



A united voice and a call to action

“We have a challenge to launch a social movement in this country, and the great news is that the Canadian Public Health Association is behind it.” These were the words from the Honourable Monique Bégin yesterday, lighting a fire beneath audience members at the Canadian Commentary on Reducing Health Inequalities plenary.

The social movement Bégin recommends is in direct response to the forthcoming report from the WHO Commission on Social Determinants of Health. “We need to identify ways to disseminate the report of the Commission and we need to also celebrate it,” she said.



Hon. Monique Bégin

As Canada’s Commissioner to the WHO Commission, Bégin said there are many situations in the world that feel overwhelming, but she encouraged the audience to focus on problems at home. “There are still people who believe that Canada is the Sweden of the Americas,” she said. “But now I know better.” Bégin listed a number of ways that Canada is failing its people: “lousy” welfare policies, unjust remuneration for women, lack of universal child care, and the appalling health of First Nations, Inuit and Métis people.

Arjumand Siddiqi added to this list the early childhood education of our nation’s most vulnerable. “Early childhood is the most important developmental phase in life,” said the Assistant Professor at the School of Public Health, University of North Carolina. Research has proven that cognitive,

language, and emotional development are not the result of biology, but are patterned by the environments children are in contact with. “That phase of our development is critical for a lifetime of health outcomes,” she said. “Some of the health inequities that we’re talking about at this conference begin in childhood.”

The final panelist, Sharon Chisholm, Executive Director of the Canadian Housing and Renewal Association, made the vital connection between health and housing. “I believe that housing is a fundamental shaper of health,” Chisholm said, citing examples of individuals who cannot afford secure housing, which precludes them from good health care and social welfare. “I see housing as a pre-determinant of health, because without it, we can’t exercise healthy practices.”

These three speakers brought very different experiences to the table, but also a united voice. “We have to catch up with 20 years of inaction. We have to do it. We will do it,” said Bégin. “We are a rich country and we want to reclaim Canada as a just and caring society.”

PUBLIC FORUM:

Health authority seeks transformation

At the Public Forum Tuesday evening, CPHA welcomed the Halifax community to a discussion of the complex links between poverty and health.

“In virtually all societies, socio-economic status and health are inextricably linked,” said CPHA Chair-Elect Dr. Cordell Neudorf. He noted that the gap between rich and poor has increased in Canada, despite rising average incomes.



DR. SHEELA BASRUR

1956 - 2008

The public health community lost a cherished friend and ally June 2 with the death of Dr. Sheela Basrur, Ontario’s first Chief Medical Officer of Health, following an 18-month battle with a rare form of cancer. Tuesday morning, Dr. David Butler Jones left a white rose on the plenary podium as a symbol of Basrur’s continuing presence.

As Toronto’s Chief Medical Officer during the 2003 SARS outbreak, Basrur’s “cool, calm voice was a key part of our ability to deal with that crisis,” Butler-Jones said. “She met each challenge, including the cancer, with courage and grace. She was in fact a calm voice in the storm. We will miss her.”

Lea Bryden, Vice President of Marketing and Corporate Communications at Capital Health, said the local health authority had undertaken a journey to “transform ourselves and the way we think about and act in our relationship to health.”

With the arrival of a new CEO, Capital Health began a planning process that revealed a series of “inconvenient truths,” Bryden said. The organization’s

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approach to health was not holistic, leading its practitioners to “treat body parts, but not people.” In an organization that was often more responsive to administrative needs than it was to patients and citizens, it was hard to see how an issue like poverty would fit a health agenda.

The organization was focused on headline stories like hospital wait times, to the detriment of underlying determinants of health, and there had been little effort to engage citizens in decisions about health system planning and spending.

“If we are to honour our mandate to improve health in our community, we need to broaden our perspective,” she said. “We need to be acting on all 12 factors that determine health, not just the one about hospitals and health services.”



Public Forum panelists (clockwise from lower left) Megan Leslie, moderator Ron Strang, Dennis Raphael, Francisco Rico-Martinez, and Bonnie Anderson

The public and community health teams at Capital Health had held that perspective for some time, Bryden acknowledged, but “when they’ve come knocking on our doors at the highest levels in our organization, we haven’t always been home.” When CEO Chris Power arrived, she asked what it would take to turn Capital Health into a “world leading haven of health, healing, and learning.” The transformation process was the result.

Smoking, alcohol tip the balance in European health inequalities

The European welfare state has done a good job of protecting people from diseases of poverty, but was never set up to prevent diseases of affluence, according to Prof. Johan Mackenbach, Chair of the Department of Public Health at Erasmus MC in Rotterdam, The Netherlands, and Editor in Chief of the *European Journal of Public Health*.

As a result, many of the dominant health conditions in Europe “are diseases that you will not get if you are not prosperous,” Mackenbach told a Tuesday morning plenary session.

The persistence of health inequalities in spite of universal health care, social security, education, and employment protection has been “one of the big riddles” in Europe, he said. Researchers have hypothesized that the effort to reduce material and income inequalities has not affected underlying differences in social status, or that increased social mobility has allowed for a form of health-related selection that actually contributes to inequality.

In a study of 22 European countries, Mackenbach found dramatic regional differences in the degree of health inequality. In Eastern Europe and the Baltic republics, these differences related to smoking patterns, excessive alcohol consumption, and relative efficiency of health care delivery.

But he said the huge disparities suggest a message of hope.

“These variations in health inequalities mean that there is enormous potential for improvement. If we can bring down the magnitude of health inequalities in Eastern Europe to a level more



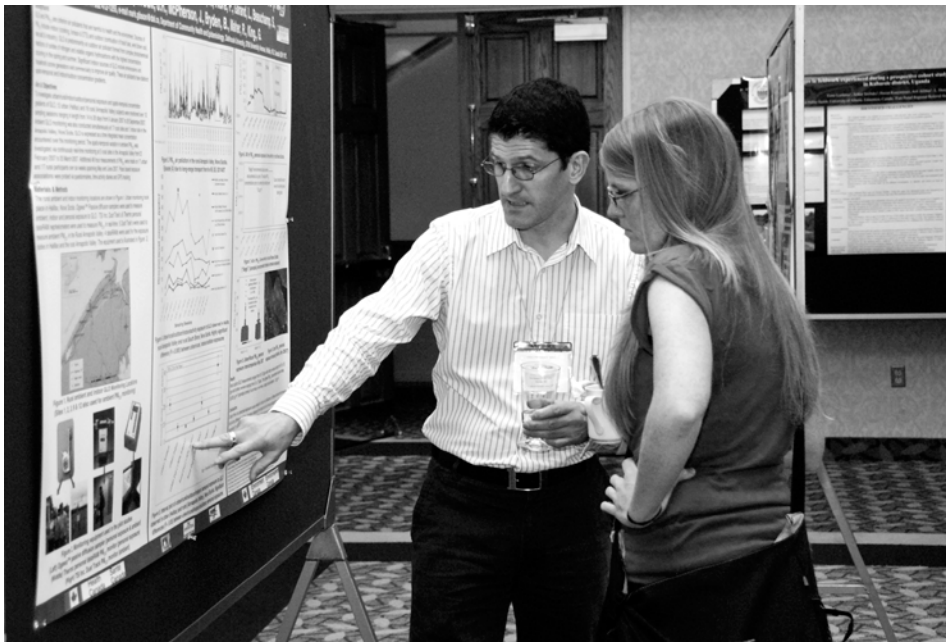
Prof. Johan Mackenbach

similar with Western Europe, we will have achieved a lot.”

There are also important differences in degrees of health inequality, with corresponding opportunities for improvement, among Western European countries.

Mackenbach stressed that policies to reduce health inequalities must be “tailored to the situation in a particular country. Spain requires a completely different set of measures from Sweden,” and Sweden’s needs differ from those of the Baltic republics.

The central paradox, he said, is that people with more money still live longer, despite broader distribution of income and access to health care. “If we cannot explain this, I think we have a serious problem.”



The resilience of systems

by THOMAS HOMER-DIXON, Ph.D

Researchers studying the behaviour of diverse systems, including ecologies and market economies, have discovered some interesting common patterns that point to challenges and opportunities facing public health in Canada.

Over time, these systems tend to become more complex, internally connected, and efficient, whether or not they need to become more complex to solve their problems. Eventually they become so well adapted to a specific range of circumstances—and so well organized as efficient and productive systems—that when a shock pushes them outside that range, they can't cope.

As these systems become more brittle, they become less adaptive and innovative in the face of the unexpected. They usually must go through some kind of breakdown or collapse process, before reorganizing themselves in new configurations.

What do these findings mean for public health? Confronted with aging populations, sophisticated technologies, and increasingly savvy, Web-empowered consumers, the cost and complexity of health care are rising relentlessly. As these rising costs run into funding constraints, efforts to maximize efficiency further increase the system's complexity and reduce its resilience.

The most adaptive complex systems in the world are highly distributed. Decentralization, with good information connections among the system's components, allows for more diverse approaches to innovation and rapid learning across the entire system. In health care, and in public health, we must allow as much distributed innovation and "safe-fail" experimentation as possible.

Health care professionals, and the Canadian public in general, must also realize that crisis can be salutary—that it's often in times of system failure or breakdown (as witnessed during the SARS crisis) that we experience the greatest opportunity for innovation and fundamental reform.

Mental health and public health must stand on the same platform

Common ground must be found for mental health and public health, to address needs, panelists said at the Mental Wellness session.

The Mental Health Commission of Canada advocates integrating the system to address a person's needs, whatever they are, said Gillian Mulvale, Senior Policy Advisor. The Commission sees mental wellness and mental illness as a "continuum all of us are on," she said. "The categories are not exclusive." In fact, someone with mental illness is entirely capable of experiencing mental wellness at the same time. An important goal of the Commission is to work with recovery.

Recovery is also an important theme among First Nations people. Currently there is no translation for mental illness within this community. They are working on ways to restore wholeness, balance, and relationship to family, community, ancestors, and the land. In healthier communities, everyone shares responsibility for solving a problem, which protects people from feeling helpless and demoralized.

The framework for understanding mental illness is different between Aboriginal and Western societies, said Bill Mussell, a private consultant who works extensively with Aboriginal health. The first task in some communities is "decolonization education." Many young people do not know who they are, or where they belong, and "identity is critical." The natural response when someone needs help is for family and community to gather around the person.

The panel and audience agreed it was time for mental health and public health to stand on the same platform. In 1999, the Canadian Population Health Initiative was created to help synthesize public health policy and share knowledge about mental health. Asked how to involve youth, Director Jean Harvey said, "Throw it back to youth": create an environment that lets them come up with their own solutions.





The chronic disease panel Tuesday called for 'assertive knowledge translation.'

Reducing chronic disease and inequity depends on 'working outside our mandates'

The failure of the free market, along with a lack of government action, is a leading factor in chronic disease, said John Millar, Executive Director, Population Health Surveillance and Disease Control, Provincial Health Services Authority, British Columbia.

Tuesday's panel on chronic disease and inequities identified four areas to examine for a healthier future. Public health is in the process of shifting its thinking in each of these areas, which include:

- Learning to collaborate with, even take the lead from, other sectors
- Moving out of "issue silos"
- Finding ways to gather data and evaluate
- Turning into sound bites the complex message that the burden of disease relates directly to the determinants of health

"We need to master assertive knowledge translation," said Tim Hutchinson, Director, Chronic Disease Prevention Division, PHAC.

Public health can build on existing programs, said Kari Barkhouse, Chronic Disease Prevention Coordinator, South Shore Health, Public Health Services. Barkhouse used the example of adding social justice and equity principles to healthy eating programs in schools to illustrate her point. She added that there is still a question of how to address bullying and mental health issues in this context.

As part of working collaboratively, "we also need to create a good business case that the business community can buy into," Millar said.

"It's not a quick win," said Nancy Hodinott, Director, Chronic Disease and Injury Prevention, Nova Scotia Department of Health Promotion and Protection. "It takes time to move the system through change, but we have things in place to build on. Our challenge is to share what we are learning and work outside our mandates."

in the halls

"I'm not sure I see any barriers this year. The stars are aligned to make this a good time to address health inequalities. Toronto Public Health is celebrating its 125th anniversary this year, and we'll be holding a symposium based on the determinants of health. It's a way of recognizing the strong relationship between the social determinants of health and engaging with our community."

- Toronto, Ontario

"When we banned smoking in public places, and Nova Scotia banned smoking in cars with children, it worked because we supported it with strong social policy that made it unacceptable to harm other people with second-hand smoke. The barrier is that there's still this idea that people have the right to harm their own health, and I would agree with that. But we can prevent people from harming other people by the consequences of their actions, and that includes their own children."

- Halifax, Nova Scotia

"We have to continue to sensitize Anglophones on the Island about the importance of Francophones receiving services in their own language. When they don't, it affects the quality of their health care. With serious health issues, and with mental health and addictions where you're talking about really heavy issues, it creates barriers and risks if you can't get services in your language."

- Wellington, PEI

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