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votre spécialiste en promotion de la santé*

*Engaging citizens and civil society
in creating population health and
health equity*

Presentation to
Subcommittee on Population
Health Senate Committee on Social
Affairs, Science and Technology

*by Connie Clement,
Executive Director
Health Nexus / Nexus Santé*

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I will focus my comments today on community engagement to understand and change societal conditions that contribute to poor health and health inequity, and to the role that civil society can play alongside governments. Health Nexus (Nexus Santé in French) is a bilingual organization founded under the name the Ontario Prevention Clearinghouse. Within our mission to build capacity to promote health and foster effective strategies to improve population and individual health in Ontario and beyond, one of our functions is to help health and community workers and volunteers utilize effective community engagement practices. Our current areas of focus are health equity, early child development and chronic disease prevention.

I've shaped my comments around challenges, and start first with two challenges that are over-arching.

Challenge 1: Finding Common Language

My experience is that individuals from many sectors care a lot about improving the societal conditions that diminish quality of life, give children a poor start and constrain life opportunity. These conditions are, in my language and the language of this committee, 'determinants of health.' However, many of Health Nexus's partners don't approach life or their work in terms of health.

To our society's detriment, the term 'health' has been hijacked by disease treatment. Say 'health' to many Canadians and they subconsciously translate it to equate with 'health care.' To Canadians not steeped in public health and epidemiology, disease is an individual occurrence. This view is compounded by Canadians' exposure to American views that health is personal, results from individual behaviour and luck, and is best treated through a one-to-one (lay person-to-professional) market-based relationship. With these views widely held, it is hard to build concepts of what population and societal-level *health* might look like and to engage people in discussions about how to achieve such health.

To re-claim and transform 'health' into World Health Organizations meaning is an uphill communications battle. The alternative term 'well-being' although capturing accurately our aspiration for society and its members, is soft and amorphous, although the Atkinson Society's current focus to create a comprehensive Canadian Index for Well-Being may turn that term around. My suggestion is that the words

'social' will be best understood by Canadians as capturing the social determinants of health. Thus, our change task is to bridge, link and associate health and social. At this meeting, we're all old enough to remember when health and social services ministries and committees were norm. Dividing them worked for disease treatment. It did not work for focusing public attention on determinants and inequities. We need to re-couple health and social.

Challenge 2: Moving Upstream

Every major health report in Canada has called for greater investment in prevention, health promotion, public health. Yet we don't do it. My understanding is that the percentage of health investment that goes to public health today is estimated to be slightly less than in the 1970s when *New Perspectives on the Health of Canadians* hit the Canadian stage. How can this be when we know better and all experts call for a change? The gap between knowledge and practice in this regard is vast.

Until governments are brave enough to change financial allocations based on understanding the social -- and probably financial -- benefits of moving upstream we don't have a chance of reducing health inequities. In your *Issues and Options* paper you ask if Cuba's polyclinics offer a model? Yes, and Canada already has a small number of clinics that are reflective of Cuba's clinics – our best community health centres and centres local de services communautaires come to mind. Ontario's new family health teams are aiming to become multi-disciplinary primary care centres. Yet only a tiny percentage of primary care is delivered this way. This investment must continue and be expanded.

But even this, as you know, is not enough. Many Canadians hope for the range of preventive policies – with companion upstream investments -- that protect Canadian seniors from poverty to be applied across age groups. To reduce health inequities will require investment in early learning centres, housing (transition and permanent), education, community-neighbourhood services, and income restructuring. We must stop putting 5 cents on every dollar into research, prevention programs and surveillance and 95 cents on treating illness after it occurs. The four beautiful school-aged children who are my next door neighbours and who are watching the cancer of their mother (my dear friend) worsen would have been glad if we'd figured this out

earlier. And, I hope they won't experience disappointment and anger like mine when they're my age.

Challenge 3: Political willingness and will

You've already assessed this well in your reports, and I've already touched on it in my second challenge. In answer to some of the questions you posed in your *Issues and Options* paper ...

Make health, in its broadest sense, a commitment of the Prime Minister and Cabinet, not a single ministry. Thus, if you must, put Treasury or Finance at the lead, not Health. The United Kingdom is demonstrating significant progress with this approach. In the 1980s and 1990s, when the healthy communities movement was on the upswing in Canada and internationally, many towns in Canada institutionalized commitments to become healthier communities. In most jurisdictions, lead was assigned to the public health departments. In Toronto, which had striking achievements, it was assigned to the city commissioners as a group and a standing item on every agenda. Doing this demands that no ministry be allowed to back-burner reducing inequities.

Create a *new* F/P/T committee associated with Treasury or Finance with membership from more than one field. Don't pull together just the ministers of health; instead, have various provinces and territories send differing ministers. For instance, an Assistant Deputy Minister from Alberta's Ministry of Housing and Urban Affairs has contributed to the Conference Board of Canada's Roundtable on Social Determinants of Health. The Public Health Network, a permanent structure, and initiatives such as the Integrated Pan-Canadian Health Living Strategy (which unfortunately will change more frequently as governments turn over) must be critical contributors to leadership, but not *the* leader.

Ensure that the formal public health sector is charged with contributing to reducing health inequities and protected from political interference when they do so. When I worked inside Public Health, I wouldn't have dreamed of hiring or keeping staff who didn't believe in infection principles, yet public health units employ many professionally-trained staff who don't quite believe that determinants are as important as germs, genetics and gymnastics. Sudbury and District Health Unit has

lead an Ontario effort to propose standards and requirements such that addressing inequities would become an obligatory stand-of-care for public health.

A number of health authorities and public health departments are charging ahead without the professional and legal requirement, yet many public health departments shy away from addressing inequities. They do this, in part, because of historical and demonstrated interference by politicians who are wary of public health's integral advocacy roles. Public Health must be a champion in improving population health and creating greater health equity in Canada, and this won't happen consistently until Public Health Officers are expected to do this, and can do it in a safe environment.

Challenge 4: Generating cross-sectoral commitment

A robust F/P/T government and voluntary sector partnership requires clear expectations – with commensurate resources – and vertical and horizontal structures. Non-profit or voluntary sector organizations play numerous roles that contribute to population health. The so-called civil society raises awareness, generates innovation, engages communities and individuals from diverse backgrounds. In 2008, the Caledon Institute¹ identified key roles in addition to direct service provision: collect and interpret data; act as convener; and monitor progress. The 'convener' role relates most to identifying common interests, mutual gain and coordination, cooperation and collaboration, early steps to creating cross-sector commitment.

Unfortunately, in part because resources in the non-profit world are always scarce, competition – rather than consistent cooperation – is too often the norm. Non-profit organizations can be encouraged to better define common interests and develop joint actions by investment in common planning, analysis of policy that will achieve multiple ends, and collaborative measurement of impact. Policy influence to drive forward and also affect government priorities must be recognized as a central function of non-profits – including charitable organizations. And, in Canada, we need non-profit policy training and policy-related tool development.

¹ Torjman, Sherri, *Voluntary Sector Roles in Public Health*, Caledon Institute of Social Policy, April 2008 [ISBN 1-55382-273-0]

(See also my notes above in challenge 1 about terminology barriers, and below in challenge 6 about networks.)

In answer to some more of the questions you posed ... Focus on vulnerable populations *and* powerful determinants such as early child development and income support. Population health by definition and methodology anticipates and requires complex approaches that address the vulnerable, the whole population and influence 'modifiers' – those factors that can be socially modified and which have great impact, e.g. access and availability to determinants such as food, housing, income, education. Vulnerable populations must lead the way – helping the least healthy become healthier will have the greatest impact for all of society.

Push for separate, yet intricately linked and embedded, population health and anti-poverty strategies. This allows more entry points for differing sectors and builds the message that health and social are welded at the hips.

Challenge 5: Building public awareness

I brought with me today some samples of social marketing undertaken in Ontario to generate awareness on the part of the public about determinants of health. The campaigns, although lead by differing organizations and utilizing differing partnership models, involved ourselves (Health Nexus) and associations representing public health, community health centres and nurses. In keeping with most social marketing campaigns, all were evaluated by reach and recall not, unfortunately, by the extent to which they shifted understanding or thinking. You will, however, find these posters years after the campaigns in community offices.

Change in awareness can be made with reasonably small budgets, but some budget and some Federal, national-level and provincial/territorial investment is critical. Currently, investment is not backing verbal commitment. Some ideas I'd like to see fly are:

- small communications budgets for agencies to tell local success stories that link policy and service change with inequity with health;
- health status reports (which are becoming more and more common) that address inequity and health up front, forcefully and with metrics;

- common messages development across sectors using 'upstream', prevention and inequities language;
- use electronic alerts and pre-package info to make it easy for non-profit organizations to echo calls to action, media releases, etc. across sectors;
- integrate concepts of population health, community engagement, inequity and equity into school teaching. This can be done by providing more context to community service assignments, by reinstating civics classes and by embedding concepts throughout the curriculum. My daughter had the too rare experience of attending a grade 7-8 school in downtown Toronto where the entire curriculum was taught through a social justice lens. One of her teachers has produced a math book to help other teachers do this.
- Use social networking to work with young adults, linking population health, equity and social change across numerous sites and as part of numerous e-discussions.

All of these require some investment in. They won't happen without recognition of – and investment in -- the skills, knowledge and process supports that build capacity and coordinate initiatives.

Challenge 6: Creating and sustaining demand by community

To do this requires building local, community capacity and mobilizing communities. Monique Begin and others have in the last while called for a social movement to reduce inequities. Social movements gain momentum best, and apparently spontaneously, when personal gain is immediate and pronounced. When the goal is long-term, social benefit then clear investments are needed to help identify and communicate personal gain, and build a movement.

Your reports already mention the National Homelessness Initiative – which effectively utilized local councils and included investment in building local capacity – and Urban Development Agreements – where, my impression is, models varied yet investment and capacity building were also locally focused. Let me share a few more examples:

Ontario's tobacco initiatives are highly respected around the world. We invested in building local and provincial structures, assigned accountability and created clear goals. We used multiple strategies with inter-sectoral partners to educate, offer services (such as cessation) and influence policy. Policy focus was local (e.g.

municipal by-laws) as well as Federal (e.g. market regulation). Local action and coordinating committees were established, and youth engagement was required. None of this is cheap, yet it works. It's from the efforts to reduce tobacco use that the concept of an effective 'dose' for community prevention was developed.

Health Nexus uses an engagement model to build partnership to prevent chronic diseases that brings together individuals from community services and across the continuum of health care from health promotion, primary prevention, acute care, rehabilitation and long-term care. The intention is not to form new standing networks, but to generate new relationships and amplify existing relationships, and create space for long-term visioning to prompt short-term planning tables. In one region, we know that seven collaborative initiatives have grown out of our initial several-month-long engagement investment. In that same region, we're now researching the nature of the networks that have evolved to better identify and address continuing weaknesses.

The tools and methods are varied: coalitions, coordinating committees, school councils, peer leadership, community champions, dialogues, open space events, citizen juries, amateurs, community audits. I could go on, and this type of list exemplifies both the strength and dilemma of community organizing. By its very nature community methods vary by setting, issue, time and thus evaluation studies find little replication of method. Even so, research regarding evidence of impact by community engagement and mobilization methodologies² is emerging. Increasingly studies are finding level 1 and especially level 2 evidence (that is, evidence showing a causal relationship between the intervention and a result; and good-methodology-evidence that shows the intervention may have lead to a particular impact).

Scotland has established national standards for community engagement and developed principles and indicators. The indicators to be measured by Scottish-funded projects related to: involvement, support, planning, methods, working together, sharing information, working with others, improvement, feedback, and

² Although for today's presentation I've merged community engagement and mobilization, the two can be considered quite different. At its simplest forms, engagement is often reduced to consultation; it often refers to mechanisms to influence the work of governments and institutions. Community mobilization, in contrast, generally refers to methods to change community environments to result in better outcomes for everyone in that community. Community most often refers to geographic communities, yet also refers to communities defined by culture, faith, sexual orientation, common interest, etc.

monitoring/ evaluation. It is very feasible to, using Federal resources, encourage community specificity and leadership while ensuring accountability and reporting sufficient to compare locations and interventions.

Looking at just one aspect of community engagement, methods to purposefully develop and support networks are evolving rapidly and gaining increasing academic research attention. Using network or relationship approaches is based on understanding that behaviour is rooted in social relationships and that social capital can be measured through cooperation, reciprocity, trust, information and cohesion norms.³

At Health Nexus we're working with some Americans to pilot in Ontario software that helps us analyse a network or group of relationships to understand who is an innovator, leader, grunt-worker; who has many or few relationships; who reaches out to champion the cause or build new links; who makes referrals to others; etc. The group with which we're working has experience in U.S. private sectors, for instance helping a bank identify that Hispanic women are the neighbourhood leaders but said bank only knew Hispanic men. We're excited and believe this work has promise for our work, and many provincial and national initiatives in Canada.

As an extra note, in your *Issues and Options* paper you asked about arguments to engage and convince the private sector that reducing health inequities is not yet a nice-to-do goal, but requires must-do-now attention. Here, I believe the argument is how much the private sector pays for expanded health insurance benefits, even in Canada with our semi-universal health care. As you already know, if Canada can reduce health inequities, the savings are immense. Some of these savings will play out in reduced incidence of chronic disease burden, improved mental health and reduced substance misuse, all of which now cost private sector firms huge amounts.



When Canadians understand the extent to which neighbourhood, race, housing, income, etc. are associated with reduced health, especially for children, our strongly held value of 'fairness' is touched. The Saskatoon Regional Health Authority surveyed

³ Scott, Catherine & Hofmeyer, Anne, *Networks and social capital: a relational approach to primary healthcare reform*, Health Research and Policy Systems 2007, 5:9.

local residents about priorities. Then the surveyors took time to explain some local inequities – realities like 93% of kids in affluent neighbourhoods being immunized according to schedule, but only 44% of children in the poorest neighbourhoods receiving immunizations appropriately. When they were then asked again about priorities, respondents shifted their answers. Unfairness was a rallying point for Saskatoon residents to recommend investing more upstream, even being willing to take away a bit from treatment.

This is where we must start to build communities that care, comprised of individuals who will demand change so that all Canadians have the best start in life, throughout life.

Connie Clement, Executive Director, Health Nexus/ Nexus Santé, March 12, 2009
c.clement@healthnexus.ca www.healthnexus.ca