Senate Sénat
CANADA

A HEALTHY, PRODUCTIVE CANADA:
A DETERMINANT OF HEALTH APPROACH

The Standing Senate Committee on Social Affairs, Science and Technology
Final Report of
Senate Subcommittee on Population Health

The Honourable Wilbert Joseph Keon, Chair
The Honourable Lucie Pépin, Deputy Chair

June 2009

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http://senate-senat.ca/health-e.asp

Ce rapport est également offert en français

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HEALTH IS LARGELY DETERMINED BY FACTORS OUTSIDE THE HEALTH CARE SYSTEM:

[L]ack of health care is not the cause of the huge global burden of illness; water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social and economic forces that fail to make clean water available to all; heart disease is not caused by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by moral failure on the part of individuals but by the excess availability of high-fat and high-sugar foods. The main action on social determinants of health must therefore come from outside the health sector.

[from the World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation – Health Equity Through Action on the Social Determinants of Health,* 2008, p. 35.]

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LIST OF RECOMMENDATIONS

1. **That the Prime Minister of Canada take the lead in announcing, developing and implementing a population health policy at the federal level;**

   That a Cabinet Committee on Population Health be established to coordinate the development and implementation of the federal population health policy;

   That the Prime Minister of Canada chair the Cabinet Committee on Population Health;

   That the Cabinet Committee on Population Health comprise the relevant departmental ministers including, but not limited to: Human Resources and Skills Development, Indian and Northern Affairs, Finance, Health, Environment, Justice, Agriculture and Agri-Food, Industry, Public Health Agency, and Status of Women.

2. **That the Prime Minister of Canada convene a meeting with all First Ministers to establish an intergovernmental mechanism for collaboration on the development and implementation of a pan-Canadian population health strategy;**

   That the Premiers announce, develop and implement in their respective jurisdiction a population health policy that is modelled on the federal population health policy;

   That, in each province and territory, Premiers establish and chair a Cabinet Committee on Population Health.

3. **That the Treasury Board of Canada Secretariat pro-actively undertake to enhance the range of models and resources available for the management of horizontal and vertical collaborations.**

4. **That the Government of Canada increase funding to the Public Health Agency of Canada for the creation of a policy and knowledge node that will act as a resource for the implementation of population health and health disparities reduction policies and initiatives both horizontally (at the federal level) and vertically (through intergovernmental collaboration).**

5. **That, wherever feasible, local /municipal governments across the country adopt and implement a broad population health**

approach within their boundaries and in collaboration with federal, provincial and territorial governments.boundaries and in collaboration with federal, provincial and territorial governments.

6. **That the Health Goals for Canada agreed upon in 2005 be revived and guide the development, implementation and monitoring of the pan-Canadian population health policy.**

7. **That the Population Health Promotion Expert Group accelerate its work to complete within the next 12 months the development of a national set of indicators of health disparities;**

   That the indicators of health disparities be appropriately matched with the Health Goals for Canada.

8. **That the Department of Finance, in collaboration with the Privy Council Office and the Treasury Board Secretariat, conduct an interdepartmental spending review with the aim of allocating resources to programs that contribute to health disparity reduction.**

9. **That the Government of Canada require Health Impact Assessment (HIA) to be conducted for any policy, plan or program proposal submitted to Cabinet that is likely to have important consequences on health;**

   That the Privy Council, in collaboration with Health Canada, develop guidelines for implementing the Cabinet directive on HIA;

   That the HIA guidelines be developed using existing material;

   That the Government of Canada encourage the use of HIA in all provinces and territories.

10. **That the Government of Canada support the development and implementation of Community Accounts, modelled on the Newfoundland and Labrador CA, in all provinces and territories.**

11. **That the Canadian Institute for Health Information (CIHI) be designated as the lead in the development, management and maintenance of the pan-Canadian population health database infrastructure;**

That CIHI immediately begin work to establish the necessary vertical integration of data with key partners.

12. **That Statistics Canada, in collaboration with Canada Health Infoway Inc., the Canadian Institute for Health Information and other key stakeholders, develop standards to facilitate the linkages between the Community Accounts and Electronic Health Records while ensuring the protection, privacy and security of personal information;**

    That work on the development of appropriate standards for the protection, privacy and security of personal information be completed within the next 12 months.

13. **That the Canadian Institutes of Health Research (CIHR) work in collaboration with relevant federal departments and agencies to assess current investment in population health intervention research and reach consensus on and determine an appropriate level of funding in this field;**

    That the Government of Canada increase its investment in population health intervention research to match the level agreed upon by CIHR and other relevant department and agencies;

    That future population health intervention research funded by the government of Canada build on the capacity and strengths of existing networks and research centres and foster collaborative partnerships among municipal, provincial and federal research agencies as well as academic partners for a focused research agenda;

    That the Government of Canada devise competitive operational funding mechanisms that will best support innovative, leading-edge research on population health intervention;

    That the Government of Canada consider joint funding mechanisms for inter-provincial and international comparative research on population health interventions;

    That the Government of Canada examine the eligibility criteria for human health research infrastructure funds in Canada and consider how these could be better aligned with population

health intervention research involving implementation mechanisms in health and other sectors;

That population health intervention research on housing, early childhood development and mitigating the effects of poverty among Aboriginal peoples and other vulnerable populations be considered priorities.

14. **That the Treasury Board of Canada Secretariat review and revise grant and contribution reporting requirements among federal departments and agencies to enhance horizontal and vertical coordination of reporting.**

15. **That the Treasury Board of Canada Secretariat encourage multi-year funding of projects that have multi-year timelines. The Treasury Board of Canada Secretariat should also encourage multi-year funding among federal granting agencies, where appropriate.**

16. **That the Government of Canada include support for local analysis and evaluation capacity in the design of programs aimed at improving population health and reducing health disparities.**

17. **That the Government of Canada work with other levels of government and the non-governmental sector to support the integration or coordination of community-level services within a determinant of health framework.**

18. **That Aboriginal peoples – First Nations, Inuit and Métis – be involved in the design, development and delivery of federal programs and services that address health determinants in their respective communities.**

19. **That the Prime Minister of Canada, as a first step toward the development and implementation of a pan-Canadian population health strategy, work with provincial and territorial Premiers, as well as with First Nations, Inuit, Métis and other Aboriginal leaders in closing the gaps in health outcomes for Aboriginal Canadians through comprehensive, holistic, and coordinated programs and services.**

20. **That the following health determinants be given priority: clean water, food security, parenting and early childhood learning, education, housing, economic development, health care and violence against Aboriginal women, children and elders.**

21. **That the Government of Canada work with all provincial and territorial governments to implement Jordan's principle for all programs, initiatives and services that address the health determinants of Aboriginal peoples in all age groups**

22. **That the Government of Canada, in collaboration with its provincial and territorial counterparts, as well as the appropriate First Nations, Inuit and Métis organizations, support and fund appropriate structures and mechanisms across the country that will facilitate the development and implementation of comprehensive, holistic, and coordinated programs and services that address health disparities in Aboriginal communities.**

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, February 24, 2009:

The Honourable Senator Eggleton, P.C., moved, seconded by the Honourable Senator Fraser:

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 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 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.

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

Paul C. Bélisle

Clerk of the Senate

MEMBERSHIP

The Honourable, Wilbert Joseph Keon, Chair of the Committee
The Honourable, Lucie Pépin, Deputy Chair of the Committee

The Honourable Senators:

Catherine S. Callbeck
Andrée Champagne, P.C.
Joan Cook
Nicole Eaton
Joyce Fairbairn, P.C.

Ex-officio members of the Committee:

The Honourable Senators: James Cowan (or Claudette Tardif) and Marjory LeBreton, P.C., (or Gérald J. Comeau).

Other Senator who have contributed substantially to this study: The Honourable Senators Eggleton, C.P.

The Committee would like to thank the following staff for their hard work in the preparation of this report:

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Monique Régimbald, Administrative Assistant, 2nd Session of the 40th Parliament

LIST OF ABBREVIATIONS

BCHC: British Columbia Healthy Communities

CA: Community Accounts

CIHI: Canadian Institute for Health Information

CIHR: Canadian Institutes of Health Research

CLSC: *Centre local de services communautaires*

CMA : Census Metropolitan Area

COAG: Council of Australian Governments

EHR : Electronic Health Record

EIA: Environmental Impact Assessment

F/P/T: Federal/Provincial/Territorial

HIA: Health Impact Assessment

LEF: Learning Enrichment Foundation

LICO: Low income cut-off

NGO: Non-Governmental Organization

NSERC: National Science and Engineering Research Council

OECD: Organisation for Economic Development and Cooperation

PHAC: Public Health Agency of Canada

SSHRC: Social Sciences and Humanities Research Council

UK: United Kingdom

WHO: World Health Organization

FOREWORD

Canada is generally perceived as one of the greatest countries in the world in which to live. It has a vast and diverse geography rich in natural resources, clean air and a vast territory. When it comes to health however, we unfortunately have serious disparities. Some Canadians live their lives in excellent health with one of the highest life expectancies in the world; paradoxically others spend their life in poor health, with a life expectancy similar to some third world countries. The unfortunate Canadians, who suffer poor health throughout their lifetime, are frequently less productive adding to the burden on the health care delivery system and social safety net. We can not correct this inequity through the health care delivery system itself, regardless of the expenditure we devote to it.

We must change our way of thinking and recognize that good health comes from a variety of factors and influences, 75 percent of which are not related to the health care delivery system. Therefore we must become proactive and support communities, cities, provinces, territories and a country in producing citizens in good health, physical and mental well-being and productivity. Passively waiting for illness and disease to occur and then trying to cope with it through the health care delivery system, is simply not an option. Hence, we must address all of the factors that influence health and through a population health approach, overcome inequities and foster well being and productivity.

The knowledge and technology to do so are now available but more research is required. Change will demand the attention of all individuals, NGOs, businesses, communities, all levels of government and all sectors of our Canadian society. Success will require leadership from our prime minister and first ministers, from our mayors, municipal leaders, community leaders and the leaders of our Aboriginal peoples. A whole of Government approach is required with intersectoral action embracing business, volunteers and community organizations. This will not be easy, but it can and must be done. We cannot afford to do otherwise.

A population health information system with longitudinal capacity that can monitor, evaluate and report on well being throughout the human life course is required. Community initiatives that integrate education, health and social services are required so we can reduce disparities, stem the prevalence of disease and increase productivity. We must not be intimidated by this task, which is doable and which will eventually lead to a nation with health equity, well-being and drastically improved productivity. The challenge is for every Canadian, the benefits are to every Canadian.

INTRODUCTION

Achieving health equity within a generation is achievable, it is the right thing to do, and now is the time to do it.[1]

With the tabling of this final report, the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology has come to the end of a long journey that began in February 2007, during the 1st session of the 39th Parliament, when the Subcommittee 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 the determinants of health." This mandate was renewed in October 2007, at the beginning of the 2nd session of the 39th Parliament, and once again in February 2009 during the 2nd session of the 40th Parliament.

This report is therefore the culmination of a two-year study by the Subcommittee. During this period, the Subcommittee sat for 52 hours, held 30 meetings, heard the views of over 117 witnesses and received hundreds of written submissions. Members also visited 6 Canadian communities and completed a fact-finding mission in one country. We wish to express our sincerest thanks to all those who gave us their advice on what needs to be done to improve the health of Canadians, reduce health disparities and foster Canada's productivity. We have given serious consideration to their comments and suggestions and find them particularly timely in the context of the current economic slowdown.

Our final report was preceded by four interim reports:

- *Population Health Policy: International Perspectives* presents an analysis of government policy to improve population health and reduce health disparities in Australia, England, Finland, New Zealand, Norway and Sweden. In recent years, many of these countries have taken bold steps to implement whole-of-government approaches to close the gap in health outcomes between healthier and more vulnerable population groups.

- *Maternal Health and Early Child Development in Cuba* summarizes the Subcommittee's findings on the content, structure, cost, management and impact of maternal health programs and early childhood education initiatives in Cuba. A key player in the country's successful approach to maternal health and early childhood development is what Cubans call "polyclinics." The role of the polyclinics is far more extensive than that of a health clinic as Canadians would understand that term. These local establishments ensure integration of science, knowledge transfer, parent education and community mobilization, in the premise of a strong multidisciplinary primary health care sector.

[1] World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation – Health Equity Through Action on the Social Determinants of Health*, 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

- *Population Health Policy in Canada: Federal and Provincial/Territorial Perspectives* describes previous efforts of the federal, provincial and territorial governments to develop and implement population health policy. Both the federal and provincial/territorial governments have devoted considerable attention to population health over the past 35 years. However, there is still no national plan in Canada to reduce health disparities and improve overall population health status.

- *Population Health Policy: Issues and Options* outlines the major issues facing the development of population health policy in Canada and presents policy options to improve overall health status and reduce health disparities.

These reports served to launch a public debate on the role of governments, more particularly the federal government, in the development and implementation of a determinant of health approach for Canada. They also formed the basis for further hearings and consultations with Canadians from across the country. This final report, which is the result of this consultation process, completes the Subcommittee's journey. It contains recommendations that can be grouped into four categories:

- A new style of governance: leadership from the top to develop and implement a population health policy at the federal, provincial, territorial and local levels with clear goals and targets and a health perspective to all new policies and programs.
- The foundation: a sound population health data infrastructure coordinated by the Canadian Institute of Health Information and based on the Newfoundland and Labrador model of Community Accounts with appropriate linkages to the Electronic Health Records. Statistics Canada and relevant stakeholders will develop standards to ensure the protection, privacy and security of personal information. This database infrastructure will be combined with strong population health intervention research to inform public policy.
- Building healthy communities: because the determinants of health play out at the local level, governments must draw upon and further reinforce the expertise and capacity of citizens to build the strong and inclusive communities that are required for a healthy and productive population. The Cuban polyclinics represent a promising model of intersectoral collaboration at the local level that could be adapted in some Canadian communities.
- A priority focus on First Nations, Inuit and Métis peoples in the development and implementation of a pan-Canadian population health policy and the reduction of health disparities, working with existing leadership to meet current needs, celebrate unique cultures and create new opportunities for the future.

The Subcommittee feels that there is a real window of opportunity for implementing its recommendations. There is a wide range of support from the business sector, rural, urban and Aboriginal communities, non-government organizations, research institutes, universities, professional associations, health authorities, government representatives, etc. Moreover, there is momentum both at the national and international levels with the evidence-based recommendations in the final report of the World Health Organization (WHO) Commission on Social Determinants of Health, the first report of

Canada's Chief Public Health Officer, and the Conference Board of Canada's Roundtable on the Social Determinants of Health, to name a few. Many other countries – such as England, Finland, Norway and Sweden – and a number of provinces – including Newfoundland and Labrador and Quebec – have actively developed actions and programs designed to reduce health disparities and, accordingly, we strongly believe that now is the time for the federal government, in collaboration with other levels of government, to take action on the determinants of health in Canada. In fact, it is not an exaggeration to say that no society can reverse the current downward economic trends and then sustain economic progress if it neglects the health of its people. Not doing so will aggravate the already serious health disparities that exist in this country and compromise future economic prosperity.

PART I: POPULATION HEALTH AND HEALTH DISPARITIES2

1. POPULATION HEALTH

Our study of the determinants of health began with the notions of health and population health. The Subcommittee adopted the well known WHO definition of **health** as "a state of complete physical, mental and social well-being" and "a resource for everyday life".[3] In this perspective, good health is a major source for social, economic and personal development and an important dimension of quality of life. In corollary, the concept of **population health** is based on the understanding that health is determined as much or more by social, economic, environmental and cultural factors than it is by genetic or medical factors. That is, factors such as income, level of education, occupation, social hierarchy and housing, which are all **determinants of health**, have direct and indirect consequences for the health and well-being of the population. Many of these factors play out largely in Canadian communities – the cities, towns, neighbourhoods and regions where people live, learn, work and play. For this reason, the Subcommittee's approach to population health focuses on the **community setting**. Moreover, the impacts of health determinants vary at different stages of people's lives. Accordingly, our population health approach adopts a **lifecourse perspective** – encompassing influences from before birth, through childhood and adolescence, and during adult years. The determinant of health approach envisioned by the Subcommittee is depicted in Chart 1.

> *(...) I think the issue about population health is not just health; it is population. It is very broad.*
>
> *Jean-Marie Berthelot, Vice President of Programs, Canadian Institute for Health Information, 27 March 2009 (3:74).*

The combination and interaction of the health determinants result in differences in health status; this in turn gives rise to **health disparities** between individuals and among various segments of the population. There is a wide consensus, both nationally and

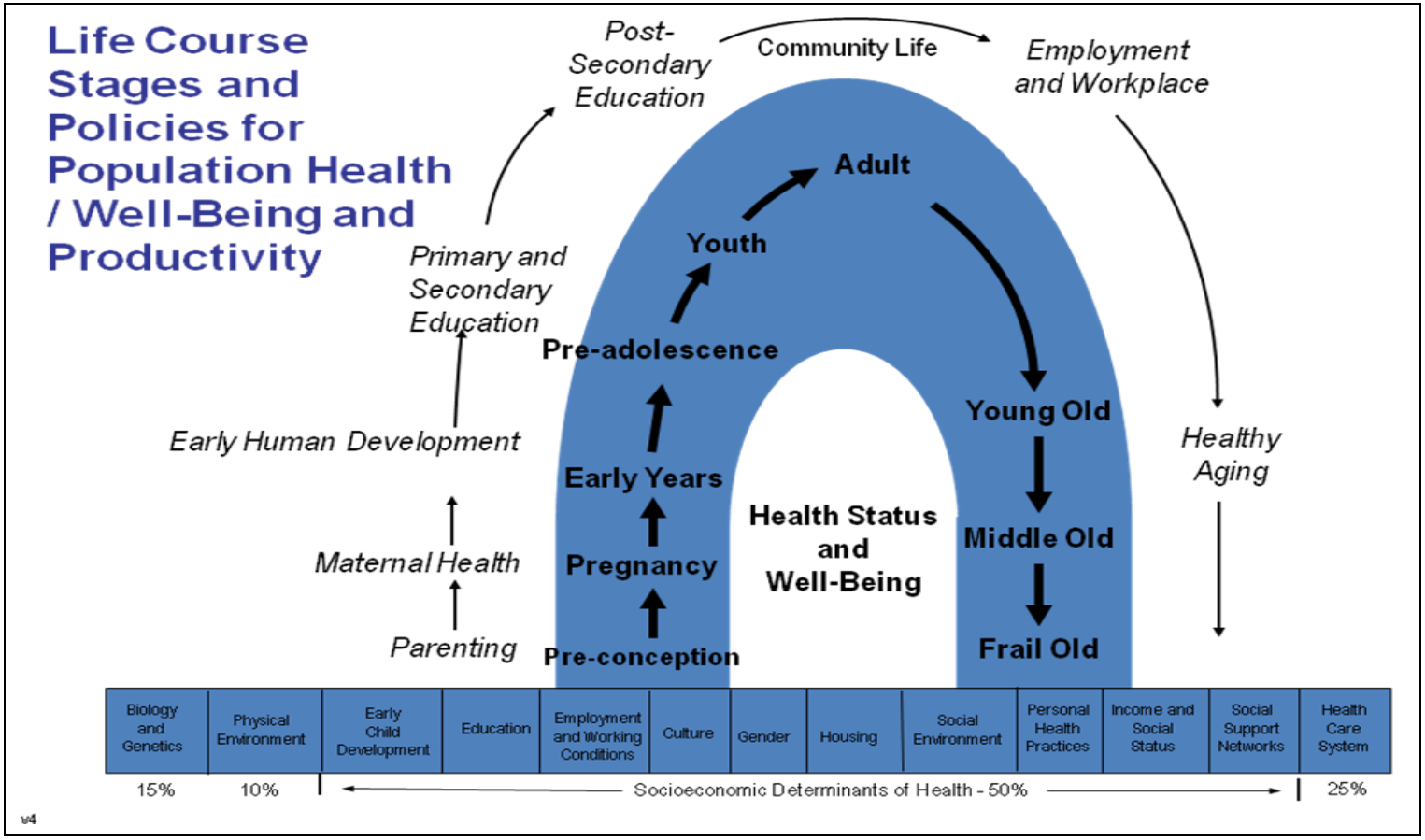
[2] In this report, the testimony received by witnesses printed in the *Minutes of Proceedings and Evidence of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology* will be thereafter referred to only by issue number and page number within the text.

[3] World Health Organization, http://www.who.int/en/.

internationally, that the vast majority of disparities in health are avoidable, unfair and thus inequitable. These **health inequities** result from the external environment and other social and economic conditions that, while largely outside the control of the individuals affected, are amenable to mitigation by the implementation of well-crafted public policy that we refer to as **population health policy**.

Population health policy is by nature intersectoral – it is designed to address, in a coordinated fashion, the range of determinants that influence health. Such **intersectoral collaboration** has two dimensions: horizontal and vertical. The horizontal dimension links different departments such as education, finance, employment, social services, environment, health, 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 to each other and with groups, institutions, organizations and businesses in the community. Intersectoral action is most successful when it results in a "win-win" situation, whereby the participants at every level gain something.

CHART 1



Source: Parliamentary Information and Research Service, Library of Parliament.

Members of the Subcommittee believe that there is a definitive demand for population health in Canada, but it is not labelled as such. Advocates working against poverty, exclusion, and environmental degradation, like those promoting the status of women, public housing, safe drinking water, and social justice, more broadly all call for action that would reduce disparities and improve health – allowing every Canadian to develop, live and contribute to society to her or his fullest potential. Unfortunately, there is no simple or single terminology to refer to this. While the Subcommittee, along with public health and health promotion experts, refers to it as *population health*, *well-being* and *health inequities*, economists and business entrepreneurs think about it as *human capital*. For their part, social scientists and biologists see it in terms of *human development* while environmentalists address it under the issue of *environmental sustainability*. And for Aboriginal peoples, it is about *holistic health* and *wellness*. No matter how we phrase it, the ultimate goal of this report is to put people – their physical and mental health, well-being and quality of life – at the centre of public policies. This is what the Subcommittee recommends in its call for a determinant of health approach in Canada.

> *The demand may exist, but it is fragmented and, in my opinion, unidentifiable for the political order at this point in time.*
>
> *The Honourable Monique Bégin, 18 April 2008 (4:104).*

> *Fundamentally, all roads lead to population health. Whether it is economic issues, income security issues or environmental issues, they all come back to population health.*
>
> *Mel Cappe, President, Institute for Research on Public Policy, 26 February 2009 (1:15).*

2. FROM HEALTH CARE TO THE DETERMINANTS OF HEALTH

As mentioned above, the determinants of health encompass personal, cultural, social, economic and environmental factors. Chart 1 – and evidence from the Canadian literature – suggests that the **health care** system is one contributor to population health, but it only accounts for 25% of health outcomes regardless of the level of funding it receives. Too often, the health care system reacts after the fact, once diseases and illnesses (many of them preventable) have occurred. Clearly, health is more than health care and, of them all, the socio-economic environment is the most powerful of the determinants of health. This emphasizes the need to take an active instead of a passive approach to health and to act before the individual gets sick.

The basic biology and organic make-up of the human body are a fundamental determinant of health, accounting for 15% of health outcomes. In some instances **genetic endowment** appears to predispose certain individuals to particular diseases or health problems.

Housing or lack of adequate housing (overcrowding, substandard dwellings, homes requiring significant repairs, homelessness, etc.) contributes to increased stress, morbidity, mortality, social exclusion, physical and mental illness. Needless to say, health begins at the household level; therefore, promoting population health begins with

having available, affordable and healthy housing. Other human-made elements of our **physical environment**, such as safe workplaces, and communities, well-designed cities, roadways, etc., are vital to a healthy population, as are clear air, water and soil. Overall, some 10% of health outcomes are attributable to the physical environment.

Fully 50% of the health of the population can be explained by socio-economic factors. The social and economic determinants of health are complex and intertwined and we describe some of them below.

Early childhood development, from pre-conception to pregnancy and parenting through the early years of life, is often considered as a powerful health determinant and is a critical element of the life course approach to population health. Scientific evidence demonstrates that experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life affects the person's subsequent health, well-being, coping skills and competence.

Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy. Individual responsibility for health is another important element of a whole-person, whole-government approach to population health.

There is also strong and growing evidence that **income and social status** are positively associated with health. Even more notably, people's health is affected by how wide the difference in income is between the richest and poorest members of the society. So while people with lower income and social status have less control and fewer choices in their lives, this is even more the case when the income gap in the society is very wide.

Evidence shows that **employment and working conditions** have a significant effect on a person's physical and mental health and social well-being. Earned income provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When someone loses these benefits, the results can be devastating to both the health of the individual and his or her family.

Finally, the Subcommittee heard evidence of the impact of **culture** and **gender** on health. Race, ethnicity or cultural background can influence population health by affecting people's vulnerability to the risks to which they are jointly exposed. In addition, society ascribes different roles, personality traits and relative power to males and females, all of which can affect people's health. A gender-based approach to population health recognizes the differences between women and men; this helps identify the ways in which the health risks, experiences, and outcomes are different for women

and men, boys and girls, and to act accordingly. Moreover, a population health approach must be culturally appropriate and flexible enough to take into account the specific needs of the different cultural and ethnic groups that make up our country.

3. THE EXTENT OF HEALTH DISPARITIES

> *Some Canadians are much healthier than others. Poor health outcomes are more likely among: children and families living in poverty; the working poor; the unemployed/underemployed; those with limited education and/or low literacy; Aboriginal and remote populations; newcomers; persons suffering from social exclusion; the homeless; and those who have difficulty securing affordable housing.*[4]

Throughout its study, the Subcommittee received compelling evidence on the extent of health disparities. Wide disparities in health exist among Canadians – between men and women, between regions and neighbourhoods, and between people with varying levels of education and income. Although 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.

As shown in Table 1, the difference between health outcomes for Canadians as a whole and for Aboriginal peoples – First Nations, Inuit and Métis – is striking. For example, the average lifespan for Inuit women is 12 years less than the average for Canadian women, while for men the comparable gap is 8 years. Table 1 also shows that the socio-economic status of each Aboriginal group is lower than that of non-Aboriginal Canadians on virtually every measure. Educational attainment is lower, fewer people are employed, and average incomes are lower. Smoking is much more prevalent among Aboriginal peoples than other Canadians. Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, University of Victoria, prepared for the Subcommittee a document which presents the most comprehensive collection of data on the burden of illness and the extent of health disparities among First Nations, Inuit and Métis. His paper acknowledges that the poorer conditions faced by Aboriginal peoples are contributing to their lower health status relative to non-Aboriginal Canadians. These poorer conditions in turn find their origin in the process of dislocation as a result of colonization which rendered Aboriginal peoples and communities as socially excluded from the rest of Canada.[5]

[4] BC Healthy Living Alliance, *Submission to the Subcommittee*, 8 June 2008, p. 2.
[5] Jeff Reading, *A Life Course Approach to the Social Determinants of Health for Aboriginal Peoples*, 30 March 2009.

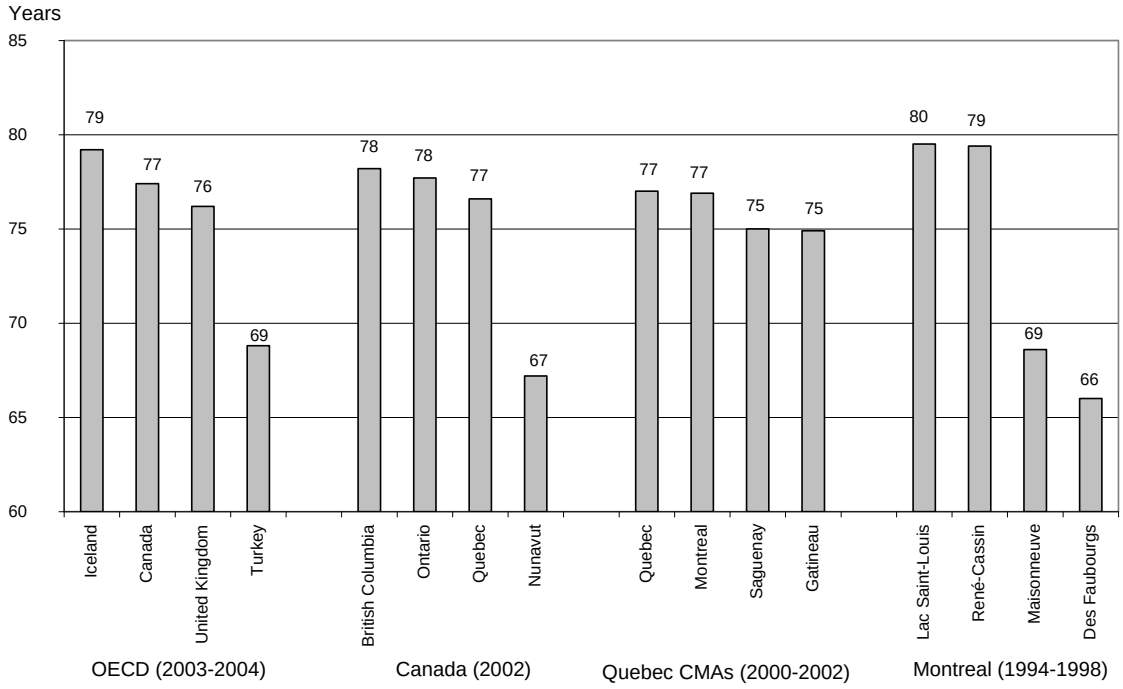
TABLE 1
INEQUALITIES IN HEALTH DETERMINANTS: MUCH REMAINS TO BE DONE TO IMPROVE THE HEALTH STATUS OF ABORIGINAL PEOPLES

	Non-Aboriginal Canadians	First Nations	Inuit	Métis
Health Status				
Life Expectancy at Birth (Men)	76	69	68	n.a.
Life Expectancy at Birth (Women)	82	77	70	n.a.
Education (% 15 Years and Over)				
No Degree, Certificate or Diploma	33	55	66	46
Bachelor's Degree Graduation	16	4.1	1.9	5.3
Employment (% 15 Years and Over)				
Unemployment Rate	7	22	22	14
Worked Full Year, Full Time	37	23	23	31
Income (% 15 Years and Over)				
Low Income in 2000	16	40	24	28
Lifestyle (% of Population)				
Daily Smoking	22	38	61	37

n.a.: Not available.
Source: Canadian Population Health Initiative, *Improving the Health of Canadians*, 2004. http://secure.cihi.ca/cihiweb/products/IHC2004rev_e.pdf

The Subcommittee also heard repeatedly about health disparities between and within countries. For example, Chart 2 shows that Canada's life expectancy is one of the highest internationally. However, not all Canadians enjoy a long lifespan. Across the country, there is an 11-year disparity in life expectancy between provinces and territories, from a low 67 years in Nunavut to a high 78 years in British Columbia. Moreover, there are differences within individual provinces. For example, in Quebec, there is disparity in life expectancy between Montreal and Gatineau. Looking even more locally, research by the Montreal public health department estimates a 14-year difference in life expectancy among the areas within the city. These findings highlight the need to adopt a community-level approach to population health.

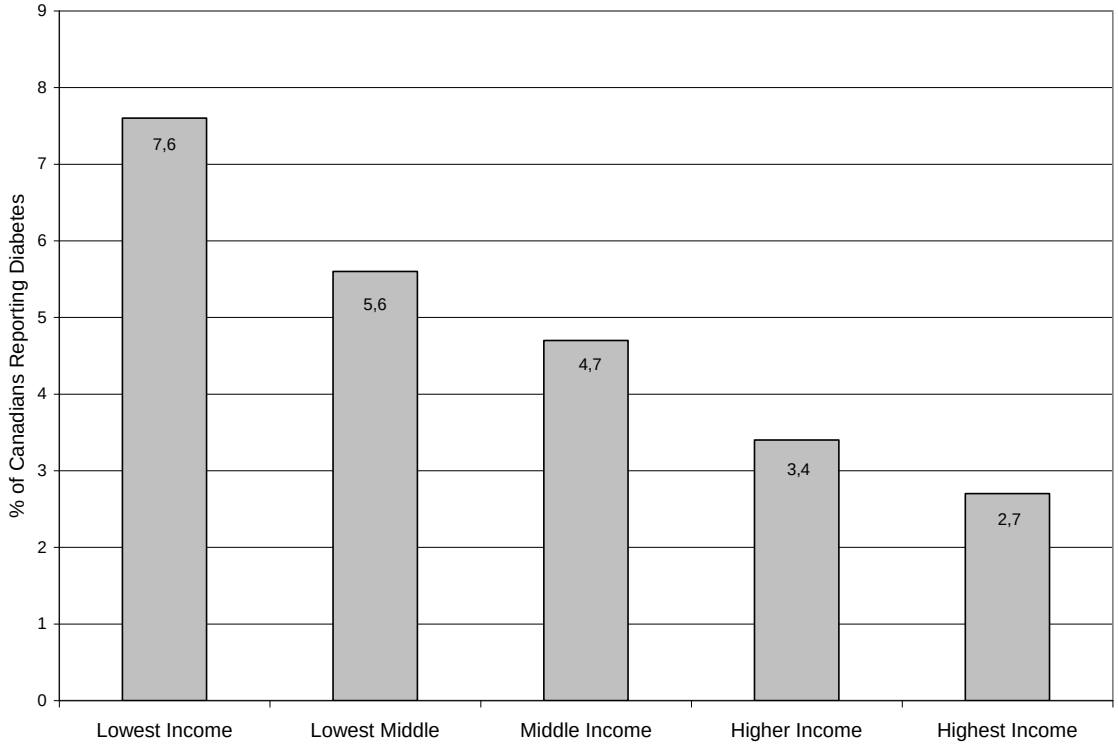
CHART 2: WHERE YOU LIVE MATTERS TO YOUR HEALTH
DIFFERENCES IN LIFE EXPECTANCY AT BIRTH, MEN



Source: Reproduced from Glenda Yeates, "Health Disparities in Canada," *Submission to the Subcommittee*, 18 April 2008.

Chart 3 shows that the prevalence of illness – in this particular case diabetes – steadily decreases as income level increases. Put differently, health status improves in a stepwise manner for each increment in income. The presence of this health gradient is not unique to Canada; it has been empirically demonstrated across jurisdictions, nationally and internationally, and at local, neighbourhood and regional levels. However, the level and degree of the gradient slope is not consistent between jurisdictions. The gradient among industrialized nations is steepest in countries such as the United States, and much less steep in countries like Norway and Sweden.

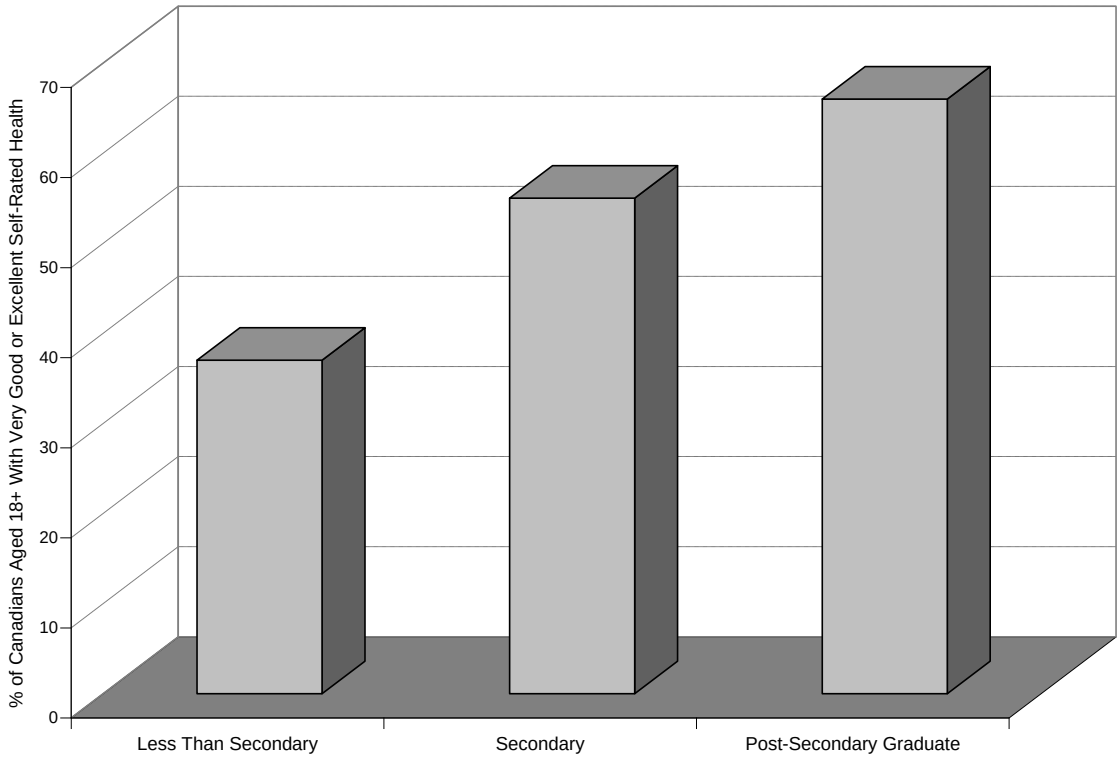
CHART 3: THE SOCIO-ECONOMIC GRADIENT IN HEALTH



Source: Statistics Canada, *Canadian Community Health Survey (Cycle 3.1)*, 2005; Parliamentary Information and Research Service, Library of Parliament.

The 2005 Canadian Community Health Survey reported that Canadians living in households with the lowest levels of education are less likely to report having excellent or very good health. Clearly, Chart 4 shows a health gradient whereby an additional level of education is associated with an increase in the proportion of those reporting excellent or very good health.

CHART 4: EDUCATION IS A STRONG HEALTH DETERMINANT



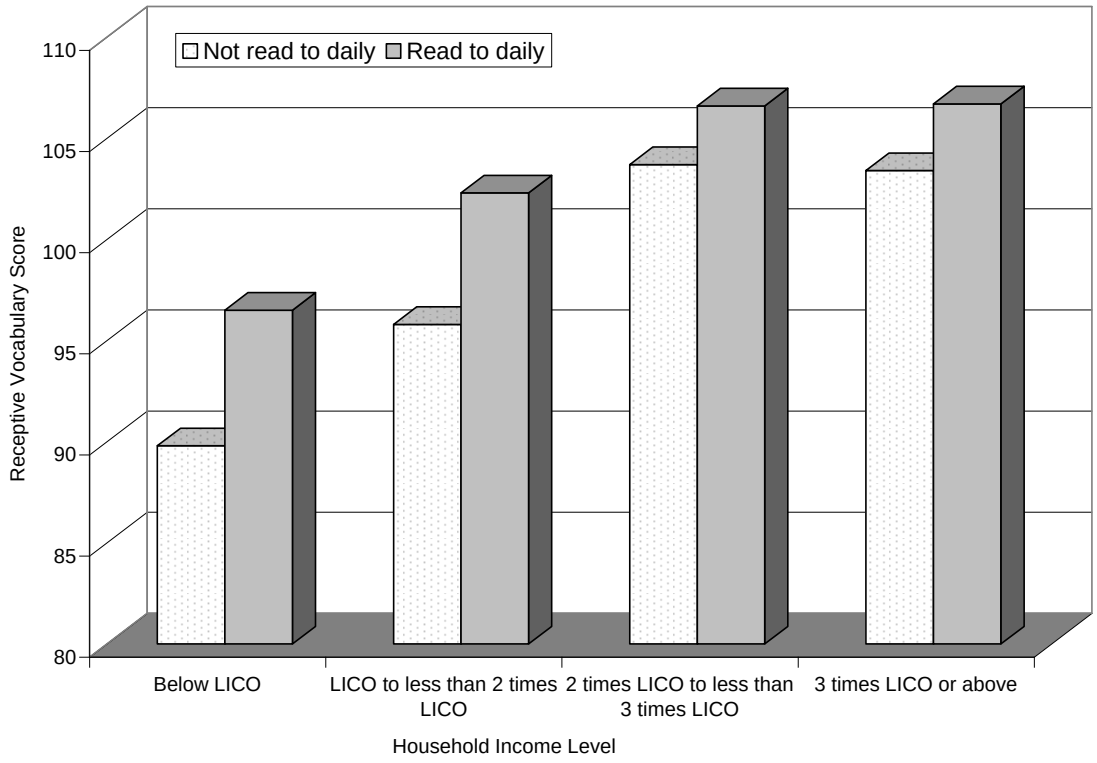
Source: Statistics Canada, *Canadian Community Health Survey (Cycle 3.1)*, 2005; Parliamentary Information and Research Service.

Numerous witnesses stressed the importance of addressing health disparities as early as possible. Chart 5 shows that the health gradient is evident in the earliest years of life. It also indicates that parental involvement in children's early learning is important to success across all incomes. In each household income level, especially among families with the lowest incomes, children who are read to daily have better receptive vocabulary scores than children not read to daily. These are very critical findings, given that human capital in adulthood is to a large extent already determined during childhood. More precisely, measures of child development, such as cognitive and verbal ability, predict measures of human capital in adulthood, such as earnings and employment, as well as involvement in criminal and other risky behaviours. It is not surprising that child development is strongly related to a child's socio-economic background. Many children from disadvantaged families fall

> *(...) if we do not start to improve the broad determinants of health for our children and youth, it will ultimately have a huge impact on our economy. Children will not be finishing school or going on to post-secondary education and taking on the roles in our economy that we would want for our economy to grow.*
>
> *Marie Adèle Davis, Executive Director, Canadian Peadiatric Society, 28 May 2008 (7:21).*

behind early in life and find catching up later very difficult. This underscores the need for a lifecourse approach to population health.

CHART 5:
THE GRADIENT IN HEALTH IS EVIDENT IN EARLY CHILDHOOD



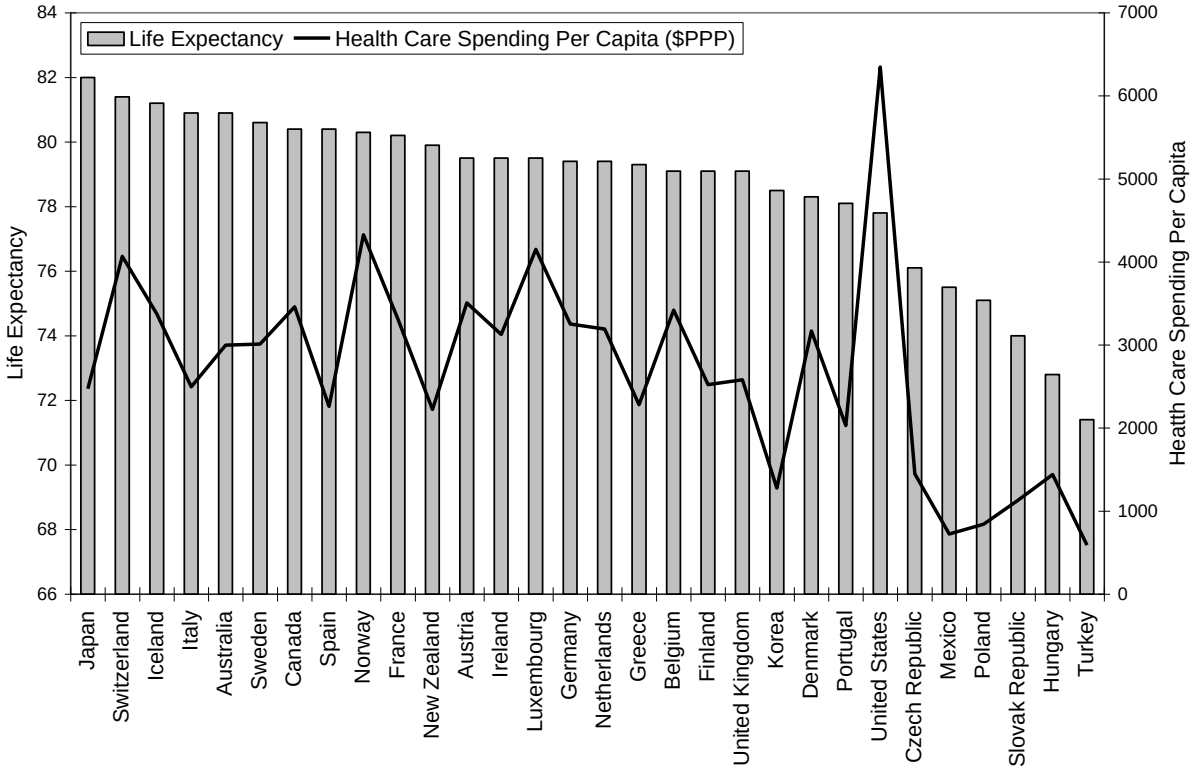
LICO: Low income cut offs.

Source: Reproduced from Eleanor M. Thomas, *Readiness to Learn at School Among Five-Year Old Children in Canada*, Research Paper, Statistics Canada, Catalogue No. 89-599-MIE, 2006, p. 11. http://www.statcan.ca/english/research/89-599-MIE/89-599-MIE2006004.pdf

To sum up, the evidence received by the Subcommittee shows that Canadians at the highest levels of education and income are the healthiest and lose fewer years of life to premature death than those with lower education and income levels. It has been estimated that if all Canadians had the same rate of premature death as the most affluent one-fifth of Canadians, there would be a 20% reduction in premature mortality across the population. This would be equivalent to wiping out all premature deaths from either cardiovascular diseases or injuries.[6]

[6] *The Chief Public Health Officer's Report on the State of Public Health in Canada*, Public Health Agency of Canada, 2008, p. 67. http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/pdf/cpho-report-eng.pdf

CHART 6:
INVESTING MORE IN HEALTH CARE –
NO GUARANTEE OF BETTER HEALTH, OECD 2005



Source: *OECD Health Data, 2008*, and Parliamentary Information and Research Service, Library of Parliament.

Moreover, and we heard this over and over again throughout our study, health is largely determined by factors outside the health care system. Perhaps more importantly, Chart 6 illustrates that spending more on health care is no guarantee for better health. For example, the Euro-Canada Health Consumer Index places Canada 23rd out of 30 in Total Index Score, and 30th out of 30 in Best Value for Money Spent. In other words, this index shows that Canada spends more money on health care to achieve worse results than the other countries surveyed.[7] Clearly, a determinant of health approach is needed if Canada is to move forward in the economy of the 21st century. In fact, the Subcommittee strongly believes that we cannot afford not to.

[7] Health Consumer Powerhouse and Frontier Centre for Public Policy, *Euro-Canada Health Consumer Index 2008*, FC Policy Series No. 38. http://www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf

4. THE CASE FOR ACTION, THE COST OF INACTION

> *(…) all private sector businesses have good reason to take action on the (...) determinants of health as they will inextricably benefit from healthier employees, customers, and communities generally. In fact, the essential business case for business engagement is about competitiveness, productivity and profitability. Governments and communities wishing to harness the capacity of corporate Canada to drive better health outcomes should recognize this fact and use it to align their efforts accordingly.*[8]

Taking action on the determinants of health has the potential to improve population health outcomes by addressing the causes of illnesses and injuries before they occur. There are sound economic and social reasons to improve the physical and mental health of the population. The benefits of population health policy extend beyond improved health status and reduced health disparities to 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 are better engaged in their communities and this contributes to social cohesion and well-being. A healthy population requires less government expenditures on income support, social services, health care, and security. Simply put, Canada's health and wealth depend on the health of all Canadians.

In the current economic context, population health policy – which puts people's health, lives and well-being at its centre – represents a sound approach to economic recovery. With the economy slowing down, unemployment is on the increase and the living conditions of individuals and families are seriously threatened or already affected. There is a general feeling that there could be devastating long-lasting consequences on health and well-being with growing health disparities, income inequalities and housing and food insecurity. In this perspective, investing in population health should be an integral part of the discussions on economic recovery plans.

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, communities and societies to function well. Therefore, health must be supported throughout all stages of life from conception to childhood through adulthood and old age. In addition, the Subcommittee believes that governments have a moral obligation to foster the social, economic, cultural and environmental conditions that empower individuals, communities and societies to create and maintain good health for all citizens. This is a major challenge that can only be tackled through population health policy, a whole-of-government approach that targets health disparities in all policies (education, social and cultural services, economic policy,

[8] Conference Board of Canada's Roundtable of the Socio-Economic Determinants of Health, *Submission to the Subcommittee*, 29 June 2008, p. 3.

environmental policy, food policy, income support, housing and infrastructure, taxation, etc). Of course, this will require a profound structural change both in public policy and governments' approach to the development and implementation of public policy.

Certainly, adopting and implementing a population health policy is not without its challenges, but a lack of action will produce more challenges and even greater health disparities in Canada. A lack of action will be very costly in terms of direct health care costs, social costs related to welfare and crime, lost productivity and reduced quality of life. These costs are substantial, have a negative impact on the whole economy and must be borne by all levels of governments and individual households. This report invites all governments – from the federal to the local – as well as businesses, voluntary organizations, communities and citizens, to work together to improve health for all Canadians and reduce health disparities among various population groups.

> *One problem is that we see the cost of acting but we do not see the cost of not acting. Conditioning must be done to explain to the public that not addressing this problem, whether in social housing, income security or any of these elements, will make things worse down the road. The public says: Do I want my tax dollars going to that problem now? The answer is: Yes, otherwise, we will pay a bigger price.*
>
> *Mel Cappe, President, Institute for Research on Public Policy, 26 February 2009 (1:22).*

The Subcommittee strongly believes that spending on population health is an investment, not an expense. And it is a wise investment with short, medium and long term benefits. Obviously, any spending decision has an opportunity cost. Now we need to prioritize investments to address health disparities. This requires efficiency: making the best use of available resources.

PART II: HEALTH PAYS OFF – ACT NOW

1. WHOLE-OF-GOVERNMENT APPROACH

> *(…) population health in all the dimensions in which the Subcommittee is examining the issue is clearly a matter of great importance to the government and to the people of Canada. The idea of taking a whole-of-government approach to this important set of issues makes good sense, not least because so many different jurisdictions and institutional actors are in play.*[9]

1.1 A Question of Governance

A population health approach requires addressing, in a coordinated fashion, the range of determinants that influence health. Within a single government, this requires a whole-of-government or horizontal approach that brings together different departments and agencies (education, finance, employment, health, environment, etc.). Concerted

[9] Jim Mitchell, Co-Founder, The Sussex Circle, 26 February 2009 (1:14).

action, collaboration and coordination of efforts on population health – difficult as we realize that is to achieve – is imperative, because the Subcommittee believes it is unacceptable for a privileged country like Canada to continue to tolerate health disparities. It is also imperative in the current economic recession which may lead to a widening of disparities. Doing so, of course, will require a profound structural change in the government's approach to the development and implementation of public policy. Even though the approach we recommend here does not yet exist, many of the essential components are already in place.

Throughout the study, we asked witnesses how the machinery of government must be structured to accommodate a whole-of-government population health approach within the federal government. How to break down the current silos and enhance horizontality were issues often raised. We heard repeatedly that leadership at the highest levels and from the central agencies is essential for a whole-of-government approach to be successful. Witnesses often mentioned the unique, whole-of-government policy adopted in England to reduce health disparities. The policy, whose implementation was led by the Prime Minister, involved 12 central departments and agencies together with a number of regional and local authorities. Through an interdepartmental spending review, the UK Treasury identified how public spending could best be applied to reduce health disparities. Another noteworthy example of interdepartmental cooperation and coordination is Australia's approach to "Closing the Gap on Indigenous Disadvantage"; a new initiative led by Prime Minister Kevin Rudd. An Indigenous Affairs Committee of Cabinet has been established to set directions and it is chaired by the Prime Minister. The Cabinet Committee ensures coherent direction across government departments and agencies in the areas of community safety, early childhood, housing, education, health and economic participation.

> *(…) the critical factor is that the Prime Minister makes this issue a government priority and tells Canadians that it is a government priority.*
>
> *Jim Mitchell, Co-Founder, The Sussex Circle, 26 February 2009 (1:20).*

The question of who should chair a federal "Cabinet Committee on Population Health" was often raised by witnesses. The Hon. Monique Bégin. P.C., former Commissioner, WHO Commission on Social Determinants of Health, recommended that it be chaired by a powerful minister, preferably the Prime Minister or his/her deputy, or the Minister of Finance, but not by the Minister of Health. Other witnesses shared her views. Similarly, the Subcommittee strongly believes that the matter of who chairs the Cabinet Committee on Population Health is crucial since clear direction must come from the Prime Minister on actions to reduce health disparities.

> *Ministers of health have the biggest share of the government budget. The natural fear of imperialism, which at times is not only a fear but a reality, and the fact that the minister of health is the voice of the most powerful lobby of any society, in my humble opinion and experience, namely, organized medicine, play against these ministers.*
>
> *Monique Bégin 18 April 2008 (4:105).*

Above all, it is clear to the Subcommittee that no one disputes the importance of population health and the need to reduce health disparities. In our view, population health is not a partisan question either. All political parties are committed to reducing health disparities in Canada and, accordingly, this must be top priority on the government agenda. Therefore, the Subcommittee recommends:

That the Prime Minister of Canada take the lead in announcing, developing and implementing a population health policy at the federal level;

That a Cabinet Committee on Population Health be established to coordinate the development and implementation of the federal population health policy;

That the Prime Minister of Canada chair the Cabinet Committee on Population Health;

That the Cabinet Committee on Population Health comprise the relevant departmental ministers including, but not limited to: Human Resources and Skills Development, Indian and Northern Affairs, Finance, Health, Environment, Justice, Agriculture and Agri-Food, Industry, Public Health Agency, and Status of Women.

In a federation where population health policy cuts across federal/provincial/territorial (F/P/T) as well as regional responsibilities, there is a critical need for a coordinating structure to support and enhance consensus and collaboration. It is fair to say that different approaches and priorities across jurisdictions at F/P/T levels have been a constant element of the backdrop to population health policy development and implementation in Canada. The Subcommittee believes that the Prime Minister must, once again, show leadership and engage and support other levels of government in advancing the population health agenda across Canada. We believe that the approach we envision should be applied to all levels of government. Therefore, the Subcommittee recommends:

That the Prime Minister of Canada convene a meeting with all First Ministers to establish an intergovernmental mechanism for collaboration on the development and implementation of a pan-Canadian population health strategy;

That the Premiers announce, develop and implement in their respective jurisdiction a population health policy that is modelled on the federal population health policy;

That, in each province and territory, Premiers establish and chair a Cabinet Committee on Population Health.

In addition to the political leadership and coordinating structures needed to implement federal and provincial population health strategies and policies, many specific models and new mechanisms will be required to advance horizontal (at the federal level) and vertical (intergovernmental) initiatives. Witnesses before the Subcommittee identified many successful models that should be learnt from and, where appropriate, expanded to enhance interdepartmental and intergovernmental collaboration. Federal examples of these include Urban Development Agreements, which bring together federal, provincial and municipal governments to take comprehensive approaches to urban revitalization, Action for Neighbourhood Change, which united a number of federal departments around coordinated action for neighbourhood revitalization, and the Canadian Rural Partnership, which seeks to promote rural considerations across the federal government and in partnership with communities. Provincial examples include Healthy Child Manitoba, and ActNow BC, both of which we profiled in our interim report on F/P/T perspectives.

The lessons from these innovations must be more systematically captured and built upon if we wish to significantly enhance the ability of governments to achieve the degree of horizontal and vertical collaboration needed for population health. Because the Treasury Board of Canada Secretariat is the federal body which establishes the terms and conditions of funding agreements, the Subcommittee recommends:

That the Treasury Board of Canada Secretariat pro-actively undertake to enhance the range of models and resources available for the management of horizontal and vertical collaborations.

The Subcommittee acknowledges that a pan-Canadian effort to reduce health disparities requires both expert knowledge and connectivity. Expert knowledge is needed to support the Cabinet Committee on Population Health and connectivity is required to ensure appropriate links both horizontally and vertically. We believe that the Public Health Agency of Canada (PHAC), which reports to Parliament through the Minister of Health, is well-suited for this undertaking.

PHAC and Health Canada, prior to the Agency's creation, have for many years been at the forefront of research and policy, both domestically and internationally, on population health. Along with the formation of the Agency came the development of the Pan-Canadian Public Health Network which is comprised of federal, provincial and territorial representatives. With this history and these connections, the Agency is well-placed to act as a resource for the transfer of knowledge and effective connectivity that will be required by new collaborative and intersectoral approaches to population health and health disparities reduction. Therefore, the Subcommittee recommends:

That the Government of Canada increase funding to the Public Health Agency of Canada for the creation of a policy and knowledge node that will act as a resource for the implementation of population health and health disparities reduction policies and initiatives both

horizontally (at the federal level) and vertically (through intergovernmental collaboration).

Since most of the determinants of health play out largely at the community level, there is a clear role to be taken by local/municipal governments. Ideally, the same focus and energy on population health by federal and provincial/territorial governments should be applied by local/municipal leaders. We recognize, however, that municipalities have different capacities and resources. Therefore, the Subcommittee recommends:

That, wherever feasible, local /municipal governments across the country adopt and implement a broad population health approach within their boundaries and in collaboration with federal, provincial and territorial governments.

To this point, the Subcommittee has been looking at coordination from the top down. We, however, are convinced that coordination must also be implemented from the bottom up. A top-down commitment and bottom-up input into the delivery system would be a combination that would work. Coordination at the local or community level is discussed in Section 3 below.

1.2 The Need for a Vision

> *(...) a set of national health goals, provided they are not simply generalities but actually have some substance, would play a major and highly beneficial role in focusing health information development.*[10]

The ultimate objective of the Subcommittee's recommendations calling for a whole-of-government approach to population health is better health outcomes and the reduction of health disparities. The overarching vision behind our approach, as stated previously, is to allow every Canadian to develop, live and contribute to society to her/his fullest potential. This, in turn, will increase productivity and strengthen prosperity for generations to come. But to have any force, this vision must be grounded in appropriate targets and benchmarks. As can be seen in the following paragraphs, much work has already been done in this area.

The findings of the international and pan-Canadian reviews of population health policy prepared for the Subcommittee suggests that tangible and measurable health goals, objectives and targets are essential components of a whole-of-government approach to population health. 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, some goals and targets focused on specific health outcomes (e.g., reduced mortality and morbidity), while others focused on the adoption of healthier behaviours; a few countries, like England and Sweden, set targets for the reduction of health disparities.

[10] Michael Wolfson, Assistant Chief Statistician, Statistics Canada, 30 April 2008 (5:9).

In Canada, each province articulated health goals between 1989 and 1998, but by the end of the 1990s they were no longer being applied.[11] In 2004, an important step to advance the population health agenda was taken when Canada's First Ministers agreed to commit to the development of "goals and targets for improving the health status of Canadians through a collaborative process with experts."[12] A set of health goals was agreed upon by the F/P/T Ministers of Health in 2005. Goals were developed for each of the following four areas: basic needs in the social and physical environment; belonging and engagement; healthy living; and, a system for health (see table below).

HEALTH GOALS FOR CANADA	
Basic Needs (Social and Physical Environments)	• Our children reach their full potential, growing up happy, healthy, confident and secure. • The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy – now and for generations to come.
Belonging and Engagement	• Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities. • We keep learning throughout our lives through formal and informal education, relationships with others, and the land. • We participate in and influence the decisions that affect our personal and collective health and well-being. • We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.
Healthy Living	• Every person receives the support and information they need to make healthy choices.
A System for Health	• We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world. • A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

Source: *Health Goals for Canada – A Federal, Provincial and Territorial Commitment to Canadians*, October 2005, http://www.phac-aspc.gc.ca/hgc-osc/home.html.

[11] Deanna L. Williamson et al., "Implementation of Provincial/Territorial Health Goals in Canada," *Health Policy*, Vol. 64, 2003, pp. 173-191.
[12] First Ministers Meeting, *A 10-Year Plan to Strengthen Health Care*, Ottawa, 14 September 2004, p. 9, http://www.scics.gc.ca/confer04_e.html.

Led by the Public Health Agency of Canada, the Health Goals were developed through a broad consultation and validation process involving provinces, territories, public health experts, stakeholders, and citizens who shared their knowledge and vision for a healthy Canada. Over 300 stakeholders and experts participated in 12 provincial and territorial roundtables, five thematic events, five regional deliberative dialogues and consultations with Parliamentarians. Beyond that, almost 400 individuals, groups, and organizations provided input via an e-survey or by holding their own consultations. This consultation process culminated in the drafting of goal statements, which were validated with government and non-government partners, public health experts, and stakeholders. Although impressive, this thorough consultation process did not evolve into a pan-Canadian strategy nor did it result in any measurable actions.

In light of the international evidence on the implementation of health goals and, despite the lack of progress in this area on the Canadian scene, the Subcommittee concluded in its *Issues and Options* paper "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."[13] We strongly believe that, if revived, the Health Goals for Canada framework, strengthened by benchmarks and indicators, can potentially serve as a mechanism to guide federal, provincial, territorial and local investments to enhance health. Therefore, the Subcommittee recommends:

> *I have to say, I do not think Canada needs to go and get new goals. We have goals. We need the indicators, we need the targets and we need the strategies of what, by when, by how. (…) So the overarching goal as a nation is that we aspire to a Canada in which every person is as healthy as they can be, physically, mentally, emotionally and spiritually, is the medicine wheel.*
>
> *The Hon. Carolyn Bennett, M.P., 11 June 2008 (7:80).*

That the Health Goals for Canada agreed upon in 2005 be revived and guide the development, implementation and monitoring of the pan-Canadian population health policy.

The Health Goals for Canada must be matched with appropriate indicators/targets on health disparities. Although there is currently no agreed upon national set of indicators of health disparities, work has been undertaken by the Population Health Promotion Expert Group to develop such a set of indicators. The Subcommittee is pleased that this F/P/T Expert Group has been tasked to develop coherent and comprehensive pan-Canadian indicators of health disparities. Therefore, the Subcommittee recommends:

That the Population Health Promotion Expert Group accelerate its work to complete within the next 12 months the development of a national set of indicators of health disparities;

[13] Subcommittee on Population Health, *op. cit.*, p. 15.

That the indicators of health disparities be appropriately matched with the Health Goals for Canada.

1.3 Interdepartmental Spending Review

In England, the new whole-of-government policy on population health was initiated in response to a 2002 Treasury-led interdepartmental spending review which examined all government programs to identify how public spending could be applied to greatest effect on the reduction of health disparities. The results from this spending review informed departmental spending plans for the 2003-2004 through 2005-2006 fiscal years. Furthermore, the results generated mandatory commitments to actions to reduce health disparities.

At the federal level in Canada, there have been a number of government-wide exercises to review and reallocate expenditures since 2003. The government has explained that, because demands for resources are constantly evolving, programs need to be reviewed on a regular basis. Since there is already a review process in place, the Subcommittee believes that an interdepartmental spending review should be undertaken, similar to the 2002 UK Treasury review, to identify programs that influence health and to reallocate funding to programs that focus on health disparities. Therefore, the Subcommittee recommends:

That the Department of Finance, in collaboration with the Privy Council Office and the Treasury Board Secretariat, conduct an interdepartmental spending review with the aim of allocating resources to programs that contribute to health disparity reduction.

1.4 A Health Lens in all Policies

As noted previously, the most powerful of the determinants of health are not themselves within the purview of the health sector. In fact, policies made in sectors other than health have the greatest potential to improve (or worsen) population health and well-being and reduce health disparities. Accordingly, numerous witnesses stressed that these policies should be assessed for their potential impact on health prior to their implementation. Health impact assessment (HIA) is the formal approach used to predict the potential effects of a policy; particular attention can be also paid to the impact on health disparities. As such, HIA practice is useful is ensuring that health-related issues are considered in government-wide policy making.

In the 1997 Memorandum on Population Health, a recommendation was made to the federal Cabinet that HIA be applied to all federal policies and programs. Although this recommendation was endorsed, subsequent funding cuts impeded its implementation and only Health Canada moved forward to apply a population health lens to its programs and initiatives. Since then, Health Canada has published, in collaboration with the F/P/T Committee on Environmental and Occupational Health, the *Canadian Handbook on*

Health Impact Assessment.[14] 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. In 1993 in British Columbia, mandatory HIA was integrated in the formal process of policy analysis at the Cabinet level, but the practice was made optional in 1999 following a change in government.

In some countries, like Sweden and New Zealand, as well as in the province of Quebec, public health legislation has been employed to embed HIA as an integral component of governmental policy development. The Quebec legislation empowers the Minister of Health to issue proactive advice to other Ministers with the goal of promoting health and supporting policies that foster the health of the population. To assist other ministries in their use of HIA, the health ministry (*Ministère de la santé et des services sociaux du Québec*) produced its own HIA guide based on models developed in Europe and adapted to interdepartmental needs.[15] To date, HIA in Quebec has been used, for example, to ban cell phone use in cars and to regulate asbestos mining.

During the Subcommittee's hearings, some witnesses referred to the current federal environmental impact assessment (EIA) process as an example of a successful impact assessment tool. A Cabinet directive calls for strategic environmental assessments to be conducted for any policy, plan or program proposal that is submitted to a Minister or to Cabinet for approval and that is likely to have important environmental effects, positive or negative. The directive also establishes criteria to help federal departments and agencies determine when such an assessment is appropriate, and offers guidance on its preparation.[16] The Canadian Environmental Assessment Agency assists departments on improving their EIA capacity. The Minister of Environment is responsible for advising other ministers on potential environmental considerations of proposals before Cabinet decisions are taken, and for advising on environmentally appropriate courses of action. This does not constitute either a veto or an approval role. In performing their duties, all individual ministers adhere to the government's broad environmental objectives and sustainable development goals. Under the *Auditor General Act*, the Commissioner for the Environment and Sustainable Development is tasked with overseeing the government's efforts to protect the environment and promote sustainable development. The Privy Council Office also plays a role, as it must ensure that departments and agencies are compliant with the directive when they review proposals going to cabinet. As well, Environment Canada provides expert advice.

In its *Issues and Options* report, the Subcommittee stated: "The Subcommittee believes that HIA could be considered as one of the first steps towards the development

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[14] Health Canada, *Canadian Handbook on Health Impact Assessment*, 2004, http://www.hc-sc.gc.ca/ewh-semt/pubs/eval/handbook-guide/vol_1/index-eng.php.

[15] Ministère de la santé et des services sociaux (Québec), *Guide pratique : Évaluation d'impact sur la santé lors de l'élaboration de projet de loi et de règlement au Québec*, 2006. http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-245-01.pdf

[16] Privy Council Office, *Strategic Environmental Assessment – The Cabinet Directive on the Environmental Assessment of Policy, Plan and Program Proposals*, 2004. http://www.ceaa-acee.gc.ca/016/CEAA-StrategicFinal_e.pdf

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."[17]

Significantly, on the basis of the testimony received, we believe that Canada already has the assets it needs to use HIA as a strategy for developing and implementing population health policy. In our opinion, legislation may not constitute the most effective means of institutionalizing HIA; it may also be a lengthy process. However, a Cabinet directive, similar to the EIA process, would be needed to impose HIA implementation. Therefore, the Subcommittee recommends:

> **That the Government of Canada require Health Impact Assessment (HIA) to be conducted for any policy, plan or program proposal submitted to Cabinet that is likely to have important consequences on health;**
>
> **That the Privy Council, in collaboration with Health Canada, develop guidelines for implementing the Cabinet directive on HIA;**
>
> **That the HIA guidelines be developed using existing material;**
>
> **That the Government of Canada encourage the use of HIA in all provinces and territories.**

2. DATABASE INFRASTRUCTURE

The whole-of-government approach to population health envisioned by the Subcommittee must rest on the development of a sound database infrastructure that will ensure the collection, monitoring, analysis and sharing of population health and health disparity indicators and an ambitious program of intervention research. 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.

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 Statistics Canada, the Canadian Population Health Initiative, the Public Health Agency of Canada

[17] Subcommittee on Population Health, *op. cit.,* p. 16.

and Human Resources and Skills Development 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 British Columbia Health and Wellness Survey. In addition, several community-based indicators of health and well-being are provided by government and non-governmental organizations including, for example, the Rural Secretariat (community information database), the Federation of Canadian Municipalities, the Atkinson Charitable Foundation and the Canadian Council on Social Development. Altogether, 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.

2.1 A Pan-Canadian System of Community Accounts

> *(…) Community Accounts is a fantastic resource. I cannot imagine my job without it; nor can I imagine any other province not having it. Community Accounts provides outstanding information that is very user-friendly, and the data can be very easily transferred into knowledge to help us better the health of our communities.*[18]

The Subcommittee heard repeatedly that, while Canada has excellent national and provincial population health data and information, it lacks strong data at the local level. Since much of the intersection of policy domains that affect population health occurs at the local level, more local information is needed. Numerous witnesses suggested that the Newfoundland and Labrador Community Accounts (CA) could be a model for the national database infrastructure needed for the implementation of a broad population health policy. Nova Scotia has implemented a version of the CA (Community Counts) and Prince Edward Island recently established CA pilot projects (within the Quality of Island Life Cooperative). The CA also offers potential for Aboriginal communities and is in fact being considered as a database model by the First Nations Statistical Institute.

The CA is an Internet-based retrieval and exchange system that provides unrestricted, free access to view and analyze social, economic and environmental data (health, income, education, employment, production, resources, crime, etc.) from a variety of sources (Statistics Canada, government departments, hospital records, etc.) at the local, regional and provincial levels. The basic building block for geography across the various data sources under the CA is the postal code. The CA is administered by the Newfoundland and Labrador Statistical Agency and is maintained within the provincial Department of Finance. It has many users, including government departments, regional authorities, communities, academia and researchers, NGOs and individuals. The CA is a key supplier of the information necessary to monitor and evaluate progress made under various provincial public policy initiatives, including the Reducing Poverty Action Plan, the Provincial Wellness Plan and the Rural Secretariat.

[18] Lisa Brown, Planning Specialist, Eastern Health, Newfoundland and Labrador, 21 May 2008 (6:121).

It is the view of the Subcommittee that the CA has been very successful in linking information about population health, community well-being, and economic development. We are particularly impressed by the progress achieved in Newfoundland and Labrador in the implementation of a sound population health database infrastructure and are pleased to see that Nova Scotia and Prince Edward Island have adopted a similar database infrastructure model. We believe that such a database is a key asset in the development and implementation of a pan-Canadian population health policy. Therefore, the Subcommittee recommends:

That the Government of Canada support the development and implementation of Community Accounts, modelled on the Newfoundland and Labrador CA, in all provinces and territories.

Another infrastructure system that offers tremendous potential for population health in Canada relates to the Electronic Health Records (EHRs) that are currently being implemented by Canada Health Infoway Inc. in collaboration with provincial and territorial governments. The EHRs contain patient health information and link various care providers within and between jurisdictions. Health information is vast and can include clinical reports, immunization data, dispensed prescription drugs, laboratory test results, diagnostic images, and past and current health conditions. As such, EHRs can provide the life course or longitudinal information that is needed for population health purposes – from pregnancy, to early child development, to schooling and adolescence, to the world of work, then retirement through old age. Moreover, like the CA, the EHRs can be aggregated and analyzed by postal code. Accordingly, numerous witnesses told the Subcommittee that there is a huge opportunity to link, for each Canadian, the data generated by emerging EHRs to a broader CA database infrastructure.

> *The potential exists for electronic health records to contribute to the data and information system components and could help form part of a foundation for a population health information system.*
>
> *Mike Sheridan, Chief Operating Officer, Canada Health Infoway Inc., 27 March 2009 (3:44).*

Given the several existing national, provincial and local sources of information on health disparities, the Subcommittee often asked witnesses who should take the lead in facilitating the establishment, management and maintenance of a national database system built on the CA and EHRs. Numerous witnesses made the plea to not create more organizations but instead to establish a partnership among the key organizations. There was strong consensus that CIHI – the Canadian Institute for Health Information – has been a successful model of partnership in Canada. Though it is a small organization, CIHI has worked to build the bridges across many other groups working at the national level, as well as across the provinces and territories. The Subcommittee concurs with witnesses that CIHI has effectively been, for the last 15 years, the repository of health information, working in partnership with all provinces and territories. Its capacity and reputation are time-proven. The next step, in our view, is for CIHI to extent its partnerships with other key stakeholders in the broad population health field. Therefore, the Subcommittee recommends:

That the Canadian Institute for Health Information (CIHI) be designated as the lead in the development, management and maintenance of the pan-Canadian population health database infrastructure;

That CIHI immediately begin work to establish the necessary vertical integration of data with key partners.

> *We must acknowledge that health information – and I say "information" because it is beyond health, it is social services and unemployment information – is a public good. (...) We must use all the information we collect on citizens in order to learn about the society; where we are, where we are going, how we are going, how we compare across the country and how we compare with other countries. That is critical in terms of effectively facilitating the collection of that information.*
>
> *Jean-Marie Berthelot, Vice-President of Programs, Canadian Institute for Health Information, 27 March 2009 (3:56).*

Witnesses stressed that linking EHR data to the CA database, however, is highly sensitive from a privacy perspective. The Subcommittee is aware that the right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, there is a need to find a good balance between protecting the information of individuals and allowing the use of information on a population group to inform public policies and strategies. The Subcommittee is aware that Statistics Canada has the strongest constitutional and legislative mandate of any organization in the country for these kinds of data linkages, as well as an unblemished record for confidentiality and privacy protection, and a history dating back to the 1960s for technical excellence and leadership in this area. Therefore, the Subcommittee recommends:

That Statistics Canada, in collaboration with Canada Health Infoway Inc., the Canadian Institute for Health Information and other key stakeholders, develop standards to facilitate the linkages between the Community Accounts and Electronic Health Records while ensuring the protection, privacy and security of personal information;

That work on the development of appropriate standards for the protection, privacy and security of personal information be completed within the next 12 months.

2.2 Population Health Intervention Research

> *Now I want to turn to the second issue of investing in more population health research and enhancing the translation of knowledge. Here I want to stress that there are two things we can do, one of which I think would be a mistake. The mistake would be to invest mostly in learning about the general determinants of health outcomes. That is the easy road, but we already know a lot about this. What we need to do is fill the enormous gap in our knowledge of what public policy interventions work. This starts to sound like program evaluation, which it largely is, but it is unbiased program evaluation adhering to high standards of quality. It is also done to consistent standards of methodology so that one can have confidence in relative benefit-cost ratios of different interventions. In Canada we have underinvested by a substantial margin in unbiased, high quality, peer-reviewed, dispassionate effectiveness evaluation, especially in the population health field.*
>
> *Cliff Halliwell, Director General, Strategic Policy Research Directorate, Human Resources and Social Development Canada, 14 May 2008 (5:12-13).*

The Subcommittee heard repeatedly that good public policy requires evidence of effectiveness, both prospectively during the phase of policy design, and on a continuing basis once the policy has been implemented. This evidence in turn depends on skillful and thoughtful analysis, which correspondingly must be grounded in appropriate data and information. Since knowledge about population health is incomplete, and will almost certainly remain so for the foreseeable future, policy development and implementation will inevitably occur in a milieu of incomplete knowledge of what works. For this reason, continuous monitoring and evaluation of policies and programs, with regular feedback to policy design, is essential. Over time, this type of research – often referred to as "population health intervention research" – will help increase our understanding about what policies and programs are effective in improving population health and reducing health disparities.

As the Subcommittee noted in its *Issues and Options* paper, it is not clear how much Canada spends on intervention research.[19] Currently, a number of federal agencies and departments play a role in the direction, funding and design of population health research, including the Canadian Institutes of Health Research, Statistics Canada, the Canadian Institute for Health Information, Health Canada, the Public Health Agency of Canada (and its 6 National Collaborating Centres), other federal departments (such as Indian and Northern Affairs Canada, Human Resources and Skills Development Canada, Environment Canada, etc.) and other research granting agencies such as the Natural Sciences and Engineering Research Council of Canada (NSERC) or the Social Sciences and Humanities Research Council (SSHRC). In addition, there are multiple provincial departments, agencies and institutes involved in intervention research. However, witnesses stressed that current funding does not reflect the burden of health disparities and that more practical, evidence-based knowledge is needed about what improves the health of the population. The Subcommittee believes that intervention research is an essential component of a whole-of-government approach to population health. Therefore, we recommend:

[19] Subcommittee on Population Health, *Population Health Policy: Issues and Options*, April 2008, p. 13.

That the Canadian Institutes of Health Research (CIHR) work in collaboration with relevant federal departments and agencies to assess current investment in population health intervention research and reach consensus on and determine an appropriate level of funding in this field;

That the Government of Canada increase its investment in population health intervention research to match the level agreed upon by CIHR and other relevant department and agencies;

That future population health intervention research funded by the government of Canada build on the capacity and strengths of existing networks and research centres and foster collaborative partnerships among municipal, provincial and federal research agencies as well as academic partners for a focused research agenda;

That the Government of Canada devise competitive operational funding mechanisms that will best support innovative, leading-edge research on population health intervention;

That the Government of Canada consider joint funding mechanisms for inter-provincial and international comparative research on population health interventions;

That the Government of Canada examine the eligibility criteria for human health research infrastructure funds in Canada and consider how these could be better aligned with population health intervention research involving implementation mechanisms in health and other sectors;

That population health intervention research on housing, early childhood development and mitigating the effects of poverty among Aboriginal peoples and other vulnerable populations be considered priorities.

3. ENGAGING COMMUNITIES

> *The surprising consistency with which health determinants emerged in our consultations with community-based organizations across Canada suggests that there is already an implicit consensus on these issues. It is safe to conclude that community-based organizations represent a rich resource just waiting to be tapped. The federal government can mobilize this resource by supporting communities to engage in intersectoral action (…).*[20]

Over the course of our study, the Subcommittee heard from a wide range of witnesses and received numerous briefs that proposed a variety of approaches to improving population health and reducing health disparities. But one critical factor was never in dispute: governments cannot act alone. The most effective actions to improve health and well-being, enhance productivity, foster social cohesion and reduce crime must be taken at the community level, and led by communities themselves.

> *The leadership has to come not only from the federal government – and I believe the federal government has a key role – but it has to come from the bottom as well. That is the only way this is going to work.*
>
> *Debra Lynkowski, Chief Executive Officer, Canadian Public Health Association, 18 April 2008 (4:83).*

We agree with the Chief Public Health Officer of Canada who, in his first report (2008), explicitly called for the strengthening of Canadian communities to address health determinants, noting that people living closest to the problem are often closest to the solution. The report stated that communities must be honoured and supported to develop their own locally-appropriate responses, building on existing knowledge, experience and energy. Interventions at the community level are most successful in reaching vulnerable populations, creating local networks, and leveraging resources. Similarly, a 2008 report published by the Canada West Foundation emphasized that the only long-term solution to street-level social issues is the prevention made possible by building strong and inclusive communities.[21]

How best to enable and support communities to take that initiative is a new role that governments are learning. Many of the recommendations in this report are designed to support the shift in this new role, including the way data is gathered and shared, how and what kind of research is undertaken, and why a whole-of-government approach is so vital. But for communities to be successful in their efforts, changes are also required in the way governments partner and support those initiatives.

3.1 Improving Reporting Requirements

A significant measure of success of the whole-of-government approach described in Section 1 will be the extent that communities are able to address complex issues with integrated,

[20] Canadian Mental Health Association, *Submission to the Subcommittee*, 2008, p. 5.
[21] Canada West Foundation, *From the Ground Up: Community's Role in Addressing Street-Level Social Issues* (2008). http://www.cwf.ca/V2/cnt/publication_200810271452.php

intersectoral responses that are supported by a range of departments and agencies from different levels of government.

Because programs supporting the determinants of health span numerous departments, initiatives taking an integrated approach to action on the determinants of health could be eligible for funding from multiple sources. The report of the Independent Blue Ribbon Panel on Grant and Contribution Programs recommended that policies should encourage reporting in ways that meet the accountability requirements of all the federal programs involved, so that a recipient receiving funding from different programs can consolidate reporting.[22] This may require legislative amendments to clarify concepts of ministerial accountability, but would permit Treasury Board to take a more holistic, responsive and coordinated approach to community investments.

Similarly, jurisdiction for the determinants of health extends across all three levels of government. For this reason, the Independent Blue Ribbon Panel report also recommended that the Treasury Board and its Secretariat, in cooperation with other orders of government, harmonize federal, provincial and municipal information, reporting and audit requirements for grants and contributions. Basing reporting requirements on existing instruments that strengthen accountability, not only to governments but also to the organization's primary constituency (its members or community), will reduce administrative burden and enhance local leadership. It is fair to say that harmonization of reporting and auditing requirements will clearly be facilitated by the implementation of Community Accounts across the country. Therefore, the Subcommittee recommends:

> *Current funding regimes and accountability actually work to curtail innovation.*
>
> *Katherine Scott, Vice-President, Research, Canadian Council on Social Development, 12 March 2009 (2:12).*

That the Treasury Board of Canada Secretariat review and revise grant and contribution reporting requirements among federal departments and agencies to enhance horizontal and vertical coordination of reporting.

3.2 Longer-Term Funding

Action on the determinants of health can often take many years before results are seen in terms of improved health status or reduced health disparities. The Subcommittee heard repeatedly that short-term, project-based funding as a principal source of revenue weakens community organizations by instilling insecurity and preventing long-term planning. Multi-year funding agreements, subject to annual appropriations by Parliament, would provide stability in the sector and reduce transaction costs for the government. Therefore, the Subcommittee recommends:

That the Treasury Board of Canada Secretariat encourage multi-year funding of projects that have multi-year timelines. The Treasury Board of

[22] *From Red Tape to Clear Results: The Report of the Independent Blue Ribbon Panel on Grant and Contribution Programs*, December 2006, http://www.brp-gde.ca/pdf/Report_on_Grant_and_Contribution_Programs.pdf.

Canada Secretariat should also encourage multi-year funding among federal granting agencies, where appropriate.

3.3 Community Data and Research

The determinant of health framework presented in Chart 1 illustrates how population health is a complex, long-term and dynamic goal. A specific intervention that works in one community at one time may not work in another community or even in the same community at a later time. Each set of circumstances is unique, so local leadership is required to draw upon the experience of what has worked elsewhere, adapt it to local realities, constantly evaluate and learn what works.

This cycle of taking action, evaluating, learning and adjusting requires that community leaders have access to local data. Local data has to be extremely refined – down to the neighbourhood or postal code level. An analysis of data at the postal code or neighbourhood level can reveal shocking disparities between local areas – the differences in life expectancy between neighbourhoods in Montréal illustrated in Chart 2 above is just one example. Another was provided by Dr. Robert Cushman when he described differences between two Ottawa neighbourhoods – the Glebe and Dalhousie – which, despite their geographic proximity, are respectively among the richest and the poorest neighbourhoods in Ottawa. Since income is such a significant determinant of health, it should not be surprising that heart disease and diabetes are two to four times more common in Dalhousie than in the Glebe.[23] Regrettably, many cities across Canada also likely have similar contrasting neighbourhoods. Because of the large disparities, actions to improve health and reduce health disparities will almost certainly have to be tailored to the different realities of each neighbourhood, but those actions must be informed by easily accessible neighbourhood-level data, down to the level of the postal code.

That is another strength of the Community Accounts model recommended above – it puts data into the hands of local decision-makers. It also brings together data from a range of federal and provincial sources to one location, presenting a comprehensive picture at the local level. The data alone, however, is not sufficient. Local capacity also has to be in place to analyze and interpret that data into meaningful feedback that can guide decision-making about local initiatives on the determinants of health. Furthermore, intervention research that can uncover the essential characteristics of successful (and unsuccessful) initiatives will contribute to our understanding of what works and facilitate the useful transfer and application of those lessons to new settings.

The key to data analysis and research is that it should be done in a way that empowers communities and builds local capacity for action over the long term. This means building in funds for research and evaluation in any program agreement. It is this evidence-based system of learning and action that will be the foundation for improving population health and reducing health disparities. Therefore, the Subcommittee recommends:

That the Government of Canada include support for local analysis and evaluation capacity in the design of programs aimed at improving population health and reducing health disparities.

[23] Dr. Robert Cushman, Chief Executive Officer, Champlain Local Health Integration Network, 1st April 2009 (:).

The federal government plays an important role in direct support to local organizations and firms. More than 50 federal departments and agencies spend nearly $27 billion each year through more than 800 grant and contribution programs.[24] Yet governmental funding structures, which are usually focussed on addressing specific issues, tend to fragment community strategies, isolating target populations and separating sectors of activity.

A number of initiatives have been undertaken in recent years to improve funding and accountability relationships between the federal government and the voluntary / non-profit sector, including the Voluntary Sector Initiative, the Task Force on Community Investments and the Independent Blue Ribbon Panel on Grant and Contribution Programs. These efforts have made some progress, but much more remains to be done. Two of the most fundamental changes that will be required to strengthen community capacity and support community-level action on the determinants of health involve improving reporting requirements and providing longer-term funding.

3.4 Coordinating or Integrating Services: Community Models that Work

Because population health is a complex and dynamic objective, coordinated action on many or all of the determinants of health at the local level is required in order to begin showing overall improvements in health outcomes. Once communities have the information and analysis necessary to properly identify and monitor the challenges they face, they must take a coordinated and strategic approach to act on those determinants locally.

Just as Canada is defined by a richly diverse social fabric, the coordinated or integrated approaches by which communities address health determinants can take many forms. The Subcommittee has been extremely impressed to learn about the wide range of successful initiatives contributing to good health, well-being, low crime and productivity in rural, urban, Aboriginal and other settings. New community-based practices, such as community economic development and the social economy, often address many of the determinants of health in a coordinated manner while empowering citizens. These integrated, locally based approaches consciously blend a range of social, economic and environmental objectives that can improve many of the determinants of health, especially for marginalized and minority groups. They are rooted in communities, depending on volunteer involvement and guided by citizens for the actions they take. It is worth mentioning a few examples here.

While in St. John's, Newfoundland and Labrador, the Subcommittee had the pleasure of visiting Stella Burry Community Services and enjoying a superb lunch at Stella's Circle restaurant. Stella Burry Community Services serves adults with social and emotional problems by: providing support and counselling to individuals who have experienced significant personal troubles such as abuse, addictions, violence and incarceration; developing affordable housing for low income individuals and families, and; offering training and skills development programs. Stella's Circle is a social enterprise started by Stella Burry Community Services in order to provide job creation and skills training opportunities in the food services industry, to offer low-cost meals to members of the Stella Burry community who are challenged to maintain good nutrition on limited incomes, and to act as a source of revenue generation for the organization.

[24] Report of the Independent Blue Ribbon Panel on Grant and Contribution Programs, *op. cit.*

Through the combination of these initiatives, Stella Burry is able to address many more of the determinants of health in an integrated manner for the population they serve.

Also while in St. John's, the Subcommittee learned about the Tamarack Institute's Vibrant Communities initiative. Vibrant Communities is a community-driven effort to reduce poverty in 15 cities by supporting collaborative local initiatives aimed at poverty reduction that engage the private sector and can improve numerous determinants of health. In St. John's, one of the Vibrant Communities' projects is the Citizen's Voice Network that meets regularly to share information, to learn, and collectively to impact policy-making and decision-making.

Social planning councils such as the Human Development Council in St. John, New Brunswick also make a valuable contribution in working with citizens and connecting community services to improve overall quality of life. The Human Development Council performs two key functions: an information role linking citizens to human services, and a proactive role developing solutions to meet community challenges.[25] The New Brunswick Premier's Community Non-Profit Task Force report insightfully advocates for more horizontal regional structures working through community organizations, with regional autonomy for service delivery, making flexibility easier and encouraging an integrated approach to individual and community issues.[26]

Québec has a vibrant community sector, with a number of different structures helping facilitate coordinated local action. There are almost 50 Community Development Corporations that bring together community organizations from a range of different sectors to facilitate training, information sharing, and supporting joint responses to local social issues.[27] Linking social, economic and environmental determinants of health locally, fourteen Community Economic Development Corporations help communities develop and implement their own solutions to economic problems by mobilizing local residents, businesses and institutions.[28] The Québec Network of Healthy Cities and Towns inspired *Vivre St-Michel en santé*, a local action committee made up of residents, community groups, businesses and government agencies committed to revitalizing the Montréal neighbourhood.[29] *Vivre St-Michel en santé* led a year-long consultation, planning and research process that involved 400 community members and stakeholders, and resulted in a comprehensive community plan to improve social and economic conditions.

In Ontario, the Learning Enrichment Foundation is one of the oldest and largest community economic development organizations in the country. Located in a major reception area for immigrants arriving in Toronto, LEF has developed a range of programs and services as part of its holistic approach. Its programs include skills training in sectors corresponding to local employment opportunities, language instruction and literacy classes for newcomers to Canada, 18 child care centres, 16 before- and after-school programs, a kitchen which prepares 500 meals a day for agencies serving the homeless, training enterprises in woodworking and food service

[25] http://www.humandevelopmentcouncil.nb.ca/
[26] http://www.gnb.ca/cnb/promos/nptf/index-e.asp
[27] http://www.tncdc.qc.ca/openfile.aspx?ID=196
[28] http://www.lescdec.qc.ca/
[29] http://www.vsmsante.qc.ca/site/index.asp?sortcode=1.1

for at risk youth, a recruitment service for employers, a technology help desk, computer access sites, a training loan fund, several social enterprises and self-employment training and support.[30]

Manitoba's Neighbourhoods Alive! program is a long-term, community-based, social and economic development program that supports and encourages community-driven revitalization efforts focusing on key areas such as housing and physical improvements, employment and training, education and recreation, safety, and crime prevention.[31] Through citizen-led Neighbourhood Renewal Corporations and a range of other programs, Neighbourhoods Alive! works with the strengths and experience of local residents to build healthy neighbourhoods.

Saskatoon's Quint Development Corporation was founded in 1995 to strengthen the economic and social well-being of Saskatoon's five core neighbourhoods through a community based approach. Community residents form at least three quarters of Quint's Board of Directors, and guide the organization's work to improve the availability of affordable housing, support business renewal and provide employment development opportunities.[32] A major new business renewal initiative is Station 20 West, a community enterprise centre that will bring together under one roof a range of businesses, services and organizations – from a library and health and dental care to groceries and household tools. It is hoped that this community hub will serve as a catalyst for the economic and social renewal of Saskatoon's core neighbourhoods.

Another important model is the Healthy Communities movement. Growing out of an international conference on healthy public policy in Toronto in 1984, there are currently provincial Healthy Communities organizations in several provinces, including Ontario, Québec and BC. In British Columbia, the BC Healthy Communities (BCHC) engages governments and community organizations to link initiatives and programs interdepartmentally and intersectorally in order to address the multiple determinants of health. BCHC also uses community facilitation, workshops, tool kits and small seed grants to support communities and community groups taking a holistic and integrated approach to improving health and well-being.

An area of connectivity that merits particular consideration is the local role of the health care system. Witnesses before the Subcommittee and our own international comparative research have confirmed that the most effective health services are those that have a strong primary health care system, connected to a broader range of health and social services. Proactive prevention programs can also have a significant impact of improving health and well-being and enhancing productivity.

Local medical and public health officials can also take a leadership role in building public understanding about the links between health determinants and population health, and support the collaborative relationships needed at a local level to address the determinants of health. An outstanding example of this role can be found in the Saskatoon

> *The "H" needs to stand for "health care" more than "hospital". My message to you is that we do not have enough resources in the community. We have to shift into the community, away from the institutions.*
>
> *Dr. Robert Cushman, Chief Executive Officer, Champlain Local Health Integration Network, 1 April 2009 (:).*

[30] http://lefca.org/index.php?option=com_content&task=view&id=1
[31] http://www.gov.mb.ca/ia/programs/neighbourhoods/
[32] http://www.quintsaskatoon.ca/aboutquint.html

Health Region's 2008 report on health disparities.[33] The Saskatoon Health Region assembled shocking but solid evidence of health disparities in the city, and then carried out over 200 community consultations with various government representatives, academics and community groups on that evidence. The report proposes a comprehensive and coordinated set of evidence based policy options that gathered substantial support through an extensive international literature review, a second round of over 100 community consultations and a telephone survey of 5,000 Saskatoon residents.

Quebec's network of CLSCs (Centre local de services communautaires) and community health centres that can be found in other provinces demonstrate how neighbourhood centres can bring together a range of services located under one roof. Our examination of the polyclinic model in Cuba left no doubt about what can be accomplished with very limited budgets through a strong primary care presence, rooted in neighbourhoods, addressing many of the determinants of health simultaneously. Cuban polyclinics take a multidisciplinary approach, ensuring the integration of science, knowledge transfer, parent and grand-parent education and community mobilization as part of a strong multidisciplinary primary health system. As part of their prevention mandate, they regularly undertake universal screening initiatives and strongly encourage immunization. They also serve as a site for both medical training and education – students in medicine and nursing receive a great part of their training in polyclinics, often the one to which they will become professionally attached after graduation. As part of an integrated community approach, polyclinics work closely with teachers in early child development, preschool and elementary schools, holding regular meetings (every six months) to discuss the overall mental and physical health of the children in the community. Neighbourhood councils ensure that services such as early childhood education programs are connected to local needs.

The integration or coordination of services at the local level can help streamline and simplify access, increase efficiency, and bridge traditional program boundaries. But ultimately, integration is a process – there is no one model that can be applied in all situations. It is, rather, a goal that must be tailored to each individual community setting. What is important is an emphasis on collaborative responses focused on local needs.

Internationally, Canada is lagging behind other jurisdictions in this regard. We can learn from our own successful examples and those in other countries, notably Sweden and the United Kingdom, to find the optimal mix of top-down and bottom-up policy models, balancing local flexibility with national accountability. Therefore, the Subcommittee recommends:

> **That the Government of Canada work with other levels of government and the non-governmental sector to support the integration or coordination of community-level services within a determinant of health framework.**

[33] http://www.saskatoonhealthregion.ca/your_health/documents/PHO/HealthDisparityRept-complete.pdf

4. ABORIGINAL POPULATION HEALTH

There is an enormous wealth of unrealized potential in Aboriginal communities whose development can be supported by the Government of Canada.[34]

Currently, Aboriginal Canadians – First Nations, Inuit and Métis – all have a health status that is well below the national average. The evidence obtained by the Subcommittee shows that the Aboriginal experience in Canada is unequal. There are striking disparities between Aboriginal and non-Aboriginal Canadians in most health determinants and the gaps are widening. In particular, the socio-economic conditions in which Aboriginal peoples live are often cited as being similar to those in developing countries. This situation is not only deplorable, it is simply unacceptable.

> *Aboriginal peoples historically and to the present day have really not been full participants in the nation state called Canada. As the political economy of Canada evolved, it became necessary to dislocate Aboriginal peoples from their traditional lands and their way of life in order to make way for settler societies. That is not my opinion; it is a matter of fact. The process of dislocation as a result of colonization meant that many Aboriginal people and communities were socially excluded from Canada. This led to marginalization in education and employment, housing, health care and many other services. This, in turn, effectively created a two-tiered society in Canada – one standard for Canadians as a whole and another standard for Aboriginal peoples.*
>
> *Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, 26 March 2009 (3:12-13).*

The Subcommittee recognizes the unique interests and specific needs of each Aboriginal group – First Nations, Inuit and Métis. We also concur with witnesses that this is inclusive of all Aboriginal peoples, who may reside on reserves or settlements, in rural or urban areas, or northern and arctic regions. The Subcommittee's approach to population health, with its focus at the community level, provides the flexibility to improve Aboriginal health and well-being while respecting social, cultural and local distinctions. We agree with witnesses who often stated that "One size definitely does not fit all." We also strongly concur with witnesses that even the most challenged and disadvantaged communities have significant and sometimes astonishing strengths, capacities and assets that can be used to enhance their physical and mental health and well-being. Aboriginal perspectives on health and well-being offer rich, holistic models. While First Nations, Inuit and Métis groups each presented their own vision and diagram of holistic wellness, these share many common elements with the framework we have illustrated in Chart 1 above. Because of the fundamental importance of respecting social, cultural and local distinctions in Aboriginal population health policies and programs, the Subcommittee recommends:

> **That Aboriginal peoples – First Nations, Inuit and Métis – be involved in the design, development and delivery of federal programs and services that address health determinants in their respective communities.**

[34] Conference Board of Canada's Roundtable of the Socio-Economic Determinants of Health, *op. cit.*, p. 14.

The Subcommittee is aware that over 30 federal departments and agencies currently deliver some 360 federal programs and services to Aboriginal peoples and communities. These programs and services encompass health, lifelong learning, safe and sustainable communities, housing, economic opportunities, lands and resources, and governance relationships. The Subcommittee strongly agrees with numerous witnesses that these programs and services could be better coordinated and integrated with the view of addressing health determinants among the Aboriginal population. A whole-of-government approach, whereby the 30 departments and agencies work together in an integrated fashion, would be a first step in the reduction of health disparities between Aboriginal and non-Aboriginal Canadians. The current federal silos hinder Aboriginal communities from developing, at their own pace and according to their specific needs, a comprehensive approach to addressing the determinants of health. Breaking down these silos requires leadership from the top. Moreover, a population health approach is highly supportive of the Aboriginal belief that to be healthy one must achieve balance in all spheres – the spiritual, mental, emotional, physical and social.

> *In the Inuit world view, health, education and social conditions are all intertwined. It is a real challenge when you have departments that work pretty much in silos. (…) It is a real challenge for Inuit to work with a system that operates in silos.*
>
> *Rosemary Cooper, Director of Executive Services, Inuit Tapiriit Kanatami, 25 March 2009 (2:41).*

Witnesses told the Subcommittee that, following a formal apology to the "Stolen Generations" in 2008, the Australian Prime Minister took the lead in implementing "Closing the Gap on Indigenous Disadvantage." The new approach rests on both new spending and redirected funding. Closing the Gap combines a whole-of-government approach at the Commonwealth level – the Indigenous Affairs Committee of Cabinet – with an intergovernmental mechanism – working in cooperation with the States and Territories – through the Council of Australian Governments (COAG). All governments together developed and adopted six main targets related to Aboriginal life expectancy, mortality rate, literacy and numeracy, employment, schooling, and early childhood.

> *It has been a year since the Prime Minister in Australia issued a statement on closing the gap. In Australia, there is a national effort to close the gap between the health status for indigenous Australians versus the mainstream. On the first day of Parliament every working year, the Prime Minister reports to Parliament on the progress the entire government is making on closing the gap.*
>
> *Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, 26 March 2009 (3:31).*

In Canada, the Prime Minister noted in his apology on behalf of all Canadians to residential school survivors that this was a new beginning and an opportunity to move forward together in partnerships. The Subcommittee believes that for the federal government, now is the time to act. Narrowing and ultimately eliminating the troubling disparities between Aboriginal and non-Aboriginal Canadians is essential to improving the health and socio-

> *In Canada, June 11 will be the first anniversary of our Parliament's apology to residential school survivors. The apology was not only about acknowledging the past but also about fundamental change. It is time to fundamentally change health systems and achieve real equity. My children and your children deserve nothing less.*
>
> *Bob Watts, Chief Executive Officer, Assembly of First Nations, 25 March 2009 (2:32).*

economic conditions of First Nations, Inuit and Métis. The approach adopted in Australia offers a very good model for Canada. Moreover, a number of pieces are already in place to move the agenda forward. In 2005, a process called the Canada-Aboriginal Peoples Roundtable resulted in a set of agreements between Aboriginal leaders and the Canadian governments, concerning standards of living and basic human rights. It set targets and allocated funding to reduce the disparities between Aboriginal communities and the general Canadian population. The degree of involvement of officials from the federal, provincial, and territorial governments, as well as Aboriginal leaders, communities, and organizations, was unique in Canadian history. The negotiations included: Inuit Tapiriit Kanatami (representing the Inuit); Métis National Council (representing the Métis); Assembly of First Nations (representing First Nations); Congress of Aboriginal People (representing urban and off-reserve Aboriginal peoples); Native Women's Association of Canada (representing Aboriginal women). The Subcommittee believes that Canada must build on this historical achievement and therefore, we recommend:

> *The Prime Minister noted in his apology on behalf of Canada to residential school survivors that this was a new beginning and an opportunity to move forward together in partnership. We are still waiting for movement. We believe that for the federal government, this is now the time to act.*
>
> *Rose Sones, Assistant Director, Strategic Policy for Health and Social Affairs, Assembly of First Nations, 25 March 2009 (2:53).*

That the Prime Minister of Canada, as a first step toward the development and implementation of a pan-Canadian population health strategy, work with provincial and territorial Premiers, as well as with First Nations, Inuit, Métis and other Aboriginal leaders in closing the gaps in health outcomes for Aboriginal Canadians through comprehensive, holistic, and coordinated programs and services.

That the following health determinants be given priority: clean water, food security, parenting and early childhood learning, education, housing, economic development, health care and violence against Aboriginal women, children and elders.

Numerous Aboriginal representatives told the Subcommittee how current jurisdictional disputes over program funding and delivery impede timely access to needed services and supports. In this context, they told us the story of Jordan River Anderson, a First Nation boy who was born with complex health needs. As his family did not have access to the supports needed to care for him at their home on reserve, they made the difficult decision to place him in child welfare care shortly after birth. Jordan remained in hospital for the first two years of his life as his medical condition stabilized. Shortly after Jordan's second birthday, doctors said he could go to a family home. However, federal and provincial governments disagreed on which government and department would pay for Jordan's at home care. The jurisdictional dispute lasted over two years during which time Jordan remained unnecessarily in hospital. Sadly, the boy passed away before the jurisdictional dispute was settled. In honoured memory of the boy, Jordan's principle was enunciated. This "child first" principle aims to ensure that necessary services for a child are not delayed or disrupted by jurisdictional disputes. In December 2007,

the federal government endorsed Jordan's principle when it adopted Private Member Motion 296. Implementing this historic child-first policy, however, requires support from all levels of government. Moreover, the Subcommittee agrees with witnesses that this principle should be extended to Aboriginal Canadians of all ages who "fall between the cracks" in the many areas where federal jurisdiction interacts with provincial and territorial responsibility. Therefore, the Subcommittee recommends:

> **That the Government of Canada work with all provincial and territorial governments to implement Jordan's principle for all programs, initiatives and services that address the health determinants of Aboriginal peoples in all age groups.**

The Committee also heard repeatedly that the Aboriginal vision of physical and mental health and well-being is rooted in the medicine wheel and that it incorporates the importance of self-determination. Some witnesses suggested that the Cuban polyclinic model could be easily adapted in many Aboriginal communities to provide integrated population health services and programs. Others noted that the development of Aboriginal community councils with structures similar in some ways to that of regional health authorities would help support Aboriginal peoples' legitimate desire to achieve self-determination in the field of population health. Still, other witnesses indicated that some Aboriginal communities already have in place structures and mechanisms to facilitate the development and implementation of population health policy. Therefore, the Subcommittee recommends:

> **That the Government of Canada, in collaboration with its provincial and territorial counterparts, as well as the appropriate First Nations, Inuit and Métis organizations, support and fund appropriate structures and mechanisms across the country that will facilitate the development and implementation of comprehensive, holistic, and coordinated programs and services that address health disparities in Aboriginal communities.**

CONCLUSION

Canada has led the world in understanding population health and health disparities. In 1974, the Lalonde report revolutionized thinking about health. This was further amplified in 1986 by the Ottawa Charter for Health Promotion and the Epp report. The Canadian Institute for Advanced Research, through its Population Health Program and such publications as *Why Are Some People Healthy and Others Are Not?*, has been seminal in understanding the determinants of health and health disparities. However, in recent years, as the costs and delivery of health care have dominated the public dialogue, there has been inadequate policy development reflecting what we have learned about population health. In fact, Canada has fallen behind countries such as the United Kingdom and Sweden in applying the population health knowledge base that has been largely developed here.

This lack of action has led to a widening of health disparities in Canada. The Subcommittee believes that it is unacceptable for a wealthy country like ours to continue to

tolerate such disparities in health. We fear that disparities may widen even further with the current economic crisis, which is unprecedented in terms of its global reach and impact. For these reasons, we propose a set of recommendations to foster health for all Canadians, and in particular our most disadvantaged groups – First Nations, Inuit and Métis peoples. Our focus on the life cycle, combined with a community-based approach, can lead to tremendous gains in health, productivity and wealth. This is possible if all governments act strategically and in a coordinated way on the determinants of health, mobilizing communities, the business sector and all Canadians behind a vision of a healthy, just and prosperous future. With the leadership of the Prime Minister of Canada, together we can achieve better health and wealth within a generation.