



Health care in Canada **WHAT MAKES US SICK?**

Canadian Medical Association Town Hall Report | July 2013

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

EXECUTIVE SUMMARY

Throughout the winter and spring of 2013, the Canadian Medical Association (CMA) conducted wide-ranging consultations to gather input on Canadians' views on the social determinants of health. Public town hall meetings were held in Winnipeg, Hamilton, Charlottetown, Calgary, Montréal and St. John's and were accompanied by an online consultation at www.healthcaretransformation.ca.

The process was framed around four questions aimed at determining what factors beyond the health care system influence health, what initiatives offset the negative impact of these determinants, what governments and health care providers should be doing to address these social determinants, and how equal access for all to the health care system can be achieved.

In every phase of the consultation, four main social determinants of health were identified by participants:

- income
- housing
- nutrition and food security
- early childhood development

Several other social determinants of health were mentioned, such as culture, the environment, education and health literacy.

Participants stressed that society, governments and health care providers all have an obligation to address such problems as poverty, inadequate housing and nutrition.

Because the health of indigenous peoples in Canada was seen as being particularly influenced by the social determinants of health, the CMA held a town hall meeting to address the challenges facing Aboriginal people and communities.

Several themes from the town hall meetings were summarized by CMA President Dr. Anna Reid:

- Poverty is the most important issue and must be addressed.
- Poverty can cause multiple morbidities and even influence early childhood neurologic development.
- Mental health issues remain “the elephant in the room” and underlie many of the social determinants of health.
- Governments need to be pressured to take action, but there is a clear role for citizens, physicians and communities to help deal with the problems.
- The capacity of non-profit organizations to help is reaching the breaking point.
- There is a link between a healthy society and a healthy economy.

- Social initiatives need specific funding and should be viewed as investments.
- There is a need to look at why society is willing to accept disparities.
- Social inequities are a major cause of stress and insecurity.
- The medical profession has the authority and voice to take leadership on these issues.
- Canadian society has suffered from a lack of imagination, will and leadership to address social inequities.
- The guaranteed annual income is a compelling concept and can have a positive impact on health outcomes.
- Structural racism keeps Aboriginal people in poverty; this must be addressed to improve health outcomes for these communities.
- The cost of doing nothing is very large, so reallocation of existing spending is important.

Based on the input received, clear areas of action have emerged :

Recommendation 1: That the federal, provincial and territorial governments give top priority to developing an action plan to eliminate poverty in Canada.

Recommendation 2: That the guaranteed annual income approach to alleviating poverty be evaluated and tested through a major pilot project funded by the federal government.

Recommendation 3: That the federal, provincial and territorial governments develop strategies to ensure access to affordable housing for low- and middle-income Canadians.

Recommendation 4: That the “Housing First” approach developed by the Mental Health Commission of Canada to provide housing for people with chronic conditions causing homelessness should be continued and expanded to all Canadian jurisdictions.

Recommendation 5: That a national food security program be established to ensure equitable access to safe and nutritious food for all Canadians regardless of neighbourhood or income.

Recommendation 6: That investments in early childhood development including education programs and parental supports be a priority for all levels of government.

Recommendation 7: That governments, in consultation with the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial–territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

Recommendation 8: That the federal government recognize the importance of the social and economic determinants of health to the health of Canadians and the demands on the health care system.

Recommendation 9: That the federal government require a health impact assessment as part of Cabinet decision-making process.

Recommendation 10: That local databases of community services and programs (health and social) be developed and provided to health care professionals, and where possible, targeted guides be developed for the health care sector.

Recommendation 11: That the federal government put in place a comprehensive strategy and associated investments for improving the health of Aboriginal people that involves a partnership among governments, non-governmental organizations, universities and Aboriginal communities.

Recommendation 12: That educational initiatives in cross-cultural awareness of Aboriginal health issues be developed for the Canadian population, particularly for health care providers.



INTRODUCTION

For the past seven years, Canada's doctors have been advocating for health care transformation to focus on the needs of patients. Two years ago, in an effort to drive change, the Canadian Medical Association (CMA) launched the National Dialogue on Health Care Transformation. Online and in a series of town hall meetings across Canada, the association asked Canadians what they thought of the present health care system and how it should look in the future.

One of the main messages the CMA heard was that the health care system is only one predictor of good health and that other factors such as housing, education and employment have an equally if not more important role in determining health outcomes. The next phase of the National Dialogue explored why Canadians get sick in the first place and focused on external factors, referred to as the social determinants of health. In partnership with *Maclean's*, *L'actualité* and the Cable Public Affairs Channel (CPAC), the CMA held five town hall meetings to look at those social determinants of health. A sixth town hall meeting was held in St. John's at the request of local community and physician groups. Feedback was also obtained from people posting comments at www.healthcaretransformation.ca.

CMA President Dr. Anna Reid noted the importance of the social determinants of health in her introduction to the latest round of town hall meetings:

“If a patient comes to a doctor with asthma, we can prescribe medication. But if that patient goes back to a home where there's mould inside the walls and the air is unhealthy, all the medication in the world won't make that person better. If a patient has diabetes, we can prescribe medication, and the physician or another health care provider can explain to that person the importance of a healthy diet. But if that patient can't afford fresh fruits or vegetables, or if there isn't a proper supermarket in the community where these foods can even be found, that diabetes is going to be much more of a challenge.”

Data were provided showing why addressing inequities caused by the social determinants of health makes economic sense as well as being a compassionate approach. Estimates show that 20% of the \$200 billion spent on health care annually can be attributed to socio-economic disparities¹ and that 50% of health outcomes can be attributed to the social determinants of health.²

Addressing why the CMA and physicians are interested in these social factors, Dr. Reid noted that physicians see

the results of health inequities every day in their clinics and emergency departments. As Dr. Reid said, “many Canadians underestimate how much poverty is among us and how many of the people in our communities lead very challenging, difficult lives.”

The discussion at the forums and online was framed around four questions:

1. Many factors influence the health of individuals and communities, such as income, early childhood development, housing and access to healthy food. How do these factors — known as social determinants — affect your health or the health of your community?
2. What initiatives or practices have you seen that offset the effects on health of these various determinants?
3. What should governments, health care providers and others do to help address the social determinants of health?
4. How can we ensure that the health care system is equally accessible to all Canadians, regardless of their income, background or other circumstances?

The response to this latest round of town hall meetings and the questions posed was enthusiastic: hundreds attended the meetings or posted comments online. Physician participants at the meetings made it clear that they felt the medical profession had an ethical duty to their patients to work toward a society in which everyone has the opportunity to lead a healthy life. Through the use of Twitter, the CMA was also able to inform a wider audience about the town hall discussions as well as promote broader discussion using the Twitter hash tag #sdoh. The CMA was applauded for addressing these complex but important issues. At all the meetings, speakers confirmed the impact socio-economic factors have on health outcomes and life expectancy. They also provided tangible examples of innovative local or province-wide initiatives aimed at addressing inequities. From the discussions, four factors were seen as having the most substantial impact on health in Canada at this time:

- income
- housing
- nutrition
- early childhood development.

Other topic areas mentioned were the environment, specifically air and water quality; the need to create healthy communities; the impact of addictions; the need for a national pharmaceutical plan; and the impact of systemic racism on the health of Aboriginal peoples. The impact of race or culture was

also seen as important factor in determining health outcomes in Canada especially for immigrants. Many speakers talked about the need for reform to the health care system, specifically for a better primary care system, more coordinated care and improved access to health care services for vulnerable individuals.

Throughout the consultation process, it was confirmed that Canada should be a compassionate society in which everyone has a right to decent living conditions and has equal access to the health care system. Although it was generally acknowledged that Canada should be doing more to address issues such as poverty and inadequate housing, audience members struggled with the challenge of how to do this while maintaining a properly funded health care system in a time of austerity. Many commented that while volunteer organizations were doing much to meet unmet needs, governments should be doing more, and charitable groups should not be expected to provide all needed services.

“Housing, food, income, education, early years’ education: all have more impact on our health than biology and our environment. We know that many of these health issues are largely out of the control of the individual and we also know we can fix them with policy. We know that the cost of inaction is far more expensive than acting ... it’s too expensive not to invest up front.”

— Panelist, Hamilton

The following is a summary of some of the feedback from the consultations as well as recommendations for further action.

INCOME: WEALTH = HEALTH

There is overwhelming evidence of the impact of wealth on health. Many studies show that people low on the socio-economic scale are likely to carry a higher burden of just about any disease.³ Data from a public survey conducted by the CMA in 2012 confirmed these findings: When asked to rate their health, 70% of Canadians earning more than \$60,000 a year described it as excellent or very good. But of those earning \$30,000 a year or less, only 40% said they were in good or excellent health.



The need to address poverty was agreed to be a fundamental concern at all the town hall meetings. Panelists and participants emphasized that poverty underpinned most other social determinants of health such as adequate housing, nutritious food and proper early childhood development. The direct link between income and good health outcomes across a wide range of countries and the subsequent benefits to the national economy from investing in the health of individuals was noted by many.

The gap between rich and poor received most discussion at the Hamilton meeting as a result of earlier work done by the Hamilton Spectator and McMaster University. The collaboration, known as Code Red, looked at the difference in health outcomes based on where people lived in the city and their social factors such as income and education. In her introduction, Dr. Reid referenced Code Red and the “staggering disparities” it found. For instance, the life expectancy ranged from 86.3 years — 5 years longer than the Canadian average — in a rich neighbourhood to just 65.5 years in a poor neighbourhood, a gap of 21 years.

“If that second neighbourhood were a country, it would rank 165th in the world for life expectancy, alongside Nepal and below Mongolia and Turkmenistan,” Dr. Reid said, adding, “Right here in Hamilton we actually have Third World life expectancy.” Study author and Hamilton Spectator reporter was acknowledged “for putting the spotlight on a reality that stands in such stark contradiction to Canadians’ expectations of our society.” A Hamilton panel member said it was “disgusting” that some people in Hamilton have a Third World life expectancy and that the implications on human capital and dignity are “too horrible to accept.”

Similar variations in health outcomes for those living in richer and poorer neighbourhoods were referenced at the town hall meetings in Calgary, Winnipeg and Montréal.

FACTS ABOUT INCOME

- 1 in 7 Canadian children live in poverty. This rate places us 15 out of 17 among similar developed countries.⁴
- Poverty in childhood can be a greater predictor of cardiovascular disease and diabetes in adults than later life circumstances and behaviour.⁵
- More than 11% of working age Canadians live in poverty. Only Japan and the United States are worse.⁶
- On the basis of a 2010 review, roughly 400,000 full-time workers aged over 25 were making less than \$10/hr — less than poverty-line wages.⁷
- The annual welfare income in Canada varies between \$3247 for a single person to \$21,213 for a couple with two children. The “best” programs provide an income at 80% of the poverty line. The lowest is barely 30% of that needed to “achieve” poverty.⁸

The moderator noted in the introduction to the Charlottetown meeting that “every community in Canada has pockets of poverty, need and want and these are the things that can kill us before our time.” At the St. John’s meeting, more than one speaker noted that although Newfoundland and Labrador has become more affluent in recent years, the income has not been equally distributed, causing a growing gap between rich and poor residents.

“Any human being can understand that a sick person cannot work, will have to purchase costly medications and, inevitably, will be poor.”

— *Comment from online consultation*

An audience member at the Hamilton meeting cautioned that poor health outcomes linked to income are not limited to poorer downtown areas, and she referenced “the hidden poverty” that is often neglected. “You have to encompass all instead of encompassing just some,” she said, adding that it

was unjust that some people in society are not valued because they do not have a good job or live in a nice house. “If you’re not making money, then you’re really not worth anything” is a societal viewpoint that can have a huge impact on some people’s health, she said.

At the Charlottetown meeting, a panel member, said that dealing with relative poverty — those who are poor in Canada’s affluent society — will have the greatest impact on health and premature death in Canada today.

At the same meeting, another panelist said the reality of the situation is that if you don’t have enough money to eat, you’re going to get sick. He said that before the Poverty Reduction Program in New Brunswick was implemented in 2010, a single person on social assistance initially received \$294/mo when the cheapest rooming house in Saint John charged \$375 a month. Although the basic assistance rate has risen to \$537/mo under the Poverty Reduction Program, it has not changed since 2008. People receiving assistance have to spend all their time thinking about where they are going to stay and what they are going to eat.

“When a person is constantly fighting just to eat and have shelter, never mind addressing illness. Canada will not gain back the potential tax dollars such citizens may contribute.”

— *Comment from online consultation*

At the Winnipeg town hall one of the panelists noted that Aboriginal children in Canada born onto reserves are born into poverty. He added that although Aboriginal parents have the same expectations as other Canadians for their children, the children “start way behind” because of their environment. “Poverty really is systemic violence,” he said. This panelist and others at the meeting linked the poverty among Aboriginal peoples in Canada to racism.

There was a great deal of discussion at the meetings about strategies to reduce poverty in Canada. The New Brunswick Economic and Social Inclusion Corporation established in that province as the result of a broad-based consultative process was singled out as a positive initiative for addressing poverty at the provincial level. The corporation developed a complex plan to overcome poverty scaled both to the community-level and at a higher level with work under way to reform social assistance and the service delivery model.



Much of the discussion at the Calgary town hall focused on the potential for more equitable incomes and therefore better health outcomes for Canadians. One of the panelists discussed her research into the guaranteed income program in Dauphin, Manitoba in the 1970s. Through Mincome (also known as the Guaranteed Minimum Income Experiment), eligible individuals would receive a guaranteed basic income through a refundable tax credit program. Using provincial Medicare data to assess the use of health care resources by people involved in the program, it was found that during the Mincome period, hospitalization rates fell, the number of physician visits dropped because of a substantial reduction in mental health complaints, and the number of accidents and injuries decreased dramatically. Single young men receiving the subsidies did reduce the number of hours they worked, but this was because they were staying in high school longer; high school completion rates increased substantially. Married women who were part of the program also worked fewer hours and were using the guaranteed income to support more parental leave when maternal leave was only about 4–6 weeks.

“People are trying to patch up the system, but we really do need the government to provide a security safety net.”

— Panelist, Charlottetown town hall

That panelist suggested that if the guaranteed income program was replicated now, similar positive results would

be seen, despite the existence of social assistance programs. This view was echoed by the participants at other town hall meetings where this approach was discussed.

Based on the input received, clear areas of action have emerged:

Recommendation 1: That the federal, provincial and territorial governments give top priority to developing an action plan to eliminate poverty in Canada.

Recommendation 2: That the guaranteed annual income approach to alleviating poverty be evaluated and tested through a major pilot project funded by the federal government.

HOUSING

After adequate income, the need for proper housing was mentioned most frequently as being a fundamental necessity for ensuring health. The multiple effects on health of being homeless or being forced to live in unsafe or unsanitary conditions were stressed by many town hall participants and online.

At the Charlottetown town hall a panelist highlighted that for those without adequate housing or the homeless, “health care is their housing.” She said it can be difficult for many Canadians to comprehend what it is like to deal with the discrimination associated with not having secure housing.

At the Montréal forum, one of the panelists noted that her organization has an inventory of 30,000 social housing units with another 22,000 households on waiting lists. She said that the issue of the lack of affordable housing leading to homelessness is going to get worse: “The increase in housing costs and the inability to pay as well as discrimination because of racism, disability or a very large family, for example, makes accessing housing problematic.”

At the same meeting another panelist noted that, according to some data, more than 75% of Montréal’s substandard housing is occupied by immigrants. Many of these immigrant families “accept the unacceptable” by living in housing where the mould causes asthma problems in children.

Record low vacancy rates for rental housing in Canada are blamed for allowing landlords to discriminate about to whom they rent, which means that people receiving government assistance or with disability, students or those with children have difficulty finding housing. It also means that people are being forced to live in rooming houses or substandard housing with mould or mildew or otherwise unsafe environments.

FACTS ABOUT HOUSING

- 30,000 people are homeless on any given night in Canada.⁹
- Premature death is 8 to 10 times higher among the homeless.¹⁰
- As many as 50,000 people are considered “hidden homeless,” living with family or friends with no prospect of permanent housing.⁹
- It is estimated that there are roughly 380,600 Canadian households living in poverty and spending more than 50% of their income on rental housing.⁹

At the St. John’s meeting a panelist said that in Newfoundland and Labrador, adequate housing is out of reach for “too many.” He asked the audience to imagine what it would have been like for the 10,000 people in St. John’s left homeless by the fire of 1892 and compared this with the “more persistent smouldering fire” of homelessness today. Others noted that the prosperity that has come to Newfoundland and Labrador has exacerbated the housing problem by raising house prices and depleting the stock of available affordable housing units.

In some Aboriginal communities, the correlation between inadequate housing and unsanitary living conditions caused by a lack of drinkable water was also raised.

The stress and subsequent mental health issues arising from being forced to live in inadequate housing in unsafe neighbourhoods was noted. An audience member at the St. John’s meeting who works in one of the only residential drug treatment programs in the city said it was important to distinguish between putting people in a rooming house and putting them in housing where they will be safe from other drug users and where there are support networks in place.

Support for the federal government’s “Housing First” strategy to provide “no-strings attached” housing for those who are homeless or have chronic mental health issues was widely applauded. One of the panelists told the Calgary meeting audience that he wants to give the federal government credit for establishing this approach as part of the national mental health strategy and for extending it for another five years in the last federal budget. He said that it shows that the federal government is willing to make a decision based on evidence — specifically, results showing the

benefits of providing affordable housing results in reduced use of primary health care services. The federal government was also applauded for the policy by one of the panelists during the St. John’s meeting. He said that bureaucrats need to move beyond thinking that housing is just an issue for the housing department and need to think about what their department can do to help support developing good practices. “Housing is where it’s at for me because you can piggyback so many other things with it,” he said, such as job training programs and seniors’ assistance programs.

A specific example referenced was The John Howard Society in Fredericton, which has built new offices with 12 one-bedroom apartments on two floors for those who have chronic problems with homelessness. The process for choosing people for these apartments is to select not low-risk people but those with many challenges. To research the impact of providing such housing, those selected were interviewed; time spent in jail, interactions with police and visits to the emergency department were documented. During the first year of residence in the apartments, these interactions were tracked closely to estimate associated costs. In that year, there was a net savings of \$210,000 from the 12 residents as a result of fewer interactions with police and a reduced number of visits to the emergency department.

A St. John’s panelist said that if the federal government is not going to adopt a national housing policy (a private members’ bill to introduce such a policy was recently rejected), government should recommit the funds that are expiring to support 600,000 social housing units in the country.

Based on the input received, clear areas of action have emerged:

Recommendation 3: That the federal, provincial and territorial governments develop strategies to ensure access to affordable housing for low-and middle-income Canadians.





Recommendation 4: That the “Housing First” approach developed by the Mental Health Commission of Canada to provide housing for people with chronic conditions causing homelessness should be continued and expanded to all Canadian jurisdictions.

NUTRITION AND FOOD SECURITY

From getting enough nutritious food to eat to the excess amount of salt and sugar in processed foods, concern about nutrition and food security was another common aspect of the consultations. This was especially true at the St. John’s town hall where audience members were keenly aware of the challenges of maintaining a healthy diet when nutritious food can be expensive and hard to find. Participants were told that eating nutritious food is a cultural issue as well as one of affordability. In many rural communities in Newfoundland, food tends to be more traditional but not necessarily healthy. Diets often involve lots of salt fish and deep-fried battered bread, “and vegetables [are] treated as a foreign object” because they are not easily available. “The whole attitude towards food needs to change and that’s where the government focus needs to be,” the audience was told.

Others at the meeting commented on how fast food and processed foods are often less expensive in rural communities and in the North. Even in St. John’s, it was noted that because milk is far more expensive than soft drinks, mothers often cannot afford milk and buy cheaper and less nutritious alternatives. An audience member who works with the

urban Aboriginal population in St. John’s said that living in an urban centre doesn’t automatically mean having access to healthy food. People from rural communities are sometimes too intimidated to go into large grocery stores because they may not recognize some of the foods. In addition, they may not be able to cook some of the food recommended by their health care provider, she said.

A few years ago, I had the opportunity to address a Cree community up north, here in Quebec. They were suffering with obesity and poor health simply because of ignorance. They made poor food choices, buying processed foods and baked goods instead of eating the wildlife available in their own back yard — moose, walleye, mushrooms, etc.

— *Online consultation comment*

One of the St. John’s panelists said the tradition of gardening and self-sufficiency among those living in rural Newfoundland has been lost. She then related the story of a disabled chef in her community who had offered cooking classes in the community centre. She said the successful initiative demonstrated the importance of engaging the community in problem solving of initiatives and discussions of how they want to improve their health.

FACTS ABOUT NUTRITION AND FOOD SECURITY

- It is estimated that about 1.1 million households in Canada experience food insecurity.¹⁰
- In March 2012, 882,188 Canadians relied on food banks to provide their basic dietary requirements.¹¹
- Heart disease, diabetes, high blood pressure, stress and food allergies are more common among families unable to ensure a stable food supply.¹⁰
- Studies of the use of physician prescriptions for exercise or healthy food found that people in many low-income communities could not access the food or exercise necessary to fill the prescription.¹²

Other audience members noted how the fast food industry is marketing its products heavily and changing people's eating habits, resulting in higher rates of obesity, heart disease and diabetes. "We're basically killing ourselves with food," he said. "It's that serious."

Organizations — many of them faith-based charities — that are working to provide proper meals for residents in their communities were identified as being focal points for both healthy eating and other initiatives to address the broader social determinants of health. In St. John's, the Gathering Place, run by the Sisters of Mercy of Newfoundland, was singled out as an exemplary program that serves meals to 160 people daily. Many who use the Gathering Place are forced to put most of their income toward housing. By offering the meals, the audience member said, the community has shown it can respond to people in need.

Our local Seniors' Centre is terrific. There are many free programs to exercise your mind or your body. There is a subsidized hot lunch. But most of all it gets seniors out of their home and interacting with people. And they have immunization clinics; an outstanding idea. I hope they have programs like this in all communities in Canada; not just in large municipalities like mine.

— *Comment from online consultation*

Another example mentioned was a food bank in Fredericton that bought a bankrupt gardening centre and is using it to create a community garden as well as programs that teach about food budgets and cooking. Those using the food bank are given a wide range of foods from which to choose rather than being given prepackaged food.

A call for a similar initiative was made by an audience member in Winnipeg, who said that many people receiving social assistance do not have a proper understanding of nutrition and often throw away the vegetables they receive from the food banks. He proposed that people receive training in cooking and proper nutrition at the food banks. He further proposed using vacant land in Winnipeg to start community gardens that could be used by Aboriginal community members.

However, a nutritionist at the Charlottetown meeting said, "We would be remiss and unethical" not to require federal and provincial governments to institute policies that will eliminate the need for food banks locally. She said that although the Harper government says it is spending \$4 million on healthy eating initiatives, this only works if people have the knowledge and skills to take advantage of them. Just contributing to a food bank does not address the root problem, she said.

A Calgary panelist said the federal government does have a leadership role with setting regulations for processed foods. The comment came after an audience member criticized the federal government for backing away on measures to control the salt content in processed foods.

Based on the input received, a clear area of action has emerged:

Recommendation 5: That a national food security program be established to ensure equitable access to safe and nutritious food for all Canadians regardless of neighbourhood or income.

EARLY CHILDHOOD DEVELOPMENT

Strong views on the importance of proper early childhood development were expressed by many advocates and audience members at the town hall meetings. "The brain cannot wait for funding," was how one participant stated the issue at the Hamilton meeting.

A Montreal panelist talked about "toxic stressors" caused by a poor environment, poverty and lack of social support that can impair early childhood development. Under extreme

conditions, he said, these stressors can lead to the volume of the brain of a three-year-old child being reduced by one-third to one-half.

A St. John's panelist talked about the importance of meeting the basic needs of newborns and of having at least one adult who cares for them consistently. As babies develop, she said, they need families and a community that nurtures their development. When children start going to school, she said, "we would hope that intellectually, physically, socially and emotionally they're developed to their optimal level," because if they enter school in a deficit situation there is a decreased chance they will graduate from high school.

"The brain cannot wait for funding."

— Participant, Hamilton town hall

The same panelist also spoke of the importance of "professionalizing early childhood education," because parents are not satisfied with having people who provide child care serve as just babysitters. She said she works with trained daycare workers; people should look at daycare as a place where children will enhance their development.

One of the Winnipeg panelists quoted a 2007 study by the Standing Committee on Human Rights that found that Aboriginal children in Winnipeg were disproportionately living in poverty, malnourished, suicidal, disabled, suffering from drug and alcohol abuse, or involved with the child welfare system. The panelist said that, although 9000 Aboriginal babies were born in the inner city of Winnipeg in 2012, there are only 200 slots for children aged three to four years in programs in those neighborhoods to help them. The panelist stressed that the parents of these children know what is required to raise their children properly and they know the types of programs needed to support proper child development — but spaces in these programs are in short supply. "They don't need to have government coming in and telling them what to do," she said. The panelist talked of the need for focused programs to deal specifically with the issues faced by Aboriginal children.

A similar point was made by a panelist at the Montréal town hall meeting. He noted that in Quebec, substantial responsibility for caring for children was transferred to the government about a decade ago, which resulted in communi-



FACTS ABOUT EARLY CHILDHOOD DEVELOPMENT

- Effective early childhood development offers the best opportunity to reduce the social gradient and improve the social determinants of health.¹³
- Children from disadvantaged backgrounds are often behind their more affluent peers in terms of readiness for school, a key factor for school achievement and later life success.¹⁴
- Fully 30% of kindergarten-aged children in Saskatoon are vulnerable in at least one development area.¹⁵
- Only 17% of Canadians have access to regulated child care.¹⁰
- Canada ranks last among 25 developed countries in meeting early childhood development objectives.¹⁰

ties disengaging. He said that communities need to reclaim responsibility for early childhood development.

A panelist in St. John's mentioned an initiative in her program that addresses both developmental and nutritional issues. The program has a community garden where staff and parents dig with the children, and the staff teach about growing plants. She said the children plant the seeds and water the plants. In addition, parents are encouraged to help work on individual garden plots and choose what vegetables they want to grow. "It's so fabulous to give a child that opportunity," she said.

Based on the input received, a clear area of action has emerged:

Recommendation 6: That investments in early childhood development including education programs and parental supports be a priority for all levels of government.

OTHER SOCIAL DETERMINANTS DISCUSSED IN THE CONSULTATIONS

In addition to the social determinants referenced earlier, a number of other issues were raised that can undermine the health of Canadians.

- **Education and health literacy:** The need for a proper education and the barriers caused by having an inadequate education were seen as a natural compounding problem for those facing the triad of poverty, inadequate housing and poor early childhood development. The correlation between low education levels and poor health was noted. Being unable to understand information about their health care was seen as a major problem for vulnerable populations. Ironically, libraries were identified as a safe haven for many homeless and those with inadequate housing.
- **Healthy environments:** The importance of having safe and healthy communities was raised in a number of contexts throughout the consultations. Poor environmental conditions, especially those occurring as a result of pollution were identified as having a negative impact on health and health outcomes. In addition to the health impact of poor air itself, pollution was also seen as a major stressor

for those trying to live healthy lives. Participants identified the need for a healthy built environment as well. Suggestions ranged from providing sidewalks clear of snow so seniors can safely walk to the grocery store, to having roads with sidewalks so people can stay healthy by walking safely.

- **Domestic violence:** Violence against women and children was mentioned as being intimately associated with conditions of low income and unsafe housing. More awareness and early intervention were stressed.
- **Health care system:** Although asked to address issues other than the health care system that impact health, many people could not avoid referencing problems with the current system that act as barriers to accessing needed care. Perhaps at the top of the list was the challenge many face in finding a primary care physician to deal with their medical concerns. Other problems with access included affordability of pharmaceuticals and availability of services in some communities. Suggested solutions ranged from primary care reform to more coordination of health care services. Physicians were also called on to do more in the way of health promotion and disease prevention.

In addition to the challenges that were identified, participants pointed to some possible solutions for addressing the social determinants of health in Canada.

- **Pharmacare:** Perhaps the most often-cited solution to help address inequities in the health care system was a



national pharmaceutical plan to cover the cost of drugs for those who cannot afford them. It was pointed out repeatedly that it is the most vulnerable Canadians who lack a plan to pay for drugs; even when deductibles are minimal, those without an adequate income often cannot afford to pay them.

- **Federal role:** The important role that the federal government needs to take in either directly funding or coordinating programs to address the social determinants of health was mentioned at every town hall meeting. The perceived abandonment of responsibility for health care by the current government was seen as a serious blow to ensuring accountability of how health care is delivered. It was also advocated that a health lens be applied to all new federal policies and programs to assess the potential impact on the health of the population.
- **Physician role:** Physicians were urged to be more aware of the problems their more vulnerable patients may have in dealing with issues as basic as eating properly or having access to transportation to attend ancillary services. Physicians involved in the consultation process acknowledged that they have a moral and ethical responsibility to help address health inequities. “Advocacy is at the core of what every physician has to do,” one physician commented. Another quoted, “The physician is the natural attorney of the poor.”

Based on the input received, clear areas of action have emerged:

Recommendation 7: That governments, in consultation with the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial–territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

Recommendation 8: That the federal government recognize the importance of the social and economic determinants of health to the health of Canadians and the demands on the health care system.

Recommendation 9: That the federal government require a health impact assessment as part of Cabinet decision-making process.

Recommendation 10: That local databases of community

services and programs (health and social) be developed and provided to health care professionals, and where possible, targeted guides be developed for the health care sector.

“We need to change our mindset that we save money by restricting access to care.”

— *Panelist, Hamilton*

ABORIGINAL HEALTH

Because of the disproportionate impact of social determinants of health on the lives of Aboriginal peoples and communities in Canada, the CMA chose to focus its first town hall meeting in Winnipeg specifically on issues of Aboriginal health.

As Dr. Reid noted in her introduction:

“I work in the emergency room in Yellowknife and every day I see desperate patients in desperate circumstances and the majority of patients I see are Aboriginal people. They lack housing, they lack adequate nutrition, they lack adequate education and they certainly lack adequate incomes. These are factors that have a devastating impact on their health.”

“Our children are standing underneath the ladder to success. We need to look at closing the gap, and that means sharing the wealth.”

— *Panelist, Winnipeg*

Dr. Reid went on to state that Aboriginal people have a higher mortality rate and lower life expectancy than the Canadian average, and she listed a number of areas such as suicide where Aboriginal people suffer much higher rates of illness and disease. She said that the disparities reflect the systemic, societal and individual factors that influence Aboriginal health. Overcrowded housing, poor access to health care and lack of nutritious food contribute to what she called “this national disgrace.” “I believe that Canada can do better and must do better,” Dr. Reid said.

Panelists at the Winnipeg meeting spoke at length about what they termed the institutionalized or structured racism

facing Aboriginal communities and people. One panelist said that the poverty facing many as a result of this racism often overshadows individual efforts to improve health.

Another panelist attributed many of the health deficits in Aboriginal communities to the loss of traditional culture. “We perpetuate stereotypes about indigenous people. We say that an individual indigenous person chooses not to stop smoking; that an indigenous person chooses not to exercise. But when you look at the emergence of smoking, obesity and chronic diseases in our community, it’s intimately linked to the destruction of our way of life.”

Although highlighted as the Winnipeg meeting, the challenges facing Aboriginal people were also raised at the other town hall meetings especially with respect to those living in urban areas. The comments and findings were echoed in a follow-up trip taken by Dr. Reid to northern Quebec.

Panelists and audience members at the Winnipeg meeting stated that there must be an acknowledgement of the racism continuing to face indigenous peoples in Canada before significant improvements can be made in health outcomes.

Directly involving directly indigenous people in programs to improve their health was identified as being fundamentally important as was the value of programs that specifically target Aboriginal people.

Based on the input received, clear areas of action have emerged:

Recommendation 11: That the federal government put in place a comprehensive strategy and associated investments for improving the health of Aboriginal people that involves a partnership among governments, non-governmental organizations, universities and Aboriginal communities.

Recommendation 12: That educational initiatives in cross-cultural awareness of Aboriginal health issues be developed for the Canadian population, particularly for health care providers.

REFERENCES

1. Public Health Agency of Canada. *Reducing health disparities — roles of the health sector: discussion paper*. Ottawa (ON): 2004. Available: <http://publications.gc.ca/collections/Collection/HP5-4-2005E.pdf> (accessed 2011 Feb. 16).
2. Keon WJ, Pépin L. *Population health policy: issues and options*. Ottawa (ON): Senate of Canada; 2008. Available: www.parl.gc.ca/Content/SEN/Committee/392/soci/rep/rep10apr08-e.pdf (accessed 2011 Jan. 14).
3. Dunn JR. *The health determinants partnership making connections project: Are widening income inequalities making Canada less healthy?* Toronto (ON): The Health Determinants Partnership; 2002. Available: www.ophn.ca/Resources/docs/incomeinequalities/incomeinequalities.pdf (accessed 2011 Apr. 22)
4. *How Canada performs: child poverty*. Ottawa (ON): The Conference Board of Canada; 2013. Available: www.conferenceboard.ca/hcp/details/society/child-poverty.aspx (accessed 2013 Feb. 8).
5. Raphael D. Addressing the social determinants of health in Canada: bridging the gap between research findings and public policy. *Policy Options* 2003; 35-40.
6. *How Canada performs: working-age poverty*. Ottawa (ON): The Conference Board of Canada; 2013. Available: <http://www.conferenceboard.ca/hcp/details/society/working-age-poverty.aspx> (accessed 2013 Feb. 8).
7. Campaign 2000. *2010 report card on child and family poverty in Canada: 1989–2010*. Toronto (ON); 2010. Available: <http://www.campaign2000.ca/reportCards/national/2010EnglishC2000NationalReportCard.pdf> (accessed 2013 Apr. 11).
8. National Council of Welfare. *Solving poverty: four cornerstones of a workable national strategy for Canada v. 126*. Ottawa (ON); 2007.
9. Gaetz S, Donaldson J, Richter T, et al. *The State of Homelessness in Canada 2013*. Toronto (ON): Canadian Homelessness Research Network Press; 2013. Available: <http://www.homelesshub.ca/ResourceFiles/SOHC2103.pdf> (accessed 2013 Jun. 26).
10. Mikkonen J, Raphael D. *Social determinants of health: the Canadian facts*. Toronto (ON): York University School of Health Policy and Management; 2010. Available: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf (accessed 2011 Jan. 14).
11. Food Banks Canada. *Hungercount 2012: a comprehensive report on hunger and food bank use in Canada, and recommendations for change*. Toronto (ON); 2012. Available: <http://www.foodbankscanada.ca/getmedia/3b946e67-fbe2-490e-90dc-4a313dfb97e5/HungerCount2012.pdf.aspx> (accessed 2013 Jul. 5).
12. Bell J, Rubin V. *Why place matters: building a movement for healthy communities*. Oakland (CA): Policy Link & the California Endowment; 2007. Available: http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/WHYPLACEMATTERS_FINAL.PDF (accessed 2011 Mar. 18).

13. Commission on the Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report/executive summary*. Geneva (CH): World Health Organization; 2008. Available: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf (accessed 2011 Jan. 7).
14. Ferguson HB, Bovaird S, Mueller M. The impact of poverty on educational outcomes for children. *Paediatr Child Health* 2007; 12: 701-6.
15. Neudorf C, Muhajarine N, Marko J, et al. *Healthy children, healthy families, healthy communities: a report of the chief medical health officer on the health status and development of young children in Saskatoon Health Region*. Saskatoon (SK): Public Health Observatory, Population and Public Health, Saskatoon Health Region, in collaboration with the Saskatchewan Population Health and Evaluation Research Unit; 2012. Available: http://www.saskatoonhealthregion.ca/your_health/PHO/SHR_Healthy_Families_2012.pdf (accessed 2013 June 19).