

**SENATE**



**SÉNAT**

***POPULATION HEALTH POLICY:  
ISSUES AND OPTIONS***

**Fourth Report of the Subcommittee on Population Health  
of the Standing Senate Committee on  
Social Affairs, Science and Technology**

Chair  
**The Honourable Wilbert J. Keon**

Deputy Chair  
**The Honourable Lucie Pépin**

**April 2008**

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(Committee Business – Senate - Recent Reports)  
39<sup>th</sup> Parliament – 2<sup>nd</sup> Session

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## ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, November 20, 2007:

The Honourable Senator Keon moved, seconded by the Honourable Senator Watt:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population — known collectively as the social determinants of health — including the effects of these determinants on the disparities and inequities in health outcomes that continue to be experienced by identifiable groups or categories of people within the Canadian population;

That the Committee examine government policies, programs and practices that regulate or influence the impact of the social determinants of health on health outcomes across the different segments of the Canadian population, and that the Committee investigate ways in which governments could better coordinate their activities in order to improve these health outcomes, whether these activities involve the different levels of government or various departments and agencies within a single level of government;

That the Committee be authorized to study international examples of population health initiatives undertaken either by individual countries, or by multilateral international bodies such as (but not limited to) the World Health Organization;

That the papers and evidence received and taken and work accomplished by the Committee on this subject since the beginning of the First Session of the Thirty-Ninth Parliament be referred to the Committee; and

That the Committee submit its final report no later than June 30, 2009, and that the Committee retain all powers necessary to publicize its findings until 180 days after the tabling of the final report.

After debate,

The question being put on the motion, it was adopted.

## MEMBERSHIP

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The following Senators have participated in the study on the inquiry on the issue of *Population Health Policy: International Perspectives* of the Subcommittee on Population Health:

The Honourable, Wilbert Joseph Keon, Chair of the Committee

The Honourable Lucie Pépin, Deputy Chair of the Committee

The Honourable Senators:

Bert Brown

Catherine S. Callbeck

Ethel M. Cochrane

Joan Cook

Joyce Fairbairn, P.C.

*Ex-officio members of the Committee:*

The Honourable Senators: Céline Hervieux-Payette, P.C. or (Claudette Tardif) and Marjory LeBreton, P.C., or (Gérald J. Comeau)

*Other Senators who have participated from time to time on this study:*

The Honourable Senators: Art Eggleton, P.C., Jim Munson, and Hugh Segal

## **ABOUT THE SUBCOMMITTEE**

In February 2007, during the 1st Session of the 39th Parliament, the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population – referred to collectively as determinants of health. The Senate renewed the mandate of the Subcommittee in October 2007, at the beginning of the 2nd Session of the 39th Parliament. Included as a central element of the study is identification of the actions that must be taken by the federal government to implement population health strategies.

The Subcommittee divided its study into two phases. The goal of the first phase was to gather evidence on the development and implementation of population health policy in various jurisdictions. Three reports were tabled in the Senate:

- *Population Health Policy: International Perspectives* (February 2008) presents an analysis of government policy to improve population health and reduce health disparities in Australia, England, Finland, New Zealand, Norway and Sweden;
- *Maternal Health and Early Child Development in Cuba* (February 2008) summarizes the Subcommittee's findings on the content, structure, cost, management and impact of maternal health programs and early childhood education initiatives in Cuba.
- *Population Health Policy in Canada: Federal and Provincial/Territorial Perspectives* (April 2008) describes previous efforts of the federal, provincial and territorial governments to develop and implement population health policy.

This report on issues and options has been developed on the basis of the findings and observations of the three phase one reports; it marks the start of the second phase of the Subcommittee's work. Its purpose is to: outline the major issues facing the development of population health policy in Canada; present policy options to a) improve overall health status and b) reduce health disparities; and launch a public debate on the role of the federal government in the development and implementation of population health policy.

With respect to the latter purpose, this paper forms the basis for public hearings and consultations with Canadians across the country. The consultation process will run through 2008; we expect to table the final report containing our recommendations in December 2008. We strongly encourage readers to review this paper carefully together with its three companion reports when preparing submissions to the Subcommittee. The deadline for written submissions is June 30, 2008. They should be sent to:

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## WHAT IS POPULATION HEALTH?

Although population health is an old and familiar term, surprisingly it does not yet have an agreed-upon international definition. When speaking about policies and approaches to improve health status and reduce health disparities, in Canada, we use the term “population health”; Sweden calls it “public health,” while in Finland the reference is to “health in all policies.” In Canada, we usually talk about “health determinants” while the WHO Commission on Social Determinants of Health, headed by Sir Michael Marmot, speaks of the “social determinants of health”; similarly for “health disparities” and “health inequities.” In our opinion, thinking and communicating clearly about population health concepts is essential for policymakers, politicians and the public to improve understanding of population health and take action to reduce health disparities. In this paper and throughout the Subcommittee’s study, the Canadian terminology is used:

- **Population health** refers to health outcomes and their distribution in the population. The health status of individuals and the population is influenced by the complex interaction of a wide range of determinants over the life course.
- The **determinants of health** encompass a wide range of personal, social, economic and environmental factors that include, for example, education; employment, income, social status, housing, gender, and culture, to name a few. Differences in health status result from the combination and interaction of health determinants and give rise to health disparities between individuals and among various segments of the population.
- **Health disparities** or health inequalities represent the variation or differences in health status, resulting from the distribution of the effects of health determinants between and among different population groups. Some disparities in health are attributable to biological variations or free choice and, as such, are essentially unavoidable; others result from the external environment and other conditions that, while largely outside the control of the individuals affected, are amenable to mitigation by the implementation of well-crafted public policy.
- A **population health policy** or population health approach refers to public policy the purpose of which is to improve or enhance the health of the population and to reduce health disparities by addressing, in a coordinated fashion, the range of determinants that influence health. Such an approach requires intersectoral action, that is, coordination among and collaboration with a variety of stakeholders.

- **Intersectoral action** for population health has two dimensions: horizontal and vertical. The horizontal dimension links different sectors such as education, health, the environment, etc. Within a single government, this can be referred to as an interdepartmental or whole-of-government approach. The vertical dimension links sectors at different levels; for example, the federal, provincial/territorial, regional, and local or municipal governments are linked both together and with groups, institutions, and organizations in the community. Intersectoral action is most successful when it results in a “win-win” situation, whereby the participants at every level gain something.

## WHAT ARE THE DETERMINANTS OF HEALTH?

The determinants of health encompass personal, social, economic and environmental factors. The following health determinants are identified in the Canadian literature:

- **Early Child Development:** Prenatal and early childhood experiences have a powerful effect on the person’s subsequent health, well-being, coping skills and competence.
- **Education:** Health status improves with educational attainment. Education can increase income and job security, and give people a sense of control over their life circumstances – key factors in good health.
- **Employment and Working Conditions:** Aside from the obvious effects of hazardous working conditions, poor health is associated being unemployed or underemployed, having stressful duties at work, and with having little control over one’s work circumstances.
- **Income and Social Status:** Health status improves at each step up the income and social hierarchy. Although prosperity itself makes a difference, narrow income disparity, i.e. an equitable distribution of wealth, is more important to the health of the population.
- **Social Environments:** The values and norms of a society can support or undermine individual and population well-being. Social stability, the welcoming and accommodation of diversity, safety, and cohesive, supportive communities all encourage good health.
- **Physical Environments:** Clean air, water and soil are vital to a healthy population, as are the human-made elements of our physical environment: adequate housing, safe workplaces and communities, well-designed cities, roadways, etc.

- **Social Support Networks:** Supportive families, friends and communities are strongly associated with high health status.
- **Lifestyle, Personal Health Practices and Coping Skills:** Personal practices and habits of daily living such as smoking, drug use, eating, and physical activity affect health and well-being. People who practice healthy behaviours and who feel effective in their own lives are likely to be successful in sustaining good health.
- **Biology and Genetic Endowment:** Biological influences on health include heredity, the function of body systems, and the processes of development and aging.
- **Gender:** Society ascribes different roles, personality traits and relative power to males and females, all of which can affect people's health. Women, for example, are more vulnerable to sexual or physical violence, low income, single parenthood, and health risks (e.g.: accidents, STDs, etc.).
- **Culture:** Race, ethnicity or cultural background can influence population health by affecting its member's vulnerability to the risks to which they are jointly exposed.
- **Health Care:** Health care services, particularly those designed to maintain and promote health, to prevent disease and injury, and to restore health and function to individuals impaired by illness, injury, or other causes, is also a significant contributor to population health.<sup>1</sup>

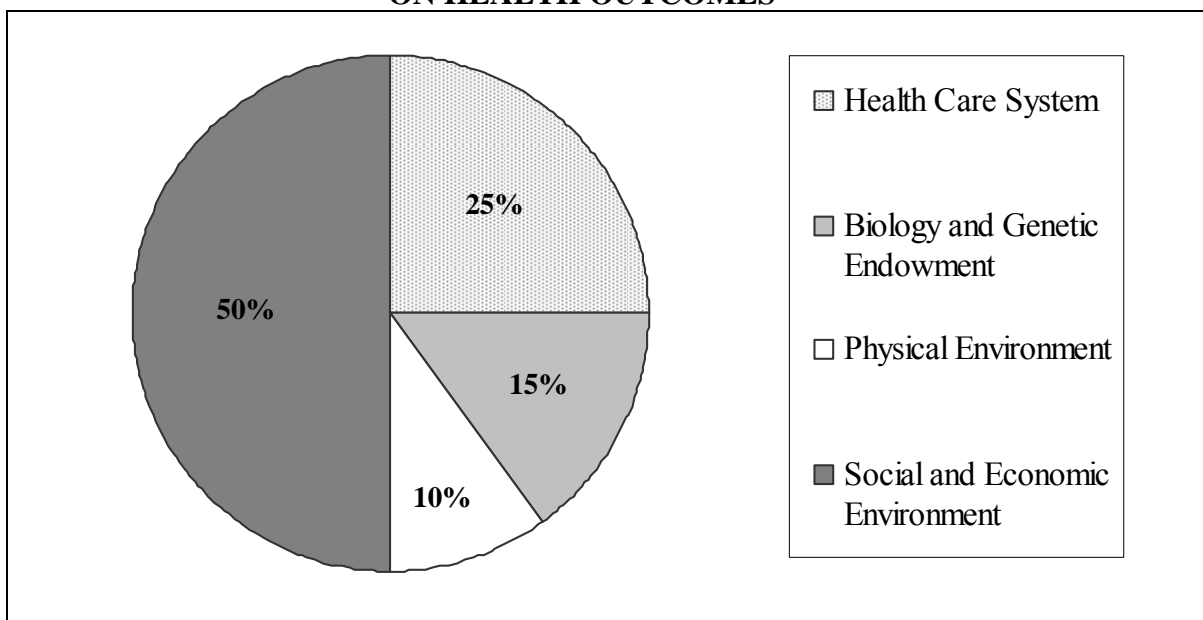
## WHAT IS THE IMPACT OF HEALTH DETERMINANTS?

Research has estimated that 15% of the population's health is attributable to biology and genetic factors, 10% to the physical environment, 25% to the reparative work of the health care system, while, fully 50% is attributable to the social and economic environment (see Figure 1). Clearly, health is much more than health care and of them all, the socio-economic environment is the most powerful of the determinants of health.

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<sup>1</sup> Adapted from: 1) Health Canada, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health*, Discussion Paper, December 1996 <http://www.phac-aspc.gc.ca/ph-sp/phdd/docs/common/index.html> and 2) National Collaborating Centre for Determinants of Health, *Determinants of Health*, 2007 <http://www.nccdh.ca/node/27>.

**FIGURE 1**  
**ESTIMATED IMPACT OF DETERMINANTS OF HEALTH**  
**ON HEALTH OUTCOMES**



Source: Estimation by the Canadian Institute for Advanced Research. Graph reproduced from the Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role, Volume One: The Story so Far*, March 2001.

Yet, knowledge and understanding about the determinants of health remains remarkably deficient. In the general public, there is a high interest in health care issues but only one in three Canadians understand the links between health and its broader non-medical determinants (e.g. income, education, housing).<sup>2</sup>

### **HOW SERIOUS ARE HEALTH DISPARITIES IN CANADA?**

Wide disparities in health exist among Canadians. While many whose health is good can expect to live long and comfortable lives, significant and avoidable ill-health is experienced by many people. Although this ill-health is distributed throughout the whole population, it is borne disproportionately by specific groups, notably Aboriginal peoples and individuals and families whose incomes are low.

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<sup>2</sup> Elyzabeth Gyorfy-Dyke, *Social Determinants of Health in Canada*, Canadian Population Health Initiative, CIHI, 8 November 2005. [http://secure.cihi.ca/cihiweb/en/downloads/SDOH\\_Sept\\_2005.pdf](http://secure.cihi.ca/cihiweb/en/downloads/SDOH_Sept_2005.pdf)

Following are a few examples of health disparities and the effect of different determinants on the health of various components of the Canadian population:

#### *Early Childhood Development*

- Prolonged and intensive stress in childhood can disrupt early development of the brain and compromise functioning of the nervous and immune systems. Children brought up in adverse environments are predisposed to social maladjustment and difficulties in school as well as to a range of health problems later in life including coronary heart disease, hypertension, type II diabetes, substance abuse, and conditions affecting their mental health.<sup>3</sup>
- Immigrant, Aboriginal and low income children, and those living in rural and remote communities are more at risk than others of experiencing a poorer start in life. Distance, availability and affordability are all significant barriers of access to early childhood education programs as are cultural barriers to Aboriginal and immigrant children when local child programming may not be culturally relevant or be provided in an unfamiliar language.<sup>4</sup>

#### *Income and Socio-Economic Status*

- In 2005, 15% of all Canadians were living in poverty,<sup>5</sup> and income inequality is increasing.<sup>6</sup> The wealthy live longer than the poor, and experience less chronic illness, obesity, and mental distress.<sup>7</sup>
- One in five Canadian children are clinically underweight at birth and, therefore, at increased risk for a number of adverse health and developmental conditions later in life.<sup>8</sup> Low birth-weight children from privileged backgrounds, however, still have a developmental advantage over normal birth-weight children born into under-privileged backgrounds.<sup>9</sup>

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<sup>3</sup> Hon. Margaret Norrie McCain, J. Fraser Mustard and Stuart Shanker, *Early Years Study 2: Putting Science into Action*, Council for Early Child Development, 2007. <http://wwwFOUNDERS.net/fn/news.nsf/24157c30539cee20852566360044448c/5e0d29958d2d7d04852572ab005ad6a6!OpenDocument>

<sup>4</sup> Public Health Agency of Canada.

<sup>5</sup> National Council on Welfare, *Poverty Trends in Canada*, Solving Poverty Information Kit, June 2007. <http://www.ncwcnbes.net/en/publications/pub-126.html>

<sup>6</sup> Andrew Heisz, *Income Inequality and Redistribution in Canada: 1976-2004*, Catalogue no. 11F0019MIE - No. 298, Statistics Canada, 2007.

<sup>7</sup> Morton Beiser and Miriam Stewart, "Reducing Health Disparities: A Priority for Canada," *Canadian Journal of Public Health*, Volume 96, Supplement 2, March-April 2005. <http://acsp.cpha.ca/shared/cjph/archives/2005/abstr2-s.htm>

<sup>8</sup> Canadian Population Health Initiative, *Improving the Health of Canadians*, CIHI, 2004. [http://www.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=PG\\_39\\_E&cw\\_topic=39&cw\\_rel=AR\\_322\\_E](http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_39_E&cw_topic=39&cw_rel=AR_322_E)

<sup>9</sup> Canadian Institutes of Health Research, *Population Health*, 2005-2006. [http://www.cihr-irsc.gc.ca/e/documents/population\\_health\\_mpk0506\\_e.pdf](http://www.cihr-irsc.gc.ca/e/documents/population_health_mpk0506_e.pdf)

- In 2000-2001, twice as many men and women in Canada's highest income group rated their health as excellent compared with those in the lowest income group.<sup>10</sup>

### *Education*

- Almost half of all Canadian adults lack the literacy necessary to participate fully in our knowledge-based economy. They face high levels of unemployment and, consequently, often live in unstable environments. Illiterate families face direct health risks derived from, for example, difficulty reading instructions for baby formulae, medications, or educational materials about health and safety.<sup>11</sup>
- The diets of families whose members are better-educated and have higher incomes more closely adhere to nutritional guidelines than of those with less education and lower incomes. Inadequate diet is linked to the development of many diseases.<sup>12</sup>

### *Geography*

- While Canada's life expectancy is among the longest in the world, it varies by 11 years across the country from a low 70.4 in Nunavut to a high 81.2 in British Columbia.<sup>13</sup>
- There is also considerable variability among provinces and territories in the percentage of people reporting their health to be excellent or very good, from a high of 68% in Newfoundland and Labrador to a low of 51% in Nunavut.<sup>14</sup>
- Measured between 1997 and 1999, life expectancy in Montréal was 78.5 years. But, it varied among neighbourhoods from a low of 71.6 to a high of 82.3 years.<sup>15</sup>

### *Aboriginal Status*

- The socio-economic status of Aboriginal Peoples – First Nations, Inuit and Métis – is lower than that of non-Aboriginal Canadians on virtually every measure (low income, high unemployment, lower educational attainment).<sup>16</sup>
- On average, First Nations and Inuit peoples' life expectancy is five to 10 years less than Canadians as a whole. Infant mortality rates among First Nations on reserve and Inuit are two to three times the Canadian rate overall. Injuries are the biggest contributor to premature death amongst the First Nations population on reserve, four times that of the Canadian population as a whole.<sup>17</sup>

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<sup>10</sup> *Improving the Health of Canadians*, 2004.

<sup>11</sup> Morton Beiser and Miriam Stewart (2005), *op. cit.*

<sup>12</sup> Canadian Institutes of Health Research (2005-2006), *op. cit.*

<sup>13</sup> Statistics Canada, *Table 102-0511 - Life expectancy, abridged life table, at birth and at age 65, by sex, Canada, provinces and territories, annual 2004, 2005.*

<sup>14</sup> Canadian Population Health Initiative, *Improving the Health of Canadians: An Introduction to Health in Urban Places*, CIHI, 2006.  
[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=PG\\_471\\_E&cw\\_topic=471&cw\\_rel=AR\\_1217\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_471_E&cw_topic=471&cw_rel=AR_1217_E)

<sup>15</sup> *Ibid.*

<sup>16</sup> *Improving the Health of Canadians*, 2004.

<sup>17</sup> *Ibid.*

- At least 33% of First Nations and Inuit people, compared to 18% of non-Aboriginal people, live in inadequate, unsuitable or unaffordable housing. Poor housing is associated with a host of health problems. For example, crowded housing is associated with increased rate of tuberculosis; among First Nations in the 1990s the incidence of tuberculosis was at least seven times higher than that of Canada overall.<sup>18</sup>
- Youth suicide rates among First Nations are five to seven times higher, and among Inuit youth 11 times higher, than among their non-Aboriginal peers.<sup>19</sup>

### *Gender*

- While women live six years longer than men, they are more likely to experience chronic conditions and limitations on their activity long-term. As for the effect of poverty, the probability of survival to age 75 for men in 1996 was 68.6% in the richest neighbourhoods and only 53.4% in the poorest. For women, the probabilities were 79.7% and 73.0% respectively.<sup>20</sup>
- The rate of smoking among certain groups of women is increasing at an alarming rate, as are its consequences, particularly cancer, respiratory and cardiovascular disorders. Single parents (primarily women), unpaid caregivers, homosexuals, bisexuals, and transgendered people are also at particular risk for compromised health.<sup>21</sup>

### *Other*

- Over an eight-year period (1994/1995-2002/2003), recent immigrants from non-European countries were twice as likely as those born in Canada to report deterioration in their health, despite the fact they were generally in better health when they arrived in Canada than those born here.<sup>22</sup>
- Individuals who lack control over their work environment are more likely to develop and die from cardiovascular disease.<sup>23</sup>
- Smoking, obesity, high stress, low household income, and a weak sense of community all have significant negative effects on health status.<sup>24</sup>

The Subcommittee believes it is unacceptable for a privileged country like Canada to continue to tolerate such disparities in health. Our challenge is to find ways to improve the health of all Canadians to equal that of those who experience the best health,

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<sup>18</sup> *Ibid.*

<sup>19</sup> Public Health Agency of Canada.

<sup>20</sup> Brent Moloughney, *Housing and Population Health: The State of Current Research Knowledge*, Canadian Population Health Initiative, CIHI, 2004.  
[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=AR\\_1129\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1129_E)

<sup>21</sup> Morton Beiser and Miriam Stewart (2005), *op. cit.*

<sup>22</sup> Canadian Institutes of Health Research (2005-2006), *op. cit.*

<sup>23</sup> *Ibid.*

<sup>24</sup> *Ibid.*

regardless of their ethnicity, social or economic position. Furthermore, we believe that the actions necessary to improve the situation will only be possible through concerted intersectoral action, difficult as we realize that is to achieve. But we know that there have been successes and we believe enough has been learned to take action successfully.

## **WHY GOVERNMENTS SHOULD IMPLEMENT POPULATION HEALTH POLICY**

There are sound economic and social reasons to improve the health of the population. The benefits of a population health approach extend beyond improved health status and reduced health disparities to affect strongly economic and social conditions. Simply put, population health policies and programs foster economic growth, productivity and prosperity. Good health enables children to perform well in school. Good health enables people to be more productive and higher productivity, in turn, reinforces economic growth. Healthy citizens who are better engaged in their communities contribute to social cohesion. A healthy population requires less of government expenditures on income support, social services, health care, and security. Simply put, the Canada's health depends on the health of all Canadians.

Good health is not only a key asset for economic development. In our highly civilized country, health for all must surely be a prime social goal – a responsibility of society as a whole. Health is a fundamental human need and, therefore, a basic human right. Good health is essential for individuals and societies to function well. Therefore, health must be supported throughout all stages of life from conception to childhood through adulthood to old age. In addition to the sound economic reasons, we believe that governments have a moral obligation to foster the social and cultural conditions that empower individuals, communities and societies to create and maintain the conditions necessary for all citizens to live their lives in good health. This is a major challenge that can only be tackled through a whole-of-government approach in which health and health disparities are targeted in all policy fields (education, social and cultural services, economic policy, environmental policy, taxation, etc). Doing so, of course, will



require a profound structural change both in public policy and governments' approach to the development and implementation of public policy.

## **WHICH ISSUES MUST BE ADDRESSED AND WHAT OPTIONS ARE AVAILABLE?**

### **Issue 1: Tracking Health Outcomes and Supporting Research on Interventions to Enhance the Health of the Population**

Awareness is growing, in Canada and internationally, of the determinants of health, the broad range of factors that affect the health of populations and its distribution among groups of people. All the countries profiled by the Subcommittee – Australia, England, Finland, New Zealand, Norway and Sweden – have established sound databases to collect and monitor indicators of health. National institutes of public health monitor and report regularly on population health in Norway, Sweden and Finland. The extent of health disparities is particularly well documented in England and New Zealand. Moreover, Australia, Finland, Norway and Sweden have established national research programs on health disparities and on the effectiveness of government interventions to foster population health.

How does Canada compare in terms of collecting, monitoring and reporting on health outcomes and health disparities? The evidence obtained by the Subcommittee suggests that Canada has sound data on population health status by determinant and on health disparities. At the national level, reliable information is provided by the Canadian Population Health Initiative, Statistics Canada and the Public Health Agency of Canada, while several useful provincial sources of health indicators and health disparities are available including, to name a few, the Manitoba Population Health Data Repository, the Community Accounts in Newfoundland and Labrador, and the B.C Health and Wellness Survey. These sources of information are assets that can facilitate the development of the focused knowledge and evidence needed to move the population health agenda forward. But there remain substantial deficiencies, however,

with data and information generally, including particularly on the health status and disparities among Aboriginal Canadians.

Canada compares favourably in terms of population health research with the work funded or performed at the national level by the Canadian Institutes of Health Research, the National Collaborating Centres on Public Health, the Canadian Population Health Initiative, Health Canada and the Public Health Agency of Canada, as well as at the provincial level by the Manitoba Centre for Health Policy, the *Institut de la santé publique du Québec*, the Ontario Institute for Work and Health and the Saskatchewan Population Health, and Evaluation Research Unit, and other such organizations. What more can and needs to be done?

*Possible Option: Expand and Enrich the Population Health Database*

More and better, more complete data and information are needed to understand better the factors that affect population health in Canada. The nature of the relationships between health and its determinants is complex; it cannot be explained in terms of single, commonly-used measures of socioeconomic status, such as income, education, or occupation. We need to ask: do we have enough and sufficiently sensitive indicators to track and assess the extent of health disparities; where are the gaps in knowledge and how can we fill them; what can be done to improve the information available on health disparities among First Nations, Inuit and Métis peoples; should Canada establish a national information database system on the health of the population and on health disparities; what role should be played by Statistics Canada, the Canadian Population Health Initiative, Health Canada, the Public Health Agency of Canada, and provincial/territorial governments and their agencies in the establishment and maintenance of a national database system; who should take the lead in facilitating the development of such a system; what can be done to reduce duplication and overlaps and to leverage the finite resources available; are there countries or provinces/territories we could use as a model when developing a national database; how can a national database on health disparities be built on existing sources, such as the Canadian Population Health

Initiative and the Manitoba Centre for Health Policy; how much funding is necessary to establish a comprehensive, well-managed national information database system on population health?

*Possible Option: Invest in More Population Health Research and Enhance the Translation of Knowledge*

It is not clear how much Canada spends on population health research. The Subcommittee was told, however, that current funding does not reflect the burden of health disparities and that more practical evidence-based knowledge is needed on what works and what does not with respect to policy and program interventions intended to improve the health of the population. How much funding should the federal government devote to research on population health and health disparities? If more funding is required, from where should it come? Should a dedicated fund be established to support population health research? What proportion of this fund should be devoted to research on the effectiveness of government interventions to optimize the health of the population and to reduce health disparities? How can research on Aboriginal health and health disparities be fostered? Given that population health is affected by the policies and actions of so many sectors, how can the various research organizations at the federal, provincial, territorial levels as well as in the private sector, establish synergistic partnerships to build, strengthen and link the Canadian population health research community altogether? Who should take the lead in knowledge translation to improve the use of evidence generated from research to inform population health policy, practice and programs? Building on the current Canadian expertise, should we establish a national research agenda to coordinate research on population health and health disparities?

## **Issue 2: Reorienting Government Policy**

There is no national plan in Canada to improve overall population health status and reduce health disparities. Our governments have not articulated the vision of a healthy society, much less the strategies or action-plans necessary to achieve it. At the

federal level, while it has talked about it, the government has not succeeded in implementing a comprehensive approach to population health.

In contrast, England has adopted a unique, whole-of-government policy to reduce health disparities involving 12 central departments and agencies together with a number of regional and local authorities. Specific national targets for reduced disparities have been set and national indicators developed to quantify regular reports on progress. Through an interdepartmental review, the UK Treasury identified how best public spending could be applied to reduce health disparities. In Sweden and Québec, public health legislation requires government departments and agencies to assess the health impacts of any proposed new law and regulation. The *Act* in Sweden also includes specific health objectives and measurable targets applicable to some 50 departments and agencies. Finland and Australia also encourage strongly the use of health impact assessment (HIA) for new legislation, regulations, and programs.

*Possible Option: Undertake an Interdepartmental Spending Review*

The Subcommittee has taken note that the support of finance departments was particularly important in every country, ensuring not only the availability of adequate funds to support the implementation of population health policy but also the compliance of other government departments with the health-oriented initiatives required. Whereas Health Departments often meet resistance and charges of “health imperialism” when seeking changes in other departments’ policies and programs that will improve health outcomes and reduce health disparities, when a central agency like Finance takes the lead genuine cooperation is far more forthcoming. England provides a good example. The spending review led by the Treasury in 2002 informed departmental spending plans for the 2003-2006 fiscal years and generated mandatory commitments for actions that, in sum, constituted implementation of a whole-of-government approach to reduce health disparities.

Should Finance Canada, in collaboration with other central agencies, conduct a similar interdepartmental spending review? Which federal departments should be subject to it? Should the outcomes result in mandatory commitments? Is this the most appropriate mechanism available to the federal government to stimulate implementation of a population health policy or should another approach be taken? If so, what should that approach be?

*Possible Option: Establish Health Goals*

Tangible, measureable health goals, objectives and targets are essential components of a population health strategy. They support identification of the areas on which to focus attention, determine the data to collect and indicators to monitor, establish benchmarks, and enable progress to be measured and reported. In the countries profiled by the Subcommittee, some goals and targets focused on specific health outcomes (e.g., reduced mortality and morbidity) while others focused on the adoption of healthier behaviours; only a few countries, like England and Sweden, set targets for the reduction of health disparities.

In Canada, each province articulated health goals between 1989 and 1998, that, by the end of the 1990s, were no longer being applied. In 2005, the F/P/T Ministers of Health established health goals for Canada that, to date, have neither evolved into a national strategy nor have resulted in measurable actions. Moreover, national targets have not been set to reduce health disparities. The Subcommittee believes that health goals can aid in mobilizing resources to support population health initiatives, in monitoring and reporting progress, and in stimulating work on the development of health indicators and of health information systems.

Should the federal government, when developing its population health policy, clearly enunciate health goals, objectives and targets? Which goals, objectives and targets would be most appropriate to inform policies to reduce health disparities? Should they be set in legislation as in Sweden? Is new legislation required or could the

necessary goals and targets by added to existing legislation by amendment? Are there better alternatives to legislation?

*Possible Option: Require Health Impact Assessment (HIA)*

The process of HIA is well developed and used in many of the countries reviewed by the Subcommittee. HIAs are performed for a variety of reasons, including addressing both the determinants of and disparities in health, assessing the role that non-health sector policies have in promoting and protecting good health, and ensuring that health-related issues are considered in government-wide policy making. In Sweden and New Zealand, unlike England where it has been advocated but never implemented, public health legislation has been employed to embed HIA as an integral government process.

In 1997, a recommendation was made to the federal Cabinet in the Memorandum on Population Health that HIA be employed on federal policies and programs. Similarly, the use of HIA has been promoted in a number of provinces and several provincial reports have recommended that HIAs be included in all Cabinet submissions. To date, only Québec has an *Act* to ensure that the impacts on health of proposed laws and regulations are assessed. The Subcommittee believes that HIA could be considered as one of the first steps toward the development of population health policy. Such assessments would lead to a better understanding of how most public policies influence population health in one way or another. In our view, HIA is a practical way to judge the potential health effects on the population of a given policy, program or project and in particular on vulnerable or disadvantaged groups; it could maximize the positive and minimize the negative health effects of proposals coming forward from all sectors of government.

Should the federal government establish a mechanism to allow for or require the application of HIA to all new public policy proposals? Would new legislation be required to do so? Is it realistic to envision HIA as a routine component of all new federal policies and programs? If HIA were to be introduced as a component of federal population health policy, what should be the role and responsibilities of Health Canada,

the Public Health Agency of Canada, and central agencies such as Finance Canada and the Treasury Board?

*Possible Option: Implement a Federal Population Health Strategy*

Although experts acknowledge that there is no single right way to enhance the health of the population or reduce health disparities, they all agree that the more focused and integrated a pan-government strategy for action, the greater the probability that health status and its distribution will change in the desired direction. Moreover, the Subcommittee's international review suggests that leadership at the highest levels, including from central agencies, is essential for a whole-of-government approach to population health to be successful. The United Kingdom provides an example of successful interdepartmental collaboration: the concerned Cabinet committee includes a dozen departments and addresses cross-cutting initiatives to improve health and reduce health disparities.

Something similar was attempted in Canada in 1997 with endorsement by the federal government of the Memorandum to Cabinet on Population Health; the proposal involved 18 departments with Health Canada in the lead. It failed in its interdepartmental co-ordinating role because significant funding cuts impeded implementation. Only Health Canada has applied a population health lens to its programs and initiatives. The lesson learned here is that although a formal commitment by government is a good first step, it must be accompanied with sustained, predictable funding to ensure interdepartmental action on population health and the policy's implementation over the long term. Shifting of the resources necessary to develop and implement population health policy is a long term process that can only be facilitated through a comparable long standing commitment on the part of successive governments.

Another approach identified in our international review is to link health explicitly to other policy fields. The population health policy emanating from the health departments in Finland, New Zealand, Norway and Sweden are linked to separate

policies on poverty, social inclusion, and social justice, all of which relate directly to underlying determinants of poor health (low income and unemployment, housing and homelessness, and social exclusion). Both Newfoundland and Labrador and Québec have adopted this approach. Elsewhere in Canada, whole-of-government approaches tend to be structured around single health determinants, such as ActNow BC's focus on personal health practices and Healthy Child Manitoba on early childhood development .

Thirty years ago the Canadian government was acclaimed worldwide for its leadership in elaborating the concept of population health and promoting population health policy. It is time, once again, for leadership in developing and implementing a pan-Canadian population health strategy. It is a feasible task, given the federal government's role in many policy areas that affect health – the environment, agriculture, economic policy, income support, health research, employment, taxation, etc. There is something there to build on. Health Canada developed in 2001 a template to guide the successful implementation of population health policy in the health sector and beyond.

How should the federal government proceed? Should it use Health Canada's 2001 template as a guide? Should it adopt the whole-of-government approach endorsed by Cabinet in 1997 together with a secure commitment of the necessary funds? If so, who should take on the role of champion for population health– Health Canada or a central agency like Finance or the Treasury Board? How can the central agencies be convinced and engaged in a whole-of-government approach to population health? What other federal departments and agencies should be involved?

Are there examples of the application of a whole-of-government approach that could be used as a model for a co-ordinated approach to population health – the National Family Violence Initiative, Tobacco Demand Reduction Strategy, or Sustainable Development Initiative, for example?

With such a wide-ranging and complex topic as population health, comprehensive, co-ordinated action on all determinants affecting the entire population



would be difficult to achieve in the short term. Would it be more effective for the federal government to take a step-by-step approach to implementing a population health strategy? If so, should the first steps focus on particularly vulnerable populations (Aboriginal peoples, children, low-income families, etc.) or should they emphasize particularly powerful health determinants such as early child development, housing, income support, etc.? Should the federal government consider developing and implementing a health strategy and a poverty strategy separately?

*Possible Option: Establish a F/P/T Population Health Policy Framework*

As in Australia, jurisdictional issues between the federal and provincial/territorial governments have been a constant element in the development of population health policy in Canada. Population health policy cuts across federal and provincial/territorial responsibilities; obviously a coordinating process is essential to achieve consensus and enhance collaboration. Between 1994 and 2004, the principal vehicle supporting intergovernmental dialogue and coordination in this field was the Advisory Committee on Population Health, a body reporting to the F/P/T Conference of Deputy Ministers of Health. This committee took a long-term, integrated view of the health of the population and advocated policy coherence across all relevant sectors. In its *Reducing Health Disparities* papers in 2004, for the first time in Canada, the F/P/T Advisory Committee on Population Health addressed health disparities from a systemic perspective, in contrast to dealing with health disparities affecting specific populations. Although a commitment in principle to address health disparities was secured at the F/P/T level, there has been no agreement subsequently on recommended actions and the designation of an organization to take the lead in addressing those disparities in Canada. Obviously, intergovernmental collaboration is essential to the successful implementation of either policies to reduce health disparities or, more generally, an overall population health strategy.

How can Canada turn knowledge into concrete action on population health at the F/P/T level? Does the current Public Health Network provide an effective forum

for population health policy discussion? Should the F/P/T Advisory Committee on Population Health be revived as a collaborative mechanism to develop a national population health strategy? Does the current Integrated Pan-Canadian Healthy Living Strategy have the potential to significantly reduce health disparities? Could it be a useful step toward the development of a broader population health strategy?

*Possible Option: Strengthen Intersectoral Action: Engaging Communities*

Policy action across sectors is essential to address effectively the determinants of health and to reduce health disparities. To repeat what has been said above, this involves not only working across departments within one level of government, but with different governments, and non-governmental partners as well. Interventions at the community level are most successful in reaching vulnerable populations, creating local networks, and leveraging resources. In fact, the active participation of civil society groups has been identified as a key success factor in cases in which intersectoral policy on health determinants has worked well both at the local and national levels. There is no one ideal model to facilitate intersectoral action, but there are successful examples the federal government can build upon, such as the Urban Development Agreements and the National Homelessness Initiative.

To foster intersectoral action, the U.K. has created regional offices that bring together many departments under one roof; Saskatchewan and Newfoundland and Labrador, have established regional structures located outside health departments that appear to have been effective in promoting collaboration and partnerships. Manitoba has adopted a community economic development framework to guide provincial policy and program development.

In Cuba, polyclinics successfully reach and engage communities in health promotion, disease prevention and early diagnosis. These clinics are spread throughout the country, involve multidisciplinary teams (doctors, nurses, psychologists, social workers, dentists, speech and language therapists, etc.) and maintain close relationships

and have personal knowledge of the population they serve. Polyclinics break down silos through considerable integration of resources and sharing of responsibility, including medical/nursing training and education, data collection, scientific research and knowledge translation.

How can the federal government collaborate better with both governmental and non-governmental partners? Have the administrative and reporting requirements placed on community-based partner organizations in intersectoral initiatives improved? Do adequate evaluation processes exist to capture the outcomes of intersectoral initiatives in complex, dynamic environments? To what extent could the polyclinic model be adapted to the Canadian situation?

### **Issue 3: Implementing an Aboriginal Population Health Strategy**

As described above, Aboriginal populations bear a disproportionate burden of the ill health, suffering, and social deprivation in Canada. Their health disparities originate in the broad determinants that affect all Canadians but also in determinants related to colonization, and their efforts to regain some level of self-determination and community control.

Given its special responsibility for Aboriginal peoples and its central role in the provision of programs and services, the federal government has a particular opportunity to engage Aboriginal leaders to find out how the application of a population health approach, together with Aboriginal concepts of health, could improve the focus, organization and delivery of those governmental services and lead to diminution of the disparities of health between those populations and other Canadians.

The need for better data on Aboriginal populations has been mentioned earlier; it is not repeated among the options below.

*Possible Option: Implement a Comprehensive Aboriginal Population Health Strategy*

The federal government can play a key role in addressing the health disparities, the unusually low health status, affecting Aboriginal peoples. It currently delivers a complex array of programs in sectors such as health, lifelong learning, safe and sustainable communities, housing, economic opportunity, land and resources, and governance and relationships. Thirty federal departments and agencies deliver some 360 programs and services at a cost of \$8.2 billion to Indians, Inuit and Métis. These programs and services, however, are not coordinated and integrated in ways that would optimally reduce health disparities. The first option would be for the federal government, and Aboriginal leaders to develop and implement a federal population health strategy by coordinating and integrating the activity of the different departments and agencies that have some responsibility for programs and services for Aboriginal Canadians. Who should take the lead and what mechanism should be used to ensure the active participation of Aboriginal Leaders in the development and implementation of this strategy?

The range of federal programs and services available to Aboriginal groups varies based on their status, negotiated agreements, jurisdiction, treaty obligations and policy decisions; some programs are delivered by Aboriginal governments themselves or are designed to complement other provincial, territorial and Aboriginal programs. In partnership with Aboriginal authorities at local, regional and national levels, should these policies be coordinated to improve their aggregate effect on the health of the population and to reduce health disparities between Aboriginal Canadians and others? Could Aboriginal communities with the capacity to discharge it have more authority over the resources available to them to strengthen local social, economic and cultural conditions in ways that produce better health outcomes?

The provincial/territorial governments also have responsibility for Aboriginal population health. This was clearly acknowledged in the 2005 Kelowna Accord, an ambitious ten-year plan to “close the gap” between Aboriginal and non-

Aboriginal Canadians in the areas of education, housing and infrastructure, health and economic opportunities – all key determinants of health. What can be done by federal, provincial and territorial governments separately and working together to advance the agenda on “closing the gap” for Aboriginal peoples?

*Possible Option: Adopt a Step-by-Step Approach to Implementation of an Aboriginal Population Health Strategy*

Rather than embarking on an approach across-the-board, the federal government could focus its population health strategy for Aboriginal peoples on selected determinants. For example, breaking the cycle of poverty and poor health that exists in many Aboriginal communities will require addressing three of the most fundamental determinants of health: income, education and housing. How do current policies and programs in these areas need to change?

Another possible option for the step-by-step approach would be to improve access to healthy food in remote communities. Currently, the federal Food Mail Program pays part of the cost of transporting nutritious perishable foods to isolated northern communities. Despite this subsidy, a nutritious diet in isolated northern communities costs roughly double what it would cost in southern Canada, a very heavy burden given the relatively high levels of un- and under-employment and of poverty in many such communities. By comparison, provincial regulations across the country ensure an equal price for alcohol regardless of location – a bottle in Northwestern Ontario costs the same as in Ottawa. Equalizing through subsidies the price of food for children makes more sense than doing so for alcohol! Should the Food Mail Program be enhanced? What other measures would improve access to nutritious food in remote communities?

*Possible Option: Strengthen Peer-Learning Among Aboriginal Populations*

While the situation overall is serious, not all Aboriginal groups have lower health status than other Canadians. Many First Nations have been effective in improving

health status in their communities and have suicide rates that are lower than provincial or Canadian averages. Despite the diversity of cultural and social conditions that exist between and among First Nations, Inuit and Métis populations, could the experience and ideas of leaders from resilient, successful communities benefit those who are doing less well? Could effective practices and approaches be shared with and adapted by Aboriginal communities? Should the federal government be supporting Aboriginal efforts to build capacity and strengthen leadership, and if so, how?

#### **Issue 4: Fostering Political Will**

Understanding the scale and causes of health disparities and identifying the most effective mechanisms for reducing them are fundamental. But that knowledge alone, while essential, is insufficient to bring about the necessary changes to policies and programs.

High-level leadership has proved to be key to most successful population health strategies internationally. But such strategies also require long-term continuity; too often they are derailed by changes in government or the adoption of different priorities by successive (or even the same) government.

Public awareness, support and engagement of the non-health sector, and consensus on key priorities is important to foster political will, generate the conditions necessary for action, and to sustain those actions over a longer term.

##### *Possible Option: Raise Public Awareness*

The impacts on health of personal lifestyle behaviours (such as eating habits, physical activity, smoking and drinking), access to health care and a healthy environment are recognized by the public; the impacts of the broader determinants, however, like early child development, education, income and social support seem to be less well understood. The Canadian media tends to overemphasize the significance of the

health care system and personal lifestyles on health and to underemphasize the role of the socio-economic environment. The general public does not easily relate to the theoretical concept referred to as “population health”. As governments are frequently guided by public opinion, there is a need to generate among the public a more balanced understanding of what creates and sustains good health.

How can we best capture the public’s interest in their own aggregate health status? What can be done to reframe the debate about health in Canada? Should the federal government be supporting public education and conducting awareness-raising campaigns on the extent and cost of health disparities? What role can the media play in enhancing public understanding of population health? Who would key partners be in changing public attitudes about health and health disparities?

*Possible Option: Mobilize and Engage the Non-Health Sector in Population Health Action*

Even though the determinants of health cut across many sectors, the Subcommittee’s federal, provincial/territorial and international review showed that the health sector remains overwhelmingly predominant when a population health approach is considered. The most successful models, however, unite a range of sectors. A key strength of Cuba’s polyclinics is their ability to integrate health, education, social services, science and knowledge translation in the delivery of services at the primary care level. In other words, the policy initiatives of all sectors must play a major leveraging role to address population health effectively; every sector must be actively engaged from the outset if health disparities are to be reduced.

Are there champions to carry the message to sectors other than health and convince them of the important stake they have in improving the health of the population? What evidence, promising practices, stories or arguments are sufficiently convincing? Once the other government sectors are convinced, how can they become actively engaged in population health? What can be done to recruit the private sector as a valuable supporter and strong advocate of reducing health disparities?

*Possible Option: Build Consensus Among Key Stakeholders on Priority Actions*

The scope of action available to government will be in part dictated by the level of support from a range of stakeholders. Building consensus both at the community level, among Canada's provinces and territories, and nationally will create a more favourable environment for population health policies. What actions are most likely to generate the most support from the widest spectrum of stakeholders? What strategies and tools are the most effective to build consensus on the need for action to reduce health disparities?



## APPENDIX 1 - WITNESS LIST

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
<b>39<sup>th</sup> Parliament 1<sup>st</sup> Session</b>			
World Health Organization Commission on the Social Determinants of Health	The Honourable Monique Bégin, P.C., Commissioner	22-02-2007	1
Institute of Population Health	Ronald Labonté, Canada Research Chair in Globalization and Health Equity	28-02-2007	1
Provincial Health Services Authority, B.C.	Dr. John Millar, Executive Director, Population Health Surveillance and Disease Control	28-02-2007	1
School of Health Policy and Management - York University	Dennis Raphael, Professor	28-02-2007	1
Public Health Agency of Canada	Jim Ball, Director, Development and Partnerships Division, Strategic Policy Directorate, Strategic Policy, Communications and Corporate Services Branch	21-03-2007	2
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, Associate Scientist	21-03-2007	2
Public Health Agency of Canada	Maura Ricketts, Acting Director General, Office of Public Health Practice, Public Health Practice and Regional Operations Branch	21-03-2007	2
Public Health Agency of Canada	Dr. Sylvie Stachenko, Deputy Chief Public Officer, Health Promotion and Chronic Disease Prevention	21-03-2007	2

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
Statistics Canada	Michael Wolfson, Assistant Chief Statistician, Analysis and Development	21-03-2007	2
Institute of Population and Public Health	Dr. John Frank, Scientific Director of the Canadian Institutes of Health Research	28-03-2007	2
Global Health and Social Policy	Dr. Jody Heymann, Canada Research Chair in Global Health and Social Policy	28-03-2007	2
McGill University	Dr. John Lynch, Canada Research Chair in Population Health	28-03-2007	2
Public Health Agency of Canada	Jim Ball, Director, Development and Partnership Division, Strategic Policy Directorate	25-04-2007	3
Indian and Northern Affairs Canada	Marc Brooks, Director General, Community Development Branch, Socio-economic Policy and Regional Operations sector	25-04-2007	3
Centre for Aboriginal Health Research, University of Manitoba	John O'Neil, Professor and Director	25-04-2007	3
Health Canada	Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch	25-04-2007	3
Institute of Aboriginal People's Health (IAPH) for the Canadian Institutes of Health Research (CIHR)	Dr Jeff Reading, Scientific Director	25-04-2007	3
Research Faculty/Saskatchewan Population Health and Evaluation Research Unit	Sylvia Abonyi, Canada Research Chair in Aboriginal Health	02-05-2007	3
National Aboriginal Health Organization (NAHO)	Mark Buell, Manager, Policy and Communication Unit	02-05-2007	3

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
University of British Columbia - Department of Psychology	Dr. Michael J. Chandler, University of British Columbia Professor and Distinguished Canadian Institutes for Health Research (CIHR) and Michael Smith Foundation for Health Research (MSFHR) Investigator	02-05-2007	3
National Aboriginal Health Organization (NAHO)	Carole L. Lafontaine, Acting Chief Executive Officer	02-05-2007	3
Toronto University	Dr. Kue Young, Professor, Department of Public Health Services	02-05-2007	3
Observatory on Ageing and Society (OAS)	Dr. André Davignon, Founder	16-05-2007	4
Nova Scotia Department of Health	Valerie J. White, Executive Director, Seniors Secretariat	16-05-2007	4
Public Health Agency of Canada - Division of Aging and Seniors	Margaret Gillis, Director	16-05-2007	4
Canadian Association on Gerontology	Mark Rosenberg, Professor Queen's University	16-05-2007	4
The CHILD Project	Dr. Hillel Goelman, Director, Senior Scholar, Human Early Learning Partnership (HELP)	30-05-2007	4
Canadian Institutes of Health Research	Dr. Michael Kramer, Scientific Director, Institute of Human Development, Child and Youth Health	30-05-2007	4
Council of Early Child Development	Stuart Shankar, Professor, President	30-05-2007	4

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	31-05-2007	4
Métis National Council	David Chartrand, Minister of Health	31-05-2007	4
Métis National Council	Marc LeClair, National Advisor to the Minister of Health	31-05-2007	4
Métis National Council	Rosemarie McPherson, National Spokesperson for Women of the Métis Nation	31-05-2007	4
BC Ministry of Health	Dr. Evan Adams Aboriginal Health Physician Advisor, Office of the Provincial Health Officer	01-06-2007	5
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	01-06-2007	5
Institute of Aboriginal Peoples' Health	Laura Commanda, Assistant Director, Partnerships, Knowledge Translation and International Relations	01-06-2007	5
Pauktuutit Inuit Women of Canada	Jennifer Dickson, Executive Director	01-06-2007	5
Native Women's Association of Canada	Claudette Dumont-Smith, Senior Health Advisor	01-06-2007	5
Indigenous People's Health Research Centre	Willie Ermine, Professor, Writer - Ethicist	01-06-2007	5
Inuit Tapiriit Kanatami	Anna Fowler, Project Coordinator, Department of Health	01-06-2007	5

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
National Association of Friendship Centres	Alfred J. Guay, Policy Analyst	01-06-2007	5
Assembly of First Nations	Valerie Gideon, Director of Health and Social Development	01-06-2007	5
University of Alberta	Malcom King, Professor, Department of Medicine	01-06-2007	5
Aboriginal Nurses Association of Canada	Julie Lys, Director, North West Territories Region	01-06-2007	5
Toronto University	Chandrakant P. Shah, Professor emeritus	01-06-2007	5
Congress of Aboriginal Peoples	Erin Wolski Health Policy Program	01-06-2007	5
<b>39<sup>th</sup> Parliament 2<sup>nd</sup> Session</b>			
Ministry of Health and Social Affairs	Irene Nilsson-Carlsson, Deputy Director General, Public Health Division	22-11-2007	1
Swedish National Institute of Public Health	Dr. Gunnar Agren, Director General	22-11-2007	1
Karolinska Institute:	Dr. Piroska Ostlin, Dept. of Public Health Sciences	22-11-2007	1
Swedish National Institute of Public Health	Bernt Lundgren, Public Health Policy Expert	22-11-2007	1
The Quaich Inc.	Patsy Beattie-Huggan, President	28-11-2007	1
McMaster University	John Eyles, Professor, School of Geography and Earth Sciences	28-11-2007	1
PEI Department of Health	Teresa Hennebery, Assistant Deputy Minister, Health Operations	28-11-2007	1
Group d'étude sur les	France Gagnon, Professor and	05-12-2007	2

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
politiques et la santé	co-chair		
University of Montreal	Nicole Bernier, PhD, Assistant Professor	05-12-2007	2
U.K. Department of Health	Dr. Fiona Adshead, Director General of Health Improvement	11-12-2007	2
B.C. Interior Health Authority	Lex Baas, Director of Population Health	12-12-2007	2
University of British Columbia	James Frankish, Professor and Director	12-12-2007	2
Ontario Ministry of Health Promotion	Pegeen Walsh, Director, Chronic Disease Prevention	06-02-2008	3
Toronto Cental Local Health Integration Network	Laura Pisko-Bezruchko, Senior Director, Planning	06-02-2008	3
University of Ottawa Heart Institute	Dr. Andrew Pipe, Medical Director, Prevention and Rehabilitation Centre	06-02-2008	3
Canadian Institute for Health Information	Glenda Yeates, President and Chief Executive Officer	13-02-2008	3
Canadian Institute for Health Information	Keith Denny, Acting Manager	13-02-2008	3
University of Manitoba	Noralou Roos, Professor, Faculty of Medicine	13-02-2008	3
Public Health Agency of Canada	Jim Ball, Director General, Strategic Initiatives & Innovations	27-02-2008	3
Finance Canada	Yves Giroux, Acting Director, Social Policy	27-02-2008	3
Treasury Board of Canada	Sally Thornton, Indian Affairs and Health	27-02-2008	3