, it does give some idea of the problem. The highest unemployment rates are found among youth: in Montreal, it hovers around 20% for those aged 15 to 24.

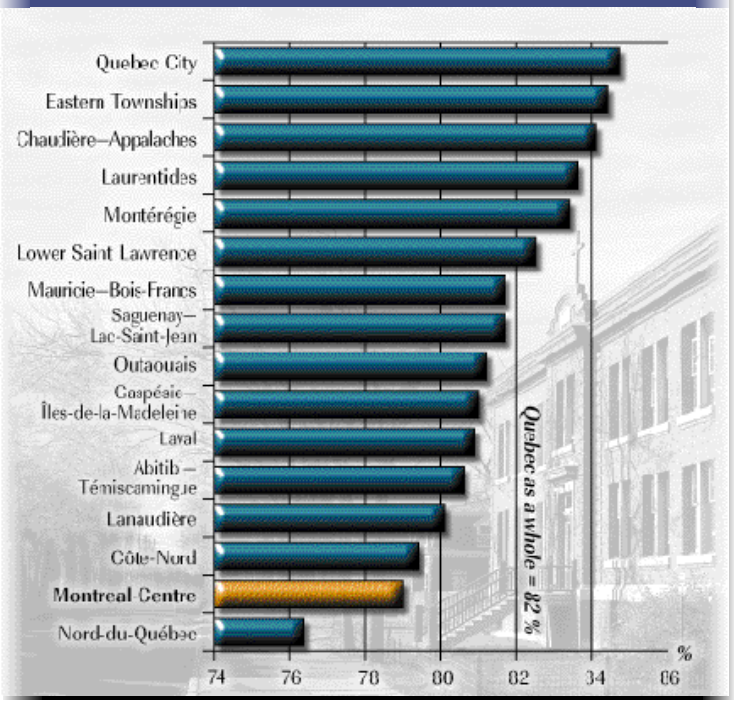
This reflects, on the one hand, the negative trend of an increasingly stringent job market and, on the other hand, the dwindling prospects of the dropouts and poorly educated who find themselves even more handicapped by the current economic situation.

Wide Gaps in Academic Performance

A higher level of education increases your chances of finding a stable, well-paid job. Education improves your ability to run your life and deal with change; it reinforces the feeling that you have some control over your destiny. All these factors have a positive bearing on health.

fig. 12

Performance on secondary leaving examinations according to administrative region, Quebec, June 1994



One of the priorities set by the ministerial plan of action for school reform is to provide support for Montreal's school system. One of the major motivations for this reform is precisely the inequalities in academic performance observed in the Montreal school system.

Second to last on secondary leaving examinations

The performance of Montreal school boards on the 1994 secondary leaving examinations fell below the Quebec average and Montreal ranked second to last among the regions, just ahead of Northern Quebec, which clearly testifies to special difficulties plaguing Montreal schools.

Significant gaps are observed between different sectors on the Island. Schools in underprivileged areas (which are also often those hosting most of the newcomers) are having a harder time. In these schools, the percentage of students falling behind in their studies is almost double that of schools in wealthier areas: 34% in the last year of primary and 65% in the first year of secondary vs 18% and 35%, respectively.

The same is observed for the rate of graduation after 7 years of schooling, an indicator which accounts for poor academic performance and dropout. Sixty-seven percent of the cohort of students entering secondary I in 1987 graduated in 1994, the same proportion as in Quebec as a whole. The percentage of non-graduates is thus very high (33%), but it varies enormously from one school board to the next, ranging from 4% to 40 %. We note that this gap is also associated with socioeconomic status: almost all the schools attended by students from underprivileged areas show the lowest graduation rates.

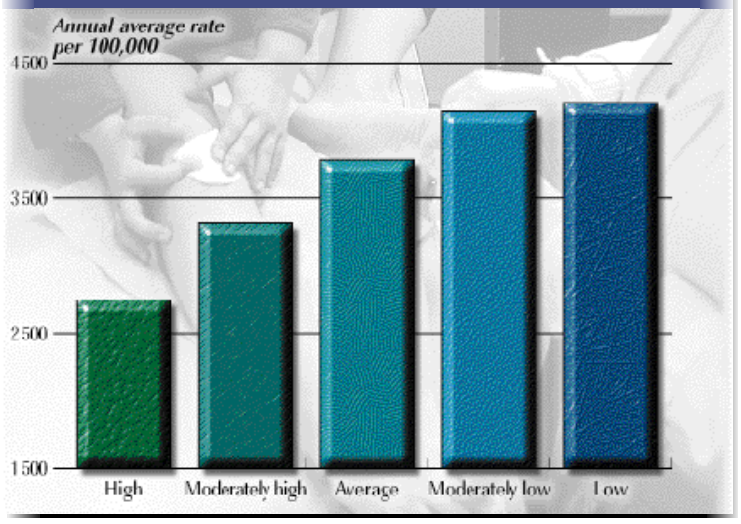
In short, youth from Montreal's underprivileged milieus struggle with a double handicap: not only are they poor, but they have slimmer hopes of using education as a lever to improve their lot. This shows why support must be provided to Montreal schools, especially those in underprivileged areas. Academic failure is often only the symptom of more deep-seated problems confronting students and their families.

Influence of Poverty on Health

The health and well-being of youth aged 6 to 24 are closely linked to their socioeconomic status. Similarly, the frequency of hospitalization in this age bracket is tied to income: the lower the income, the higher the rate of hospitalization. There is an almost 67% gap between the low and high-income groups. Other indicators are examined in the following sections.

fig. 13

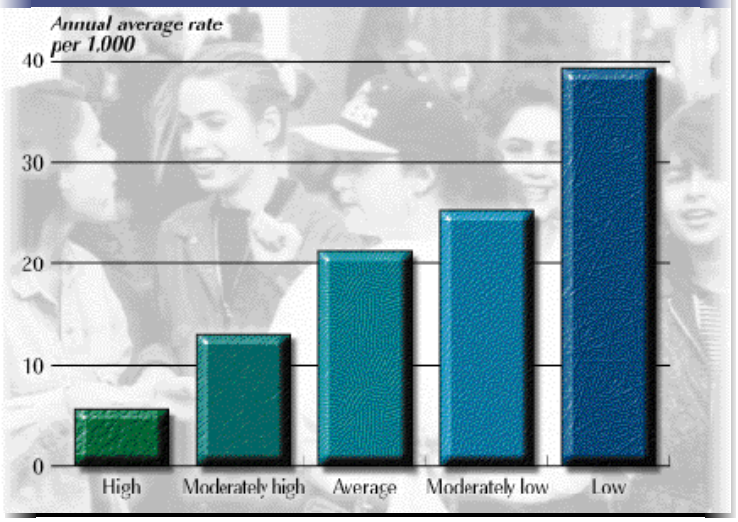
Hospitalization rate among youth 5 to 24 according to income, Montreal-Centre, 1993-1995



6 times more pregnancies among low-income adolescents

fig. 14

Fertility rate among girls from 15 to 19 according to income, Montreal-Centre, 1991-1994



As a whole, Montrealers in the 15-to-19 age group post pregnancy rates 40% higher than those for Quebec as a whole — with a 70% higher abortion rate. But the difference is still more striking when viewed from the socioeconomic perspective. Adolescent fertility rates — counting only live births — rise sharply as income declines: it is close to 6 times higher among low-income girls.

Malnutrition and overweight among school children

According to *Santé Québec*, weight problems concern our whole society, but recent data show that they are even more apparent among the young, particularly those from underprivileged backgrounds. According to a study of children aged 9 to 12 in 24 schools located in some of Montreal's multiethnic and underprivileged neighbourhoods, there were almost as many overweight as normal weight school children, notably among boys (48% vs 42%). This is an unusual situation which adds up to a lot of children who run higher risks of adult obesity with its resulting diseases: high blood pressure, diabetes, high cholesterol, and heart and circulatory diseases. Among Montrealers 15 and over (both male and female), obesity already affects a considerable number of people: according to *Santé Québec*, roughly one person in 4 was carrying too much weight in 1992-1993.

As well, inequalities in both the quality and quantity of food intake are observed between the most underprivileged groups and others. For example, elementary students in underprivileged neighbourhoods are more likely to suffer from malnutrition, receiving less than the average recommended intake of calcium. And it is an accepted fact that poor school performance is associated with malnutrition.

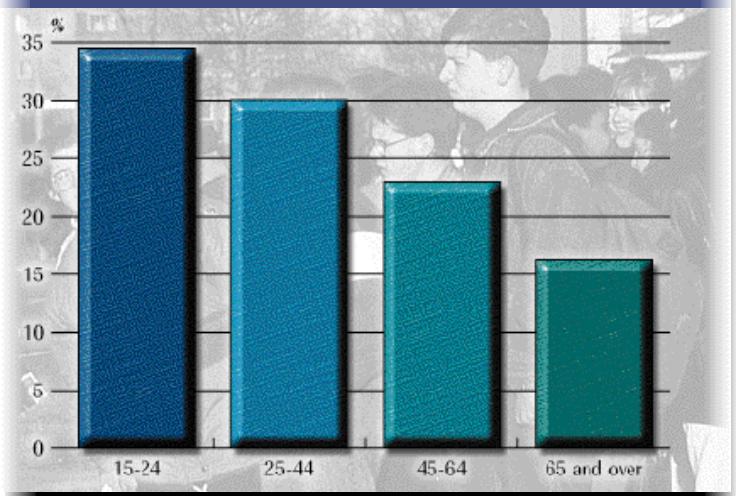
Youth: more prone to psychological distress

Psychological distress was used as a measure of mental health in surveys conducted in 1987 and in 1992-1993: the goal was to estimate the percentage of the population with symptoms which might lead to the need for specialized help. It is worth noting that the 15-to-24 group displays the highest psychological distress index: more than a third of them are affected (34.5%)

Currently available data do not allow comparison between youth from underprivileged backgrounds and others. However, for the population as a whole, it appears that psychological distress waxes as income dwindles. It has also been shown that low schooling, weak social networks, and self-perceived poor health go along with a high psychological distress index. In our view, these factors more than likely exert a similar influence on the mental health of young Montrealers.

fig. 15

Percentage of persons with a high level of psychological distress according to age, Montreal-Centre, 1992-1993



Suicide: leading cause of death

Suicide is the leading cause of death among youth aged 18 to 24 and Montreal posts an average of 31 deaths per year in this age bracket (especially among males) and 70 hospitalizations for suicide attempts. We know that youth aged 20 to 24 show the highest suicide rate. We will return to this question of suicide in the section on adults (p. 45). As for the link with socioeconomic status, we know that, when all age groups are combined, suicide touches twice as many people in low-income brackets.

Homeless youth: drugs, prostitution, HIV- AIDS:

Exactly how many homeless youth are there in Montreal? We have no assessment of the number of those who, from time to time, live on the

streets. Some say 2,000 young people between the ages of 18 and 30, others say 4,000 aged 12 to 35, but there is no way to know for sure because homelessness takes varied forms and is thus hard to assess: it can be episodic, short-term, recurrent, or continuous.

These young people are exposed to serious health problems, notably highly contagious and often fatal infections — HIV, hepatitis B and C, and STDs. Besides this, high-risk drug use (involving injection), unsafe sexual practices, and prostitution are very frequent.

Ten times more HIV

According to a study we conducted in 1995 with 919 street youth aged 13 to 25, their rate of HIV infection was 10 times higher than in the population at large, 36% of them had already injected drugs (58% with used syringes) and 37% of the girls and 21% of the boys said they had already prostituted themselves.

The above facts prompted us to pursue our investigation in order to trace the evolution of behaviour among these young people, with regard to their sexuality, drug consumption, and other factors linked to risk taking and changes in behaviour. Phase 2 of this study is now underway.

After a seven-month follow-up, we note that 7% have injected drugs for the first time, 12% having formerly done so went back to the practice, 10% borrowed a used needle for the first time, and 6% of them had their first brush with prostitution. Added to this, 63% report having seriously contemplated suicide, 38% of whom in the course of the last year. In fact, the death rate among these homeless youth is 10 times higher than usual for their age slot — especially death by overdose and suicide. The rates of hepatitis B (9% vs less than 5% in the larger population) and C (10% vs less than 1% in the population at large) are also very high.

These data have already proven very useful in planning better adapted and more effective projects and programmes. There is a project currently underway to rally the various regional youth workers around a

comprehensive service plan covering: the prevention and detection of STD-HIV; adolescent pregnancy; anti-hepatitis B vaccination; hepatitis C detection; and the detection and follow-up for drug addiction.

Higher level of violence in young couples

The sources of conjugal violence run deep and spring from a vast array of social problems involving both individuals and institutions, but rooted mainly in relations of domination and inequality between men and women. There is a scarcity of data on the scope of the phenomenon, but we do know that the reported incidence of conjugal violence is 70% higher in Montreal than in the rest of Quebec. It should be pointed out that the rate of reported incidents underrepresents the real rate of violence.

Violence against women occurs at all age levels, but it appears more prevalent among young couples. According to Statistics Canada (1993) young women constitute a very vulnerable group: the rate of aggression from a partner is four times higher. Similarly, *Santé Québec* (1995) estimates that the greatest number of victims are to be found in this group.

Aware that behaviour acquired in adolescence often lasts into adulthood, we can see that it is important to target youth, as one of our regional priorities advocates. The *"Montréal dit NON à la violence"* committee is running a communication campaign to inform and sensitize youth. In 1995, the Regional Board had already selected the prevention of violence against women as a priority and in 1996 the government of Quebec came out with its policy for preventing, detecting, and fighting conjugal violence.

Finally, violent incidents are reported by women from all socioeconomic backgrounds. But among the interrelated factors explaining such incidents, poverty and economic and psychological dependence on a partner are considered special signs of vulnerability. The highest rate of violence was, in fact, experienced by Canadian women with a household income below $15,000 (Statistics Canada, 1993).

Orientations: Better Collaboration with All Sectors

The social inequalities in health among young Montrealers pose many challenges. The problems are known but complex, and the solutions are not simple. For these problems which are at once social, familial, and personal, only innovative approaches involving youth as well as their families, their immediate life settings, and their general social environment can lead to real changes. This is the sense of our call to action.

In a context of tight resources, we must continue to invest what energies and resources we have into sectors where large numbers of vulnerable youth are living, especially since the optimal development of youth is one of the regional priorities.

At present, five CLSC districts are receiving professional and financial resources from the Regional Board in support of four strategies:

1. Development of personal and social skills in school
2. Constant and intensive support and guidance for vulnerable youth
3. Support and development of parenting skills
4. Development of favourable environments

And, in collaboration with the *centres jeunesse* and community centres, we have initiated a set of measures to prevent STD-HIV among very vulnerable youth, either those frequenting youth centres or living on the street.

Finally, there are certain needs in prevention and promotion which are still not being adequately met. So, in the footsteps of a conference attended by regional partners in prevention, a consensus was reached on orientations which mobilize all the actors.

Three of the orientations chosen have to do with optimal development of youth and are directly linked to their socioeconomic situation, especially if they are underprivileged:

- Integrating youth through academic success, job creation, and development of employability
- Supporting joint school-community action
- Providing support and guidance to youth in difficulty

Drawing on a special fund, field workers on the Island of Montreal have proposed innovative, joint projects which are scheduled to start up in early 1998.

These are the three orientations around which we would like to see schools and communities coordinate their activities, in order to meet youth and community needs more effectively. For its part, the Department of Public Health believes it can play a positive role by promoting collaboration between health and social services, schools, families, and communities.

5 *A Time to Work*

Adults 25 to 64

TODAY'S ADULTS must be very adaptable in order to handle the profound transformations of our society, transformations for which they are, in fact, partly responsible: transmutation of values, transformation of the family, disruptions in the work world, crumbling social networks...

Though they are, on the whole, doing better than their juniors or elders, a good number of today's adults are struggling against constraints linked to their participation in economic life, constraints which may trap them in a cycle of poverty: difficulty finding a place on the job market, whether this has to do with unstable and unpleasant jobs; periods of unemployment and stints on social assistance; precarious jobs; and, for older workers, the shock of being laid off at the height of their productivity with, as a consequence, the need for retraining and reintegration.

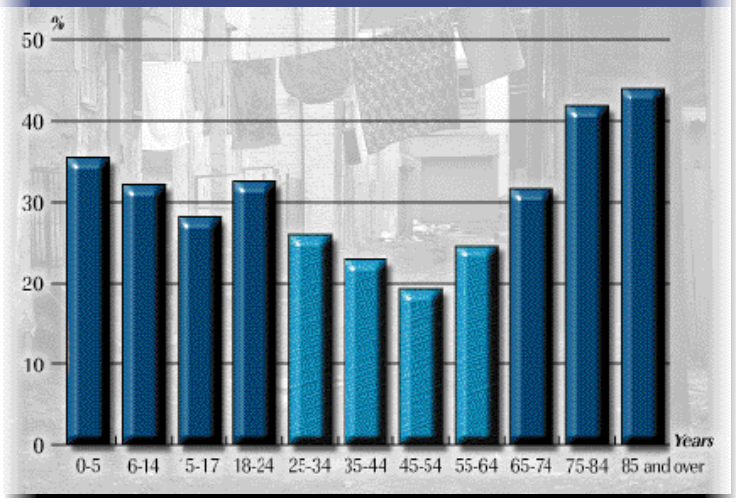
These are the conditions that lead us to examine the impact of social inequalities on health in adulthood, that period of life when chronic illnesses such as lung cancer and heart disease start to claim their victims and when AIDS strikes hardest.

Close to a Quarter of Adults below the Low-Income Threshold

Though the percentage of persons below the low-income threshold is high for all age groups, there are fewer 45-to-54 year olds in this situation (19%) than younger or older adults — a quarter of whom are living below the low-income threshold. We would also like to point out that, if low income is used as a criterion, women are poorer no matter what their age group.

fig. 16

Percentag e of persons below the low-income threshold according to a Montreal-Centre, 1990

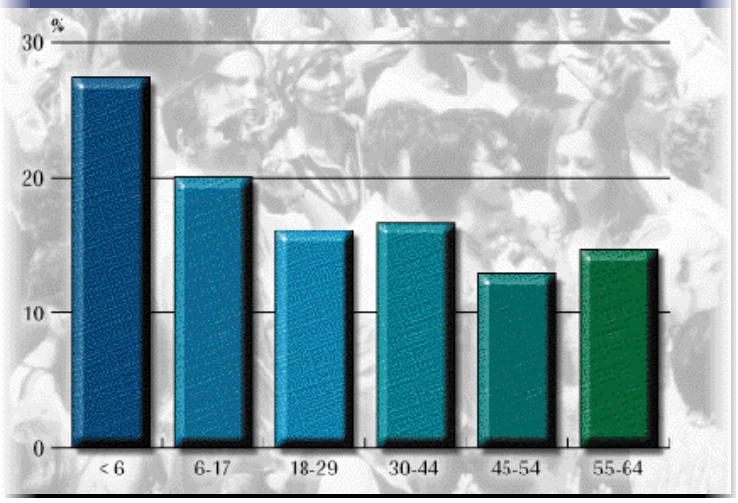


More 30-to-44 year olds on social assistance

The same trend is reflected in the 1996 income security data. Adults appear to be doing better than younger subjects: there is a clear cut-off between those under 18 and the other age groups. Among adults, those 45 to 54 are the least affected (13%) whereas those 30 to 44 are more so (17%).

fig. 17

Percentage of welfare recipients according to age, Montreal-Centre, 1996



Many unemployed among those 25 to 44

The proportion of unemployed workers declines with age and, since the mass of workers are adults, they are the ones most affected by the recent high rates of unemployment. In Montreal, the hardest hit by joblessness are males between the ages of 25 and 44 (14%); after the age of 45, the hardest hit are women.

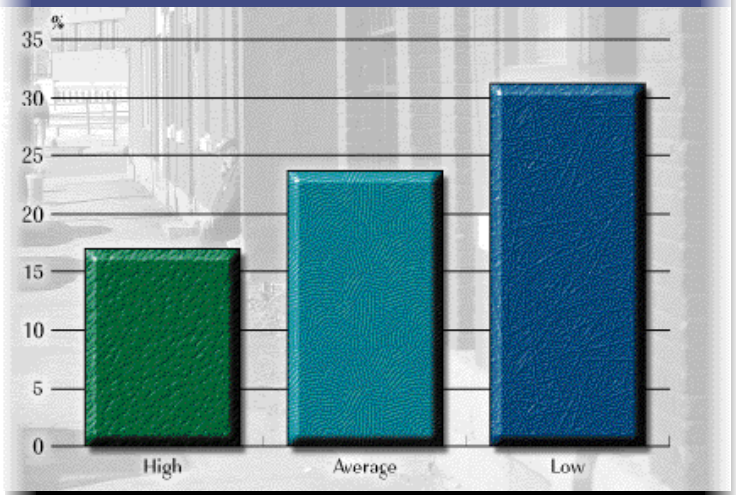
In our view, unemployment among adults aged 25 to 34 and among those over 55 reflects, to some extent, how hard it is, first of all, to join the job market and then how equally hard it is to re-enter the market after being laid off. As for women over 45, those coming onto the job market after a separation or after several years as a homemaker are the most likely to run up against these difficulties.

Social Isolation: Men More Vulnerable

Being able to count on a strong social network — mate, children, parents, friends, neighbours, work colleagues — is a very important factor in fostering health and well-being. Numerous studies establish a link between a weak social network and health problems. The social support index — the positive counterpart of social isolation — measures three interrelated dimensions: degree of participation in social life, satisfaction with one's social life, size and strength of support network.

fig. 18

Percentage of persons 25 to 64 with a weak social-support index according to income, Montreal-Centre, 1992-1993



It is among adults, especially men in the 45-to-64 age bracket, that a weak social support network is most often observed (25%). In this, Montreal is not really very different from the rest of Quebec (22% vs 20%), despite the fact that more people live alone in Montreal (18% vs 12%). But the relationship between social support and income level is very apparent: almost twice as many in the low-income group as in the high-income group.

Influence of Poverty on Health

Growing psychological distress

To better understand factors predisposing to psychological distress and thus facilitate prevention, this indicator should be related to the degree

of social isolation and poverty. With the data available it is not possible to make this link, but we do have some indications pointing in that direction. Studies show that poverty, low schooling, and a weak network of social support are associated with a high level of psychological distress. So, we may suppose that disadvantaged adults with these characteristics will probably not get by without high levels of psychological distress.

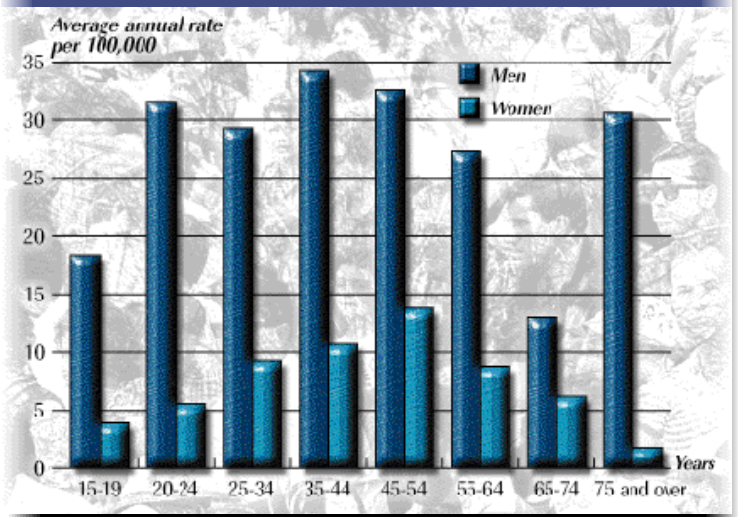
We note that Montrealers are not struggling with higher levels of distress than other Quebecers: the rates (27% and 26%) are practically the same. Setting aside youth between the ages of 15 and 24, the highest levels of psychological distress are seen among those aged 25 to 34 (30%). Moreover, in between the 1987 and 1992-1993 studies, a rising trend has been observed in both Montreal and in Quebec as a whole (from 21% to 27 %). This is perhaps not unrelated to the socioeconomic downturn. The next surveys should thus keep close track of this indicator in order to facilitate prevention.

Suicide: on the rise

We are here limiting ourselves to death by suicide even though the phenomenon is of a much broader scope. According to death records and the 1992-1993 social and health survey, each successful suicide recorded annually is matched by two hospitalizations for attempted suicide, 23 other suicide attempts, and 169 cases of people having contemplated suicide.

fig. 19

Suicide rate according to age and gender , Montreal-Centre, 1993-1995

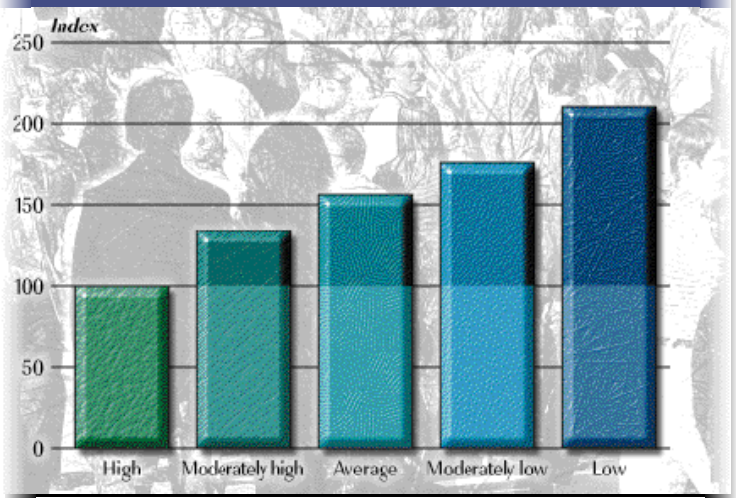


The most vulnerable group of Montrealers are those in the 35-to-44 age bracket, followed by those aged 45 to 54, then those 20 to 24. At every age and everywhere in Quebec, many more men than women commit suicide and, among women, the phenomenon rises up to the age of 54 and then subsides; inversely, there is a sharp increase in suicides among men after the age of 75.

Montreal has been seeing a rise in its suicide rate since 1992 and since slightly earlier for Quebec as a whole. The 1993-1995 period registers a 14% increase, with an annual average of 275 deaths. It might seem contradictory to observe that, while posting the highest rate of poverty, Montreal has the lowest suicide rate in Quebec, whereas we observe a strong link between poverty and suicide in our region. This may be explained by the fact that the relationship between socioeconomic conditions and suicide turns out to be very complex. Suicide is not caused by poverty, no more than it is by any other isolated factors: suicide involves an intricate weave of individual and environmental factors.

fig. 20

Suicide index according to income category, Montreal-Centre, 1991-1994



In short, even if Montreal seems slightly less affected than Quebec as a whole, we note a resurgence of suicides over the past 5 years. Many of these deaths could have been prevented. It is important to raise the priority of this problem. As one of the regions of the world with the highest rate of suicide among those aged 15 to 44, Quebec has made the prevention of suicide one of its national public-health priorities.

Smoking: very fragile gains

Smoking: another big factor in premature and preventable death. Among men and women in the 45-to-64 age group, lung cancer and coronary diseases are the two leading causes of death. It is a well-known fact that smoking is directly associated with more than 80% of lung cancers and at least 30% of coronary diseases, not to mention its impact on respiratory health, the health of the foetus, and the effects of second-hand smoke. It is calculated that, in developed countries, during the 90s, about 30% of all deaths among persons aged 35 to 69 could be attributed to smoking, which makes it the leading cause of premature deaths.

Smoking on the rise among young girls

There is, however, some good news: in 1992-1993, Montreal had 100,000 fewer smokers than in 1987, a 5% drop. These less numerous smokers were also smoking less: 10% said they smoked more than 25 cigarettes a day vs 18% 5 years before. Nonetheless, Quebec data for 1996 indicate a persistent rise in smoking among the young: close to 40% of Montrealers aged 25 to 44 already smoke and, from 1991 to 1994, the number of smokers among secondary school girls more than doubled, climbing from 17% to 37%.

Smoking is also considerably more prevalent among low-income groups: smoking drops gradually from 44% among the low-income group to 29% among high-income earners. In certain more underprivileged groups, where almost everyone smokes, this addiction is embedded in complex social or personal realities and needs to be dealt with from many different angles.

The total number of deaths attributed to tobacco use follows the same distribution as for cigarette use: the lower the income, the greater the number of victims. In comparison with the high-income group, there are 62% more deaths, 31% more cases of coronary disease, and 62% more lung cancers.

fig. 21

Percentage of smokers 15 and over according to income, Montreal-Centre, 1992-1993

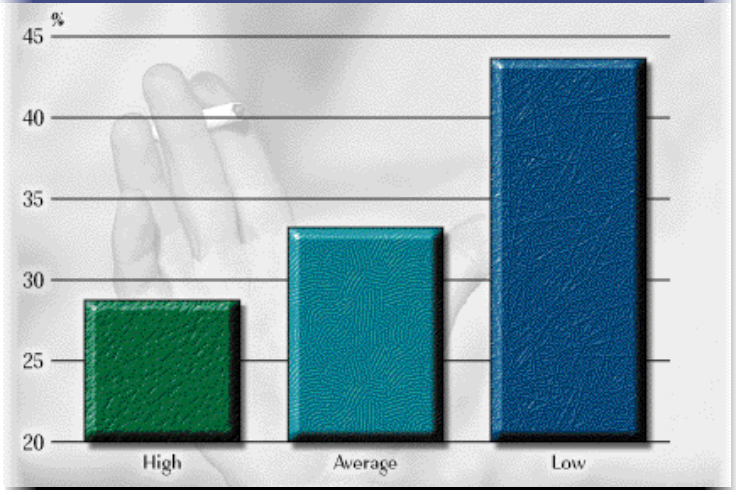
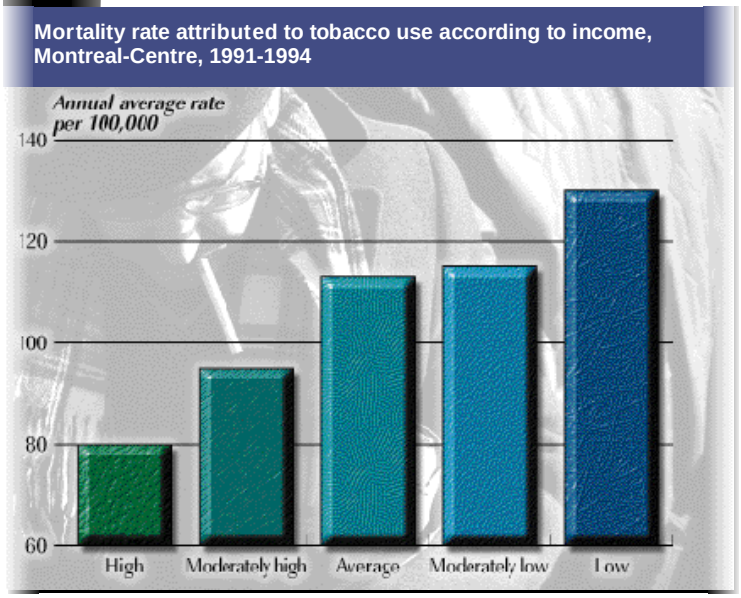


fig. 22

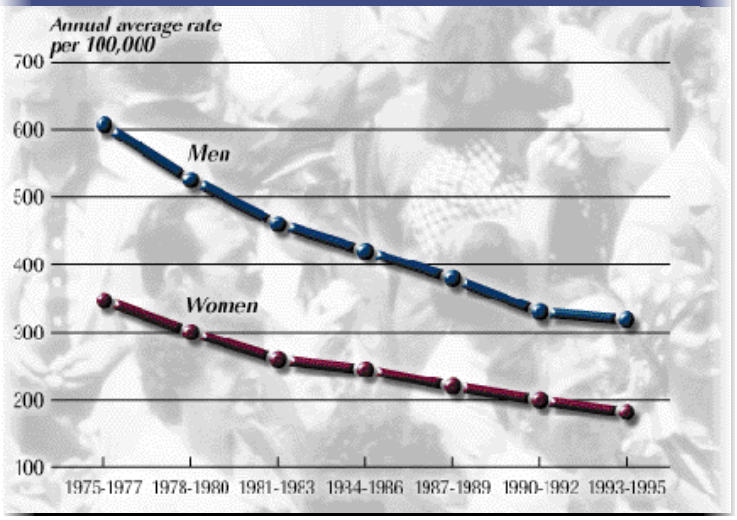
Mortality rate attributed to tobacco use according to income, Montreal-Centre, 1991-1994



Heart health: growing improvement

fig. 23

Mortality rate from cardio vascular diseases, Montreal-Centre, 1 975-1977 to 1993-1995



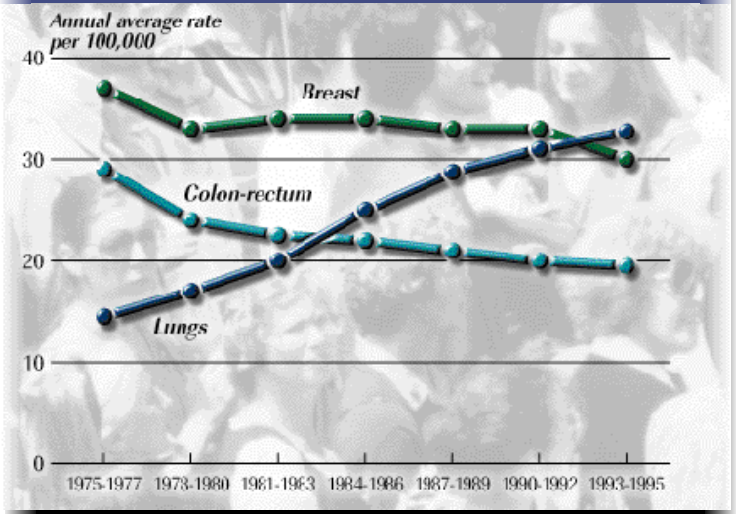
Good news: deaths from cardiovascular disease have been declining for over 20 years in Montreal. In this, Montreal compares favourably with the declining trends also observed in Quebec as a whole and in Canada. According to the experts, much of this is due to preventive measures (reduced smoking, healthier eating habits, control of high-blood pressure and blood cholesterol, increased physical activity) and to better methods of treatment. But it is possible to do better, since certain places such as France, for example, post even better results: there the rate is under 25% for men and just 23% for women.

Lung cancer: epidemic rise among women

Since 1992, lung cancer has pulled ahead of breast cancer as the leading cause of death among women. Just as deaths from breast cancer and colon-rectum cancer are slacking off, the death rate from lung cancer has shown a dramatic rise over the past 20 years among women everywhere in Quebec. Lung cancer does, however, remain less frequent than breast cancer among women. But, in a few years, lung cancer may prove a more devastating threat, especially since the detection and treatment of breast cancer are improving daily.

fig. 24

Mortality rate for women according to type of cancer, Montreal-Centre, 1975-1977 to 1993-1995



Young women must thus become more acutely aware of the serious threat smoking poses for their health. Tobacco use, especially among the underprivileged and young girls, remains a major public-health issue.

Breast cancer: national and regional priority

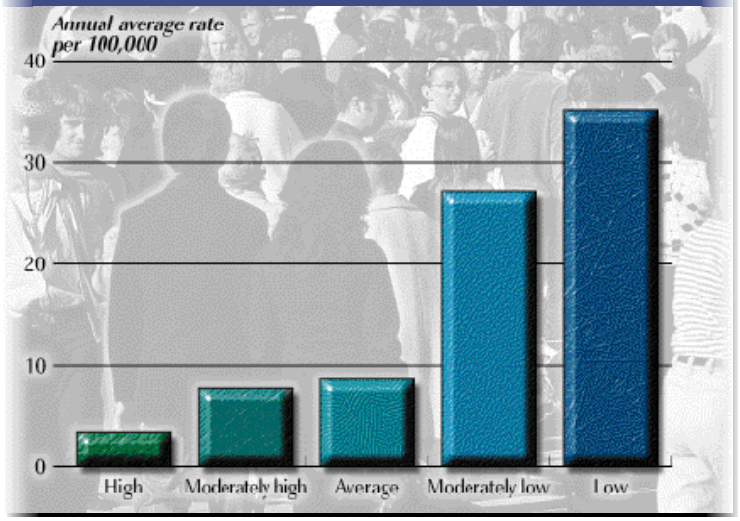
Given its frequency and fatality, breast cancer remains a priority among public-health issues. From 1991 to 1993, an annual average of 1,108 new cases of breast cancer have been diagnosed and, from 1993 to 1995, this disease caused an average of 412 deaths a year. Unlike lung cancer which has a stronger impact on the underprivileged, breast cancer is more evenly distributed. The fight against breast cancer is a regional and national priority: a systematic programme of detection is being set up throughout Quebec.

AIDS: prevention is still the priority

AIDS is a bigger problem in Montreal where, by 31 March 1997, 3,706 cases had been registered since the start of the epidemic: 77% of all the cases in Quebec. Young men, especially those aged 25 to 44, are the hardest hit and, we know that, to die from AIDS is often to die poor. The death rate by income group shows that there are 10 times more deaths from AIDS in the low-income group.

fig. 25

Mortality rate from AIDS according to income, Montreal-Centre, 1991-1994



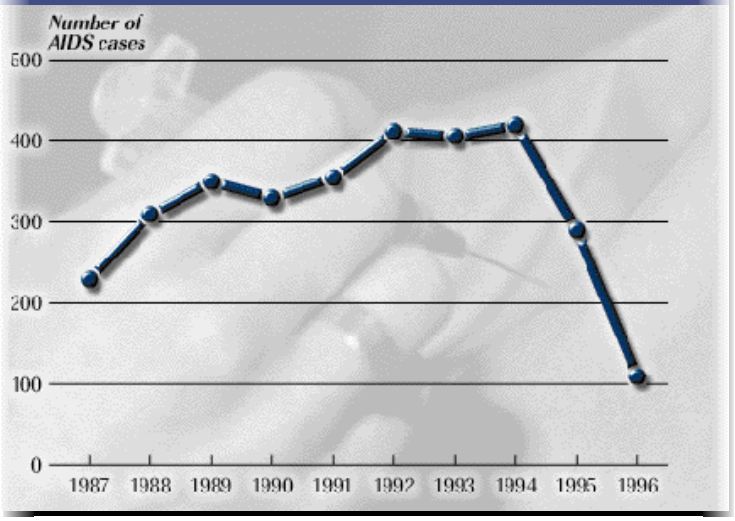
It is still difficult to interpret what seems to be the ever stronger link between poverty and AIDS. We may propose several inconclusive hypotheses. For example, a higher socioeconomic status — reflected in income and education — generally favours the adoption of preventive behaviours. Or perhaps (and even definitely for some) the poverty of AIDS patients may be a consequence of their illness and of the new treatments which keep them alive longer. The number of deaths occurring in underprivileged areas could also be inflated by the concentration (for any number of reasons) of the main group affected in a particular section of the city and by the local availability of a hospital and clinics treating large numbers of AIDS sufferers.

Since 1994, there has been a drop in the number of cases reported, whereas up until then it had been constantly climbing. New drugs may

have helped to slow down the appearance of AIDS in people infected with HIV. However, according to the experts, it is too soon to declare a victory over AIDS, as the drop in reported cases may be artificial. Some Canadian data even suggest that the number of HIV carriers and the factors of its propagation continue to increase from year to year. It must therefore be stressed that prevention still remains the best line of defense, as three-drug therapy may give a false sense of security.

fig. 26

Number of AIDS cases among persons 15 and over according to year of diagnosis, Montreal-Centre, 1987-1996



With more than three out of four cases of AIDS diagnosed in the 25-to-44 age group (9 out of 10 times a man), this is the leading cause of death in this age group where, with more than 225 deaths per year, AIDS kills two times more than suicide and 10 times more than accidents. Homosexuals and bisexuals (including intravenous drug users) are still the majority of cases reported (70%), despite a visible downward trend. In contrast, the disease is constantly on the rise among heterosexuals where cases are mainly linked to intravenous drug use which, since a decade, has been climbing wildly.

Orientations: Act where it Counts

Facing the need to guard against a rising tide of suicides, we must make suicide prevention more of a priority. As things now stand, our health promotion programmes aimed at children and youth stress orientations designed to improve the living conditions and psychosocial resources of individuals, families, and communities, especially those of underprivileged status. These are also the orientations underlying suicide prevention and those to which we must devote more programmes and resources.

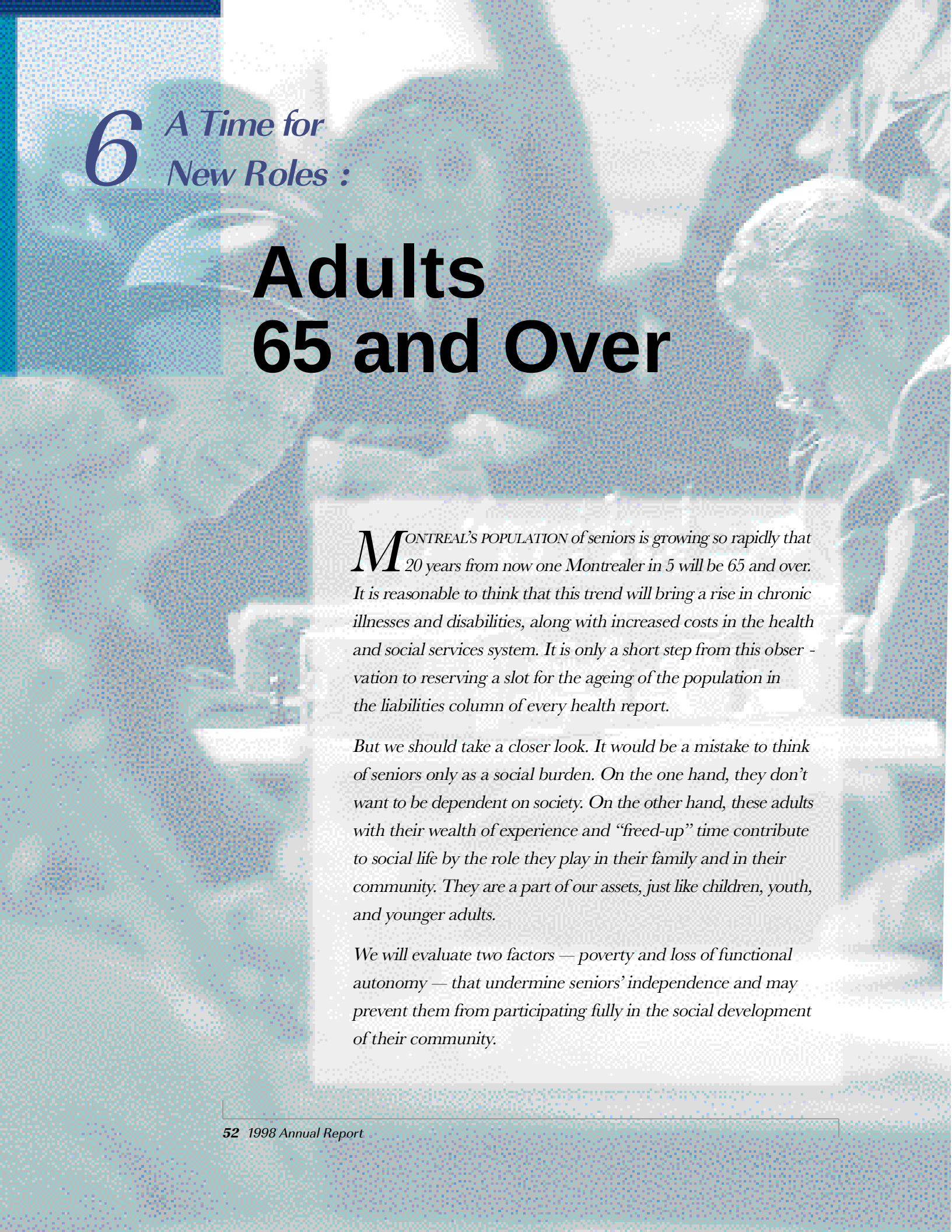
The prevention of coronary disease and lung cancer is closely linked to the fight against smoking. In view of this, the Department of Public Health must, in addition to strengthening its heart-health interventions, intensify its fight against smoking on several fronts: support for legisla-

tion tightening restrictions on, access to, and advertising for cigarettes; prevention among children and youth, especially young girls; anti-smoking programmes for smokers, especially pregnant women and youth; and promotion of smoke-free public places.

As concerns breast cancer, regional implementation of the screening programme will involve the collaboration of many partners from our network as well as from the community. Innovative approaches will be developed to reach women belonging to underprivileged or ethnocultural groups, by integrating the anti-smoking component into a more global approach to women's health and by paying more attention to women's concerns.

On the AIDS front, we feel it is necessary to pursue strategies currently backed by governments, since the epidemic is still not in regression. The key to the fight against AIDS, prevention, is primarily concerned with the groups most at risk — homosexual men and bisexual men and intravenous drug users. We must thus intensify the measures designed for them. As indicated in the section on youth, we will continue to aim our actions at high-risk youth. More attention and efforts must also be devoted to prevention among all young people; they should be reached before they become sexually active (preadolescents and adolescents): it is crucial to set up programmes in collaboration with schools and organizations working with them. To boost the fight against AIDS, we will pursue our collaboration with all the partners in the network, whether the need is for expertise, studies, or action. As for the gay community, we can say that they have taken charge of their own affairs, both in prevention and patient support. These services must thus continue to be offered on a community basis and funding for them is crucial.

Finally, the high concentration of patients in Montreal, combined with the current overhaul and budget cuts affecting the system, makes us wonder about both the availability and quality of medical and psychosocial services provided under the jurisdiction of CLSCs. The same applies to access to prescription drugs, laboratory tests, and other medical services. Considering the fear and sometimes the rejection that AIDS still, unfortunately, provokes in some, we must be vigilant so that this clientele will not, in practice, fall off the list of health and social service priorities.



6 A Time for New Roles :

Adults 65 and Over

MONTREAL'S POPULATION of seniors is growing so rapidly that 20 years from now one Montrealer in 5 will be 65 and over. It is reasonable to think that this trend will bring a rise in chronic illnesses and disabilities, along with increased costs in the health and social services system. It is only a short step from this obser - vation to reserving a slot for the ageing of the population in the liabilities column of every health report.

But we should take a closer look. It would be a mistake to think of seniors only as a social burden. On the one hand, they don't want to be dependent on society. On the other hand, these adults with their wealth of experience and "freed-up" time contribute to social life by the role they play in their family and in their community. They are a part of our assets, just like children, youth, and younger adults.

We will evaluate two factors — poverty and loss of functional autonomy — that undermine seniors' independence and may prevent them from participating fully in the social development of their community.

On the whole, their financial situation has improved over the past two decades, thanks chiefly to more generous old age pensions. Moreover, various studies show that disabilities are on the decline among seniors as in the population at large. Thus, scarcely 10% of those aged 65 to 74 need help with their daily activities (housework, shopping, outings). However, between the ages of 75 and 84, disabilities are very prevalent: half the seniors in this age bracket say they are experiencing some loss of capacity and after 85, this proportion climbs to 77%.

Nevertheless, for certain seniors, improvement means going from indigence to poverty, from welfare to an old age pension. This is especially the case for single women: close to 69% of elderly women living alone or away from their family with a non-relative are still below the poverty threshold in Montreal. And after the age of 75, the majority of the elderly are women — poor, often alone, and in poor health. We can thus not afford to close our eyes to Montreal's ageing population.

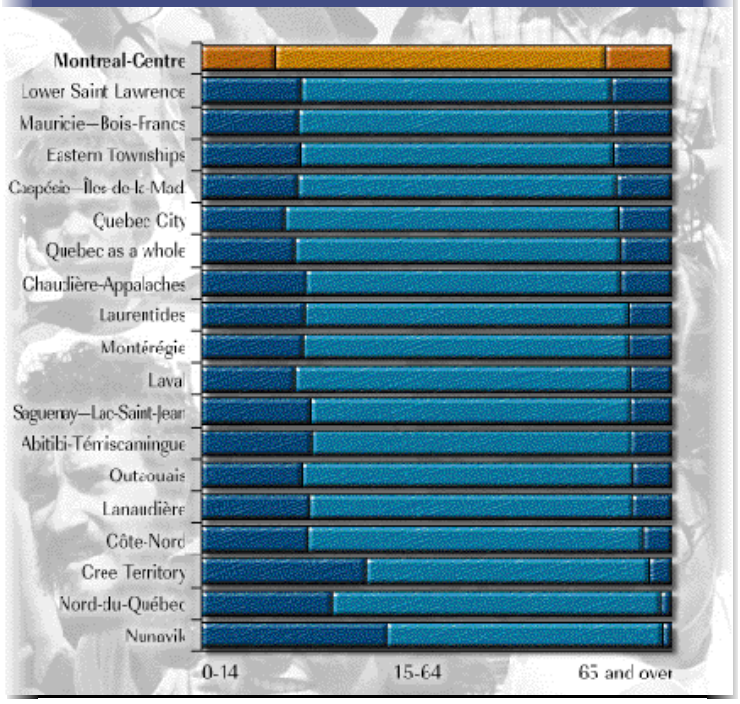
After a brief socioeconomic review, we will tackle the question of social inequalities in health, functional autonomy, and prevention and propose a few orientations.

A Rapidly Ageing Population

Montreal has aged faster than Quebec as a whole. In 1991, our region counted the highest percentage of elderly (14%) as well as the greatest number of elderly: close to a third of Quebec's elderly. This graying of Montreal will continue: from the present 270,000 (15% of the population) their numbers could rise to 370,000 by 2016 (19%). In parallel, the number of youth under 18 will continue to decline and, in less than 20 years, it will be lower than the number of elderly.

fig. 27

Percentage breakdown of population according to age, regions and Quebec as a whole, 1991



Because of their longevity, women are by far the majority among the elderly. This phenomenon is more marked in Montreal which has only 60 men for every 100 women in this age group, whereas in Quebec as a whole this ratio is 68 to 100. This trend grows stronger with age: 74 to 100 among those 65 to 74 but only 32 to 100 among those 85 and over. There is the added fact that after 75 more than 50% of women live alone, compared to about 25% of the men.

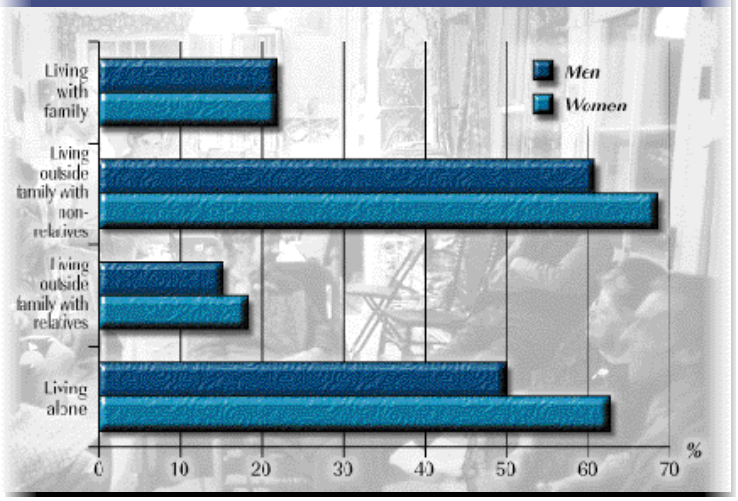
Greater Poverty than in Other Regions

In Quebec, the proportion of elderly living below the low-income threshold has been on the rise since 1990 and their number largely exceeds the Canadian average. Moreover, in Montreal, there are even more elderly poor than in Quebec as a whole: 36% against 28%. We are thus facing a very disturbing trend.

The hardest hit: seniors living alone

fig. 28

Percentage of persons 65 and over living below the low-income threshold according to type of household and gender, Montreal-Centre, 1990



More women than men live below the low-income threshold, especially women living with someone other than a relative (69%) and those living alone (63%). This poverty is probably amplified by the fact that these women live alone.

These data confirm the importance of family ties for the economic security of the elderly. They also show us what groups need more support from improved income security measures: elderly men and women living with non-relatives or living alone.

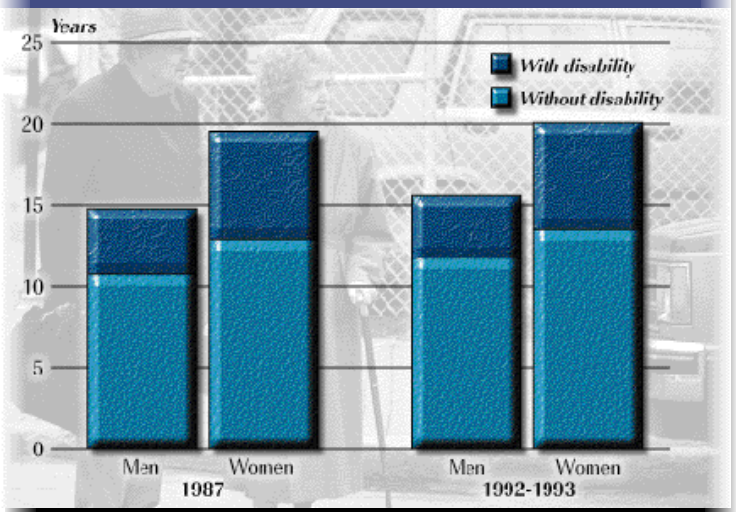
Influence of Poverty on Health

Not all elderly enjoy the same degree of health: though many are spared illness and disability until an advanced age, others are prematurely affected. Various factors explain these differences: genetic heritage, socio-environmental conditions, lifestyle choices, etc.

It is hard to say whether the socioeconomic conditions prevailing in their lives are the sole explanation of the discrepancies observed, because there are few longitudinal studies on which to base such conclusions. Nevertheless, just as in other stages of life, we note that the association between income and state of health is confirmed.

fig. 29

Life expectancy at 65 with or without disability according to gender Montreal-Centre, 1987 and 1992-1993



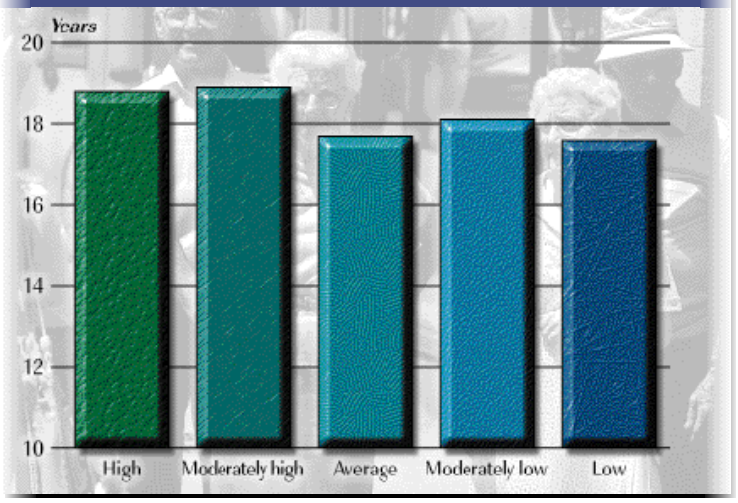
Fewer and fewer affected by disabilities

Most people reach the age of 65 relatively free of serious health problems. Women can expect to live a total of 20 years more and men can count on 16 years. On average, there is a life expectancy of 13 years without any functional disability. However, though women can expect to live longer after the age of 65, it will also be more years with a disability.

The question is whether there is, as well, any discrepancy based on socioeconomic status. This discrepancy is less obvious here, since in the low-income group, life expectancy at 65 is about 18 years as compared to 19 in the high-income group: only one year difference. This may be explained by the fact that the inequalities people experience throughout their life have already taken their toll.

fig. 30

Life expectancy at 65 according to income, Montreal-Centre, 1991-1994

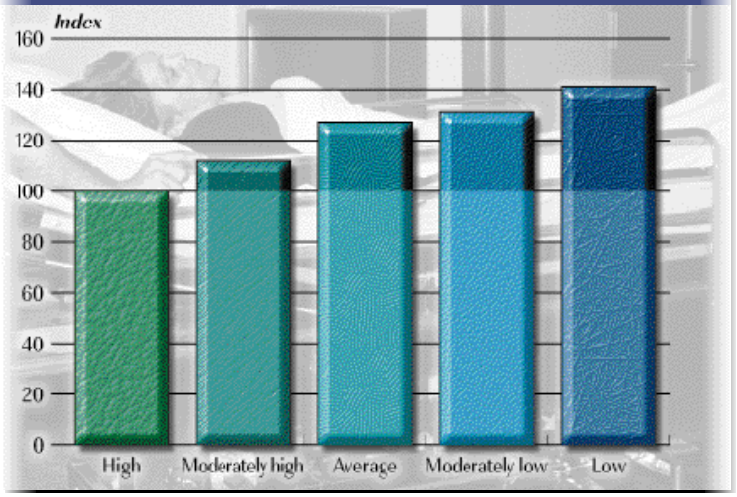


More hospitalizations

Another illustration of the link between income and health: for every 100 days of hospitalization among high-income earners aged 65 to 74, 141 are tallied among low-income earners. Similarly, the length of hospitalization increases as income declines: the poorest stay on average two days more in hospital. Later, from 75 on, the gap closes. Here also the causes of hospitalization are preventable by measures designed to integrate the elderly into the community and by home services adapted to their needs.

fig. 31

Index of da ys of hospitalization among persons 65 to 74 according to income, Montreal-Centre, 1993-1995



These four indicators — life expectancy with or without disabilities, frequency and length of hospitalizations — show the same trend: low-income seniors are in poorer health. Inequalities in health based on income thus continue among the elderly, but the gaps narrow.

Functional autonomy: improvements

After poverty, the loss of functional autonomy — living with disabilities — is the second factor of dependence and exclusion among the elderly. They are often heard to say that they do not so much fear illness and death as loss of autonomy and dependence. The disabilities or curtailment of activities resulting from illness, injury, and ageing itself can have serious consequences, what is usually referred to as a handicap.

Aware of this, the *The Policy on Health and Well-being* sets objectives for prevention: act on the causes and reduce situations leading to a handicap while also promoting the integration of seniors who are already disabled. It is worth noting that 5% of those 65 and over in our region live in long-term institutions and that 80% of the others do not report any long-term disabilities.

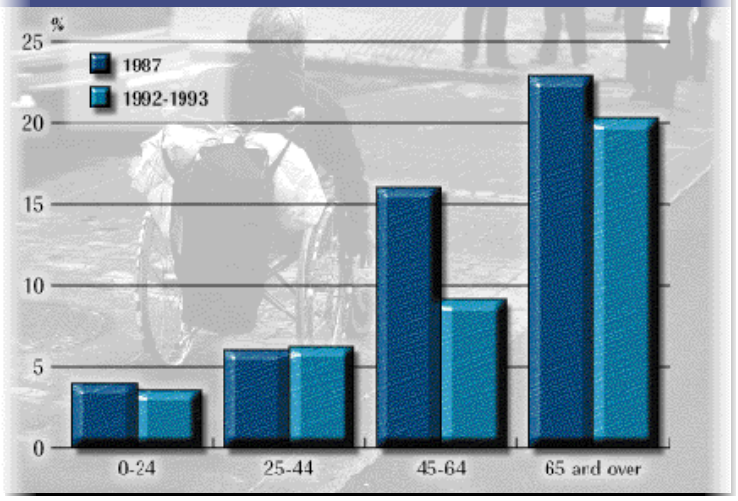
To measure functional autonomy, we use two indicators: first, the average yearly number of days of short-term incapacity in three categories: heavy (bed-ridden); moderate (home bound, unable to use metro);

slight (curtailment of activities); then, the proportion of seniors whose major long-term deficits make them dependent on help in carrying out their daily activities (personal care, serious restrictions in mobility...).

Already more prevalent at 45, long-term disabilities reach their highest levels starting at 65 when one senior in five is affected. There is no significant gap between men and women, but we note a regression for Montreal men 45 and over (from 1987 to 1992-1993), especially those in the 45-to-64 bracket. Upon studying the annual average number of days off for incapacity, we note that, in every age bracket, women chalk up more: this gap widens to 7 days a year on average in the 65-and-over bracket.

fig. 32

Percentage of persons with a long-term disability according to age, Montreal-Centre, 1987 and 1992-1993



But there are noticeable gaps

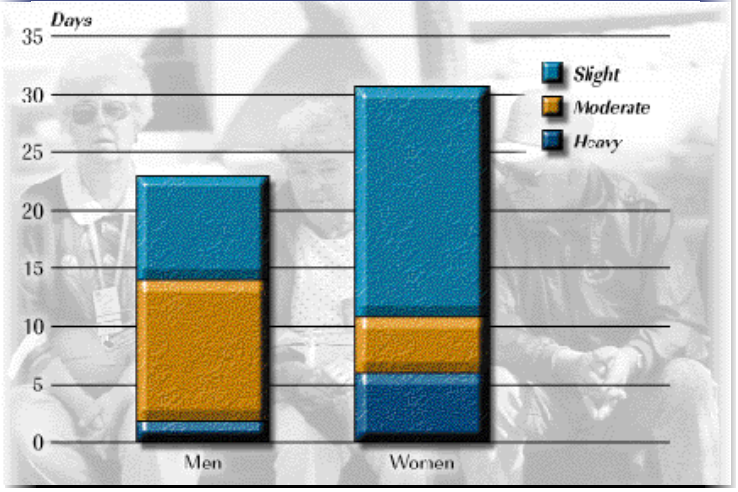
Inequalities based on socioeconomic status are also observed at this stage of life. The poorest and the less educated reported more days off for incapacity and higher percentages of limitation and dependence in daily activities.

We know, for example, that more than twice as many low-income as compared to high-income earners over 15 (13%) report having long-term limitations in their activities.

The vast majority of disabilities among men as well as women are classified as slight or moderate. But elderly women are hit with more serious disabilities: an average of 20% of reported days of incapacity are "heavy" against 8% for men.

fig. 33

Average yearly number of days of incapacity among those 65 and over according to disability and gender , Montreal-Centre, 1992-1993



Acting on preventable causes

First of all, we identify two types of problems for which upstream prevention proves to be very effective: falls — generating more than 17% of limitations in activity — and over-medication.

We also know that the main causes of limitations among those 15 and over are diseases affecting the bones and joints (26%), the respiratory system (15%), and cardiovascular system(12%). Among the elderly, the problems are identical but in chronic form. Prevention is thus aimed at treating the diseases and minimizing their consequences, at compensating for deficits with appropriate help, and at promoting social integration through adapted physical environments and adequate social networks.

We would note that absence of disease among the elderly does not always equal autonomy and well-being. We may in fact see a loss of autonomy in persons relatively free of health problems and a high level of autonomy among those suffering from several illnesses. Events common to this stage of life such as widowhood or retirement can put relatively healthy seniors in situations of social isolation which will sometimes lead to over-medication, depression, and even suicide. It is thus crucial, in each case, to take some care in adapting services to the actual situation and the true needs of the person involved.

Orientations: Adapting to the Graying of the Population

Ageing is, by definition, accompanied by a certain decline in capacities which will vary greatly from one individual to the next. At 65, most people have few health problems and can expect to live an average of 13 years without any functional deficits. So preventive measures would be in order to enhance the well-being and autonomy of seniors, thus enabling them to fully enjoy their lives and participate in social life as long as possible.

In order to remain active, seniors need friendly environments that support their autonomy. As more seniors start to lose some of their capacities at 75, means of compensating for this loss must be found. Montreal society must

adapt to a new age balance. Ensuring seniors' financial security and helping them to remain autonomous — these are two essential conditions. To fulfill them, we advocate the following orientations.

It is, in the first place, important to design policies which take into account the fact of ageing both on the scale of the population and in the context of the individual and which promote the maintenance of economic security, autonomy, integration, and social participation up to a very advanced age. Along the same lines, steps must be taken to provide enough income support to eliminate poverty among seniors living alone and without family.

With a view to helping the elderly hang on to their autonomy as long as possible, we must develop conditions favouring independence whether in private or public housing, in traffic safety, in transportation, etc. Similarly, the current restructuring and reorientation of social services must leave home-care services intact, given their impact on the health of seniors. Finally, we should remember the two top priorities in upstream prevention for this age group: falls and over-medication.

Family and community networks must receive support: their role is crucial. They are important factors in allowing seniors to remain in their natural environment and in reducing the burden on natural caregivers, friends, and relatives. The latter are the mainstays of support for the elderly, especially the women among them; they provide from 70% to 80% of the care. As to community resources, thanks to their programmes and their adapted activities, they play a crucial role in the social integration of seniors.

The elderly want to participate in dealing with the issues that concern them; we must make the effort to associate them with the planning, evaluation, and implementation of prevention and health promotion programmes. Finally, we should remember that only joint efforts at local, regional, and provincial levels will allow us to come up with measures facilitating the autonomy and social integration of seniors, whether in the area of income security, housing, public security, transportation, or health and social services.

7

Counteracting Poverty and it's Consequences

HAVING SCANNED the health and well-being of Montrealers from one end of the life cycle to the other, we note the important role played by poverty. Inequalities in health and well-being can be traced back to socioeconomic inequalities, that is to the harsh living conditions which marginalize so many of our fellow citizens, not only limiting their access to essential goods, but depriving them as well of any meaningful role in social life.

Poverty weighs heavily on health in both its material and social dimensions: poor education, dependence, precarious jobs, inactivity. And the consequences of this are reflected in most of our social and health indicators: globally, in reduced life expectancy and, more particularly, in the higher proportion of diseases or psychosocial problems, in low-birth-weight babies, in developmental problems, in school dropout rates, in adolescent pregnancies, in psychological distress, etc.

If, as a society, we want to make significant gains on the health front, we must energetically pursue our efforts to improve living conditions. It is no exaggeration to say that poverty in Montreal constitutes a major health problem — a problem all the more worrisome seeing that it persists in a global context of unprecedented wealth and technological progress.

A Challenge to Society

The problem of poverty, with the complexity of its ramifications, poses a major problem to our whole society. We cannot accept that this problem, with its consequences for health and well-being, should be a preordained fate which we must be satisfied to "manage" or one to which we must simply adapt. We are, quite to the contrary, convinced that we have at our disposal, collectively, the material means, the policy instruments, and the knowledge to tackle this problem, and we are happy to note that this stance is already inspiring a multitude of interesting initiatives. The fight against poverty will only succeed if it mobilizes social actors from all fronts — public, private, and community.

"...we have at our disposal, collectively, the material means, policy instruments, and knowledge to tackle this problem..."

The government, in its policy orientations as well as its administrative functions, does of course have a primary role to play in the fight against poverty. In a modern democratic society, the government is assigned the task of promoting economic development and of redistributing income in a more socially acceptable manner than it would be if left entirely in the hands of an unregulated market. The improvement of living conditions and the reduction of inequalities are frequently espoused as objectives; we must, however, make sure that these objectives are not forgotten in practice. For example, income security reform has raised legitimate concerns, because, among other things, it weakens the socioeconomic position of those already in difficulty.

The fight against poverty finds expression in the strengthening of social solidarity, on the neighbourhood level as well as on the regional scale. In this regard, we must salute and support the initiatives of community groups through which citizens regain control of their living conditions — whether in the fields of food, housing, popular education, job finding, etc.

We must also recognize that the development of solidarity demands the decompartmentalization of practices, pooling of ideas and resources, in other words, it demands intersectorial cooperation. In several neighbourhoods and towns in our region, citizen groups are helping to construct partnerships focused on local action. Recognizing their achievements and the potential of their cooperative efforts, the Health Board supports

several of them, notably through funding tied to regional priorities and orientations.

At the regional level, there now exists a body for intersectorial cooperation which will play an important role on the Montreal scene: the Island of Montreal Regional Development Council (CRDIM: Conseil régional de développement de l'Île de Montréal) which groups the principal social actors — public administrations (municipal, educational, health); the private sector (businesses, unions); and the community milieu. Efforts to develop a common vision are the focus of thematic work groups concerned with specific social and economic questions. CRDIM is coordinating the Regional Forum on Social Development scheduled for April 1998. This Forum is part of a pan-Quebec process organized by the Conseil de la santé et du bien-être which will be holding a national Forum on social development in early 1998. Discussions will centre on the growing phenomenon of poverty and the strategies to counteract it: the Montreal-Centre Department of Public Health is participating actively in this work and is, as well, a member of the organizing committee for the province-wide process, with a view to raising awareness concerning the issue of social development.

Specific Challenges to the Health System

In the field of health and social services, changes in the network are still a cause for concern among underprivileged clienteles. The need for this operation is not being questioned. It is not only a matter of cleaning up public finances, but of improving health and well-being by strengthening first-line services, making community care more available, and stepping up measures to promote health and prevent disease.

"...improving health and well-being by strengthening first-line services, making community care more available, and stepping up measures to promote health and prevent disease."

However, the reorganization of services and the realignment of resources between the various types of establishments (for example, reducing hospital services and reallocating the resources thus liberated to places where they will be more useful) can entail negative consequences, locally, for certain clienteles. We know that underprivileged people tend to call on emergency curative services rather than establish a stable relationship with doctors

practising in CLSCs or in a family clinic. In this context, it is important that clinical workers in the network try harder to reach disadvantaged clienteles: they must understand that in their pattern of health-care use these clienteles do not gravitate towards primary-care services. They must also develop a greater sensitivity to the socioeconomic conditions of their underprivileged clienteles and to the constraints these conditions impose.

"...it is important that clinical workers in the network try harder to reach disadvantaged clienteles..."

The establishment of a public-health system providing universal and free access to services without regard for the client's income or social status was a big step in the development of our society. Without this system, the mortality and morbidity gaps would be even greater than those observed today. The health system has thus played an undeniable, albeit inadequate, role in counteracting social inequalities. We must be careful that the reorganization of the network will not eat away at the current accessibility of the whole range of health care and services. The network will thus have to make sure that the new ways of delivering services will truly reach the whole population and, in particular, its low-income segments. Here we have a social objective which, transcending political and organizational problems, calls out, first of all, to the heart of every clinical worker's practice.

Finally, we will have to ensure that our region can still count on enough resources to meet the needs of its population. Up to now, despite the fact that socioeconomic conditions in Montreal are markedly worse than those in the rest of Quebec, the health and well-being of Montrealers have remained comparable to that of other Quebecers. This is due in part to the quality and quantity of available care. Any reduction of this level of care could easily upset this fragile balance between precarious social conditions and a relatively good state of health.

"...Any reduction of this level of care could easily upset this fragile balance between precarious social conditions and a relatively good state of health."

The Department of Public Health will continue to monitor the effects of the reorganization of the network on the health of the population. The information we, with the help of our partners, can provide on this subject will, we hope, shed some useful light on regional and national decision-making.

For the Health and Well-being of Young Children

The data we have presented clearly show that socioeconomic inequalities find expression in marked inequalities in terms of mortality and physical and social morbidity among infants. These problems worry us, both because of the damage they are now causing and because of the long-term and potentially irreversible consequences they may entail. Countless well-documented studies, including the recent report of the National Forum on Health, remind us of the urgent necessity to improve the conditions in which children develop.

For the Department of Public Health, early childhood development is a top regional priority which will continue to shape its actions over the coming years.

Society as a whole must unite to improve the conditions into which children are born and in which they spend their first formative years. Families must have at their disposal enough income to meet their basic needs. In this respect, employment opportunities must remain a high priority. For those who, despite every effort, will remain outside the job market, we must make sure that our social systems of income support are adequate, especially so that children will have the minimally decent conditions required for their development.

Over and above income support, we must also strengthen the mechanisms of aid to families. For example, the success of the "job path" component of the new income security regime will depend directly on the availability of adequate day-care facilities and effective support for community mutual-aid networks. This is especially true in the case of single-parent families. Parents must also be supported in their parenting role: for example, via a network of early childhood development centres.

"...we must also strengthen the other mechanisms of family support."

The health and social services network, along with community organizations, is already doing a great deal in this area. We must pursue these efforts and work even harder to build relations of trust with families in difficulty (as in *Naître égaux-Grandir en santé*) and to implement measures capable of reaching out to them, meeting their true needs, and helping them develop their autonomy.

In this context, the promotion of food security appears vital to any real improvement of the living conditions of families. Food security — meaning the certitude of being able to eat a healthy diet, at a reasonable cost, day after day, without relying on charity — is still not within the reach of many of our fellow citizens. This often has enormous consequences in terms of physical and mental health: nutritional deficiencies, stunted growth, weakened immune systems, interpersonal tensions, adaptation problems at school, and the loss of self-esteem and personal skills resulting from dependence.

"...food security, meaning the certitude of being able to eat a healthy diet, at a reasonable cost, day after day, without relying on charity..."

We are thus collaborating with organizations and groups already active in this field to make food security a top priority. Like many others, we believe that the first staples of food security are a regular job, a better distribution of the fruits of economic growth, more adequate income support. But concrete actions to supply people with enough food are also necessary: ensuring the geographic and economic accessibility of foodstuffs, providing popular education, developing cooking and home economic skills. We do not believe that stop-gap handouts is the way to go for the future. We would rather bank on initiatives supporting the development of autonomy and on projects with innovative and lasting responses to needs.

Over the past two years, we have broadened our approach beyond the emergency response to "the problem of hunger". We are supporting experiments in social solidarity which encourage participants to exercise the prerogatives of responsible citizenship.

We sense the existence of strong currents of voluntary mutual-aid in our region, especially at Christmas time. This surge of solidarity, which could be an extraordinary ferment for social change, is too often dissipated in well-meaning projects offering temporary relief for the symptoms rather than acting on the causes. It is our duty to explain how this solidarity can be used to make real improvements in the living conditions of our fellow citizens.

For the Health and Well-being of Youth

Like that of infants, the situation of youth causes us concern, especially since the problems observed at this stage are liable to have a negative impact for a whole life time. Youth — the age of learning — is perhaps the period of life when physical health problems are least important. It is nevertheless the time when life styles are formed for better or for worse — often under the strong influence of socioeconomic conditions. We know that a train of unfavourable socioeconomic circumstances increase the likelihood that youth will opt out of society: school dropout, adolescent pregnancy, inadequate professional training, lack of meaningful contacts with adults, failure to find a meaningful social role. The problems of adaptation experienced during the period called "youth", a period that modern societies have extended up to the age of 25, predispose us to persistent pathologies that last into adulthood and beyond.

"...a train of unfavourable socioeconomic circumstances increase the likelihood that youth will opt out of society..."

It will take the mobilization of the whole society to achieve the objective of offering youth the conditions and means to realize their potential. We must overcome the socioeconomic obstacles blocking youth and so impeding their social, intellectual, emotional, and professional development. In this respect, schools obviously have a major role to play and the educational reform currently underway is, justifiably, devoting a lot of resources to "the support of Montreal schools." But schools cannot solely and on their own steam take the turn towards success: they must be able to count on the commitment of the big social actors such as the business world and the health and social services sector.

"...schools cannot solely and on their own steam take the turn towards success..."

In the wake of the Priorité jeunesse (a joint effort the Department has been spearheading for three years with the help of partners from various sectors), our commitment to the optimal development of youth is taking shape around three regional orientations: supporting school-community initiatives; promoting the socioeconomic integration of youth, and running intensive and personalized companionship programmes for youth in difficulty. These orientations involve staying in touch with the milieu so that our public-health expertise will be readily available to integrated cross-sectorial actions, at both the local and regional level. It is in this spirit that the Department of Public Health has joined the sub-ministerial committee on support for Montreal schools.

For the Health and Well-being of Adults

The inequalities in health and well-being linked to socioeconomic inequalities persist throughout adulthood. As we have seen, this is particularly well illustrated by indicators such as the death rate from cardiovascular disease and from lung cancer. Tobacco use, the main risk factor for these pathologies (and for several others), is much more prevalent among low-income groups.

General improvements in living conditions and reduction of socioeconomic inequalities remain a must if preventable death and morbidity are to be reduced and possibly eliminated. In the name of the health and well-being of the population, we can only salute the efforts the various levels of government and citizen groups have invested in stimulating the national economy, supporting local development, and achieving greater social solidarity. But, in the fight against preventable mortality and morbidity, we in the health and social services network are faced with specific challenges; we must keep constantly in mind the higher impact these problems have on low-income groups and, consequently, adjust our heart-health or anti-smoking initiatives to the concrete realities of these groups.

For the Health and Well-being of the Elderly

The situation of the elderly is destined to become a more important issue in our region, if only because of the growing demographic weight of this age group. Even though, as a rule, the socioeconomic conditions of the elderly have greatly improved over the past twenty years, a significant number of them, especially elderly women living alone, still don't have enough income to live on and there are considerably more elderly living in poverty in Montreal than elsewhere in Canada.

Low-income seniors have more health problems than others in their age group and the functional limitations they experience are likely to be more debilitating if they cannot pay for domestic help. We must be on guard that current changes in the health and social services network which increase the need for non-hospital services among all clienteles will not reduce the services slated for the elderly who need them.

It is important that the elderly, regardless of income gaps, should have access to the support they need to live a full and independent life for as long as possible in the community.

Avenues of Action Open to the Department of Public Health

Faced with the broad health and well-being issues that we have just outlined, the services provided by the Department of Public Health are structured around five main functions:

- **Monitoring** : Documenting the evolution of needs, problems and their determinants, actions and their results.
- **Research and evaluation :** Developing effective projects and programmes to support field workers and evaluating these projects and programmes from a regional perspective.
- **Transmission of knowledge:** Disseminating both knowledge and know-how with a view to empowering actors in various sectors as well as ordinary citizens in their own communities.
- **Regional programming :** Linking public-health expertise to the programmes of the different departments of the Regional Health Board, so that the Board can fully exercise its role in improving the health and well-being of the population.
- **Strategic action** : Keeping decision-makers and public opinion informed of the Department's concerns about the social issues important to the health and well-being of the population.

Acting on all fronts

The poverty striking close to 30% of Montreal's population constitutes a problem that the Department of Public Health cannot ignore. This concern, already embedded in our 1995-1998 priorities, will be even more deeply entrenched in those for 1998-2001. The Department is thus joining other social actors on the Montreal scene as a partner who, armed with its specific brand of expertise, is determined to commit its forces to the common struggle.

We can never repeat too often that, because of its multidimensional character, poverty demands actions on all fronts, actions which will be all the more effective if integrated into a comprehensive strategy. We have underlined the things we are currently doing to improve the conditions surrounding the development of young children and youth as well as our efforts to ensure food security. The local community is the place where the fight against poverty must take root through integrated action that will revitalize crumbling neighbourhoods and promote their reconstruction from the grass roots upward. We hope that this process will be implanted as widely as possible throughout our whole region.

"...action that will revit alize crumbling neighbour hoods and promote their recon - struction from the grass roots upwards. "

We should not forget that all the sectors of society need to join hands in order for each to accomplish its particular mission, whether this involves educating, ensuring public safety, producing goods and services or preserving health.

The fight against poverty obviously requires economic development, which cannot be achieved unless it coexists with "social" measures such as more support for the family and the promotion of pro-social behaviours among adolescents. Inversely, the efforts we expend on preventive measures (such as creating better surroundings for children, improving parent-child communications or enriching the personal and social skills of youth) are not likely to go anywhere should social and economic development fail to reach those who are presently excluded.

Reducing inequalities in health and well-being is essential to the progress of our society. Such an objective calls for the enthusiastic participation of every citizen and demands the concerted efforts of all sectors of society. The Department of Public Health is resolutely setting out on this path, counting on stepped-up relations with its travelling companions.

List of Figures

The number between parentheses indicates the source which is cited in full on page 72.

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Appendix 1

Health Determinants

Environment	Montreal-Centre	Quebec
Physical and ecological		
1. Population provided with recycling services (1995) %	60.9	[66.7]
2. Population provided with water purification facilities (1994) %	100.0	[76.6]
3. Rate of automobile use (1995) %	31.7	[42.7]
Social		
Demographic		
4. Population (1991)	1,822,516	[7,081,233]
0-14 %	15.7	[19.8]
15-64 %	70.2	[69.2]
65 and over%	14.0	[11.0]
5. Growth rate (1986 to 1991) %	0.9	[5.2]
6. Comprehensive fertility index (1990-92) children per woman	1.52	[1.65]
Sociodemographic		
7. Population speaking neither French nor English at home (1991) %	15.9	[5.4]
8. Immigrants (1991) %	23.6	[8.7]
9. Single-parent families with children under 18 (1991) %	24.9	[17.9]
10. Population living alone (1991) %	17.6	[12.1]
11. Population having moved (1991) %	49.6	[43.6]
Socioeconomic		
12. Population with less than nine years of schooling (1991) %	19.5	[20.1]
13. Live births from poorly educated mothers[1] (1990-92) %	17.5 (+)	[15.1]
14. Inactive population (1991) %	44.5	[42.7]
15. Unemployment rate (1991) %	13.2	[12.1]
16. Pop. below the low-income threshold (1990) %	27.8	[19.2]
17. Recipients of social assistance (1996) %	17.5	[12.5]

Behaviour s, lif esty les and risk f actor s	Montreal-Centre	Quebec
18. Regular smokers [2] (1992-93) %	28.6	[30.4]
19. Population taking 14 drinks of alcohol and more per week[2] (1992-93) %	5.8	[6.4]
20. Population having never taken illegal drugs[2] (1992-93) %	68.1	[68.9]
21. Population / overweight[2] (1992-93) %	23.3	[24.7]
22. Motorists using restraint device[1] (1995) %	90.4	[90.2]
23. Low-weight births[1] (1990-92) %	6.2 (+)	[5.9]
24. Pregnancy rate in adolescence[1] (1993-94) per 1,000	48.6 (+)	[35.8]
25. Women having undergone a Pap test[2] (1992-93) %	64.0	[66.2]
26. Women 50 and over having undergone a mammogramme[2] (1992-93) %	44.0	[42.8]
27. Population with a high level of psychological distress[2] (1992-93) %	26.9	[26.3]
28. Population having seriously contemplated suicide[2] (1992-93) %	*3.5	[3.9]
29. Population dissatisfied with their social life[2] (1992-93) %	13.2(+)	[11.4]
30. Rate of crimes against persons[1] (1995) per 100,000	1,164.9 (+)	[670.5]
Organization of health services		
31. Short-term beds (1994) per 1,000	6.3	[4.0]
Long-term beds and spaces (1994) per 1,000	11.0	[8.1]
32. Number of inhabitants per doctor (1994)	324	[505]
33. Per capita expenditures (1994-95) current $	2,843	[2,028]
34. Average hospital stay (1993-95) days		
Total	8.9	[8.2]
Tumours	13.7	[12.8]
Circulatory system	12.3	[11.4]
Respiratory system	8.1	[6.9]
Digestive system	7.6	[6.7]
Genito-urinary organs	6.2	[5.8]
Traumas	10.8	[9.9]
35. Incidence of reportable diseases / preventable by vaccination[1] (1994)		
Whooping cough per 100,000	29.4 (-)	[60.9]

State of Health

	Montreal-Centre	Quebec
Subjectiv e state of health		
36. Population not perceiving itself as in good health[2] (1992-93) %	10.9	[10.7]
37. Population with at least one health problem[2] (1987) %	59.4 (+)	[54.5]
38. Leading health problems[2] (1987) %		
Arthritis or rheumatism	12.8 (+)	[10.0]
Headaches	10.0 (+)	[8.4]
Skin allergies and disorders	10.0 (+)	[7.9]
Back aches	9.1 (+)	[7.7]
Mental disorders	9.1 (+)	[7.4]
Allergies (other than skin and hay fever)	8.1 (+)	[6.5]
High blood pressure	7.2	[6.3]
Hay fever	8.1 (+)	[6.0]
Lesions (accidents and injuries)	5.6	[5.0]
Heart diseases	4.7	[4.1]
Objectiv e state of health		
Non-hospit alized morbidity		
39. Rate of occupational lesions[1] (1993) %	3.3 (-)	[4.0]
40. Rate of intoxication (1995) per 100,000	604.0(-)	[711]
41. Incidence of reportable contagious diseases[1] (1994) per 100,000		
Chlamydia	98.7 (-)	[109.0]
Whooping cough	29.4 (-)	[60.9]
Campylobacteriosis	24.0 (-)	[33.4]
Scarlatina	4.7 (-)	[17.9]
Hepatitis B carrier	40.9 (-)	[16.8]
Salmonellosis	15.0	[16.6]
Gonococcal infection	23.9(+)	[10.3]
Giardiasis	11.9(+)	[9.8]
AIDS	16.1(+)	[5.7]
Tuberculosis	11.4(+)	[5.0]
Hospit alized morbidity		
42. Rate of hospitalization (1993-95) per 1,000		
Total	89.7	[100.1]
Tumours	8.2	[8.3]
Circulatory system	11.9	[14.6]
Respiratory system	8.5	[10.6]
Digestive system	11.1	[12.6]
Genitourinary apparatus	6.9	[7.6]
Traumas	6.6	[8.0]

	Montreal-Centre	Quebec
43. Incidence of cancer[1] (1990-92) per 100,000		
Total	394	[391]
Colon-rectum	53	[53]
Lungs	68	[70]
Breasts in women	94	[93]
Prostate	85	[92]
Mortality		
44. Life expectancy[1] (1990-92) years	77.5(+)	[77.3]
45. Infantile mortality rate[1] (1990-92) per 1,000 live births	6.3	[5.9]
46. Perinatal mortality rate[1] (1990-92) per 1,000 births	8.4	[7.7]
47. Mortality rate[1] (1990-92) per 100,000		
Total	674 (-)	[691]
Tumours	206	[209]
Circulatory system	251 (-)	[261]
Respiratory system	52 (-)	[56]
Traumas	40 (-)	[49]
48. Suicide rate[1](1990-92) per 100,000	13 (-)	[16.3]
49. Life expectancy in good health (1992-93) years	68	[66.8]
50. Rate of potential years of life lost[1] (1990-92) per 100,000		
Total	6,656 (+)	[6,523]
Tumours	1,931	[1,922]
Circulatory system	1,274	[1,270]
Respiratory system	231 (+)	[221]
Traumas	1,224 (-)	[1,589]
51. Breakdown of victims of traffic accidents (1992-94)		
Total annual average	11,870	[50,615]
Fatal injuries %	1	[2]
Serious injuries %	9	[13]
Minor injuries %	90	[85]

Consequences of Health Problems

	Montreal-Centre	Quebec
Disability		
52. Average length of benefits for occupational lesions (1993) days	42.0	[41]
53. Population with a long-term disability[2] (1992-93) %	7.2	[7.2]
54. Disabled children[1] (1995) %	1.26 (-)	[1.39]
Use of services		
55. Rate of medical consultations (1994) %	81.8	[81.4]
56. Rate of days of hospitalizations according to diagnosis (1993-95) per 1,000		
Total	879.9	[824.8]
Tumours	129.9	[110.5]
Circulatory system	179.3	[174.1]
Respiratory system	74.5	[74.0]
Digestive system	93.3	[86.2]
Genitourinary apparatus	45.8	[45.3]
Traumas	77.5	[79.8]
57. Rate of cesarean births[1] (1993-95)	24.7 (+)	[22.7]
58. Rate of coronary bypass[1] (1993-95) per 100,000	67.3 (+)	[61.1]
Use of prescription drugs		
59. Population with three classes of prescription drugs and more[2] (1992-93) %	10.0 (+)	[8.7]
60. Number of prescriptions per person 65 and over (1994) prescriptions	26.6	[28.4]

Notes :

1. The difference with Quebec as a whole was calculated using a 0.05 level of significance.
2. When using statistical tests with a 0.05 significance level, the region is compared with the rest of Quebec.

* Coefficient of variation higher than 16.5% and less than or equal to 33.3%
The value must be interpreted with caution.

(-) (+) Value significantly lower or higher than for Quebec as a whole.

[ ] The data in brackets refer to Quebec as a whole.

Appendix 2

Some Health and Well-being Indicat ors accor ding to Income Bracket, Montreal-Centre

	1 *high*	2 *average high*	3 *average*	4 *average low*	5 *low*	*Total*
Fertility rate for women 15 to 19[1] (per 1,000)	5.7	13.1	21.3	25.3	39.2	20.2
% of regular smokers[2]	23.9		28.5		40.5	28.6
% of population consuming 4 alcoholic drinks and more[2]	6.0		4.5		4.8	5.4
% of population having never used illegal drugs[2]	64.5		72.4		71.4	68.1
% of low-weight births[1]	5.1	5.3	5.9	6.8	7.4	6.2
% of premature births[1]	6.3	6.3	6.9	7.4	7.8	7.0
% of women having had a Pap test[2]	73.0		59.1		52.8	64.0
% of women having had a mammogramme[2]	32.4		25.9		22.0	28.0
% of population with a high level of psychological distress[2]	26.1		25.7		30.9	26.9
Average stay in hospital[3] (days)	10.6	11.1	11.3	12.0	11.8	11.4

State of Health

% who do not perceive themselves as in good health[2]	8.3		10.0		18.7	10.9
Incidence of diseases preventable by vaccination[4] (per 100,000)	20.6	21.4	34.3	27.0	27.3	29.9
Incidence of sexually transmissible diseases[4] (per 100,000)	31.6	60.6	68.3	130.0	261.5	176.2
Adjusted rate of hospitalization[3] (per 1,000)	79.5	91.9	100.4	104.7	104.5	96.2
Rate of hospitalization[3] for children under one (per 1,000)	117.2	146.8	173.5	179.1	192.0	163.0

	1 *high*	2 *average high*	3 *average*	4 *average low*	5 *low*	*Total*
Adjusted rate of hospitalization for diseases of circulatory system[3] (per 1,000)	13.4	15.2	16.2	16.4	16.0	15.5
Adjusted rate of hospitalization for diseases of respiratory system[3] (per 1,000)	6.8	8.8	10.2	10.5	11.0	9.4
Adjusted rate of hospitalization for injuries[3] (per 1,000)	6.6	7.5	7.8	8.4	8.5	7.8
Adjusted rate of hospitalization for AIDS[3] (per 100,000)	7.0	24.7	29.6	58.0	86.5	41.8
Incidence of lung cancer[5] (per 100,000)	56.9	73.8	81.5	94.3	95.0	80.3
Incidence of breast cancer[5] (per 100,000)	111.3	118.4	102.4	111.2	87.8	106.6
Life expectancy at birth[1] both sexes (years)	80.0	79.0	77.4	77.0	75.4	77.7
Life expectancy at birth[1] men (years)	77.4	75.9	73.5	72.6	70.9	74.0
Life expectancy at birth[1] women (years)	82.2	81.8	80.8	80.8	79.7	81.1
Infant mortality rate[1] (per 1,000)	4.7	4.1	6.5	5.5	7.7	5.8
Adjusted rate of mortality from lung cancer[1] (per 100,000)	51.3	59.2	73.5	72.8	83.2	67.8
Adjusted rate of mortality from breast cancer in women[1] (per 100,000)	39.9	41.5	38.9	36.6	37.2	38.8
Adjusted rate of mortality from diseases of the circulatory system[1] (per 100,000)	282.5	299.8	325.7	342.3	356.5	321.3
Adjusted rate of mortality from diseases of the respiratory system[1] (per 100,000)	62.3	60.1	72.1	71.3	82.9	69.7
Adjusted rate of mortality from injuries[1] (p. 100,000)	32.3	39.2	42.5	45.2	55.3	43.1
Adjusted suicide rate[1] (per 100,000)	9.2	12.4	13.9	16.3	19.5	14.4
Adjusted rate of mortality from AIDS[1] (per 100,000)	3.4	7.7	8.6	27.1	35.1	16.6

	1 *high*	2 *average high*	3 *average*	4 *average low*	5 *low*	*Total*
Life expectancy in good health[1] both sexes (days)	70.7		67.8		62.7	68.1
Life expectancy in good health[1] men (days)	69.7		66.2		59.5	66.5
Life expectancy in good health[1] women (days)	71.2		69.1		65.7	69.5
Adjusted rate of mortality attributed to tobacco use[1] (per 100,000)	80.2	94.6	113.1	115.3	130.2	106.4
Adjusted rate of preventable mortality[1] (per 100,000)	7.1	8.5	13.7	12.0	16.2	11.5

Consequences of Health Problems

% of population with a long-term disability[2]	5.7		8.0		12.9	8.0
% of population having consulted a doctor[2]	14.9		15.8		17.4	15.7

Notes :

1. Period covering 1991 to 1994
2. Social and Health Survey, 1992-1993
3. Period covering financial years 1993-1994 to 1994-1995
4. Period covering 1990 to 1994
5. Period covering 1989 to 1993

Appendix 3

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