COMMUNITY HEALTH AND SOCIAL SERVICES NETWORK

POPULATION HEALTH INITIATIVE

A COMMUNITY GUIDE TO THE POPULATION HEALTH APPROACH

MARCH 2003

ACKNOWLEDGEMENTS

Much of the material in this guide is derived from selected documents on the Health Canada Population Health web site http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html. The CHSSN has integrated its own material and other resources into cited extracts in order to adapt the generic population health model to the realities of English-speaking communities. We would like to thank Health Canada for its collaboration. All photo images used in this document are provided courtesy of Health Canada.[1]

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The guide was prepared by Jim Carter, Coordinator of CHSSN, and can be obtained on the CHSSN web site at http://www.chssn.org, or as part of a CD-ROM entitled "A Community Guide to the Population Health Approach".

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[1] *Health Canada website and Media Photo Gallery,* http://www.hc-sc.gc.ca. Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2003.

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INTRODUCTION

The Community Health and Social Services Network (CHSSN) is a network of organizations across Quebec dedicated to supporting English-speaking communities in their efforts to improve access to health and social services in the English language.

The CHSSN promotes knowledge-based community development as a means for communities to enhance their vitality and improve the health and well being of their members. This guide introduces the Population Health Approach to community organizations pursuing this goal. Within a framework promoting population health, the guide will assist organizations in mapping the health determinants affecting their communities and provide strategies and entry points for action. Case examples in English-speaking communities are cited, and additional resources are provided to help community organizations start their own population health initiatives.

SECTION ONE

Improving health outcomes in English-speaking communities: A Framework for promoting population health

- Introduction
- What is Population Health
- Factors Affecting Health
- Target for Action
- Maximizing Potential Benefit
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Introduction

Many of our organizations are concerned with improving the health of our English-speaking communities and strive to be more effective in achieving this goal. Promoting population health aims to create conditions that support community vitality and the best possible health outcomes for community members. This section describes a framework for promoting population health. It can serve as a guide for organizations to assess key health determinants and develop strategies to improve health outcomes.

What is Population Health?[1]

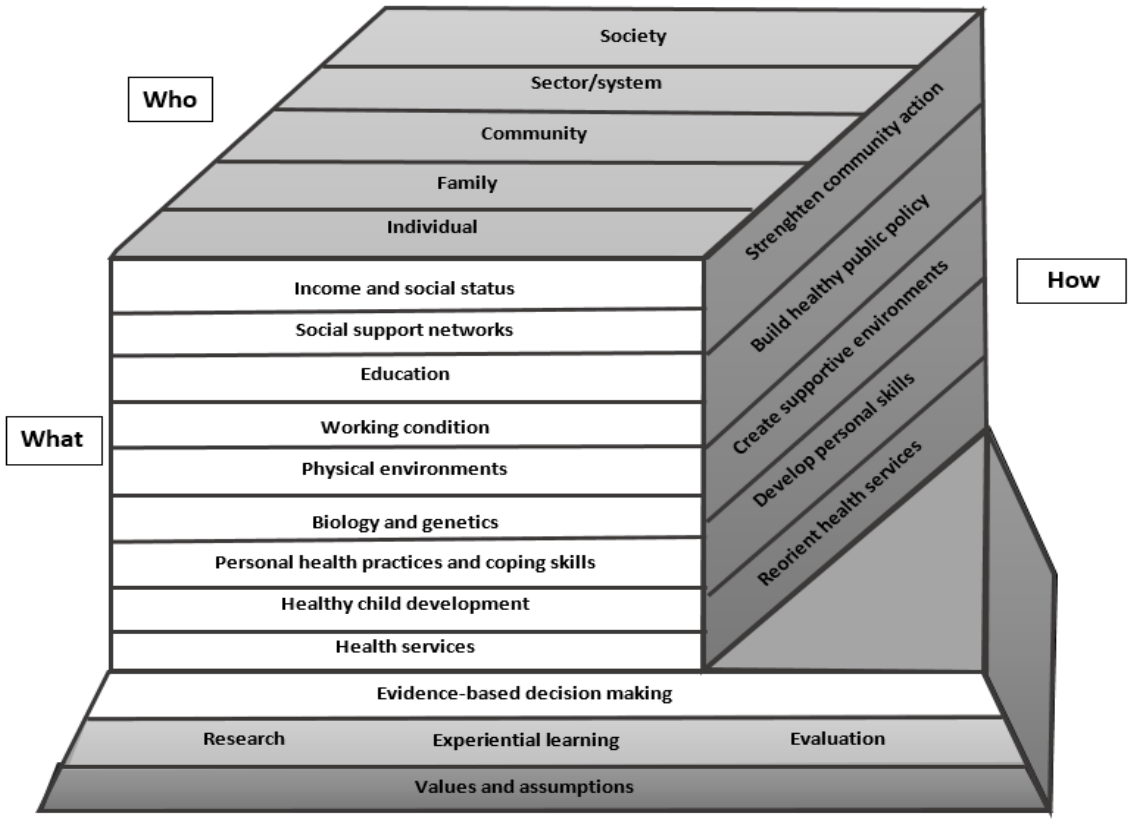
Population health is an approach that aims to improve the health of an entire population by taking into account a broad range of factors that have a strong influence on health. The population approach recognizes health as a resource that permits individuals and communities to achieve social well being and quality of life.

Factors affecting health[2]

The population health approach considers that a broad range of individual and collective factors and other conditions are connected to health status. These different influences interact with each other, which explains why some groups of people experience better health than others. These factors include:

1. Income and Social Status
2. Social Support Networks
3. Education
4. Employment and Working Conditions
5. Social Environments
6. Physical Environments
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture

Population Health Promotion Model



This model was added on 2022-08-31 (document uploaded on CHSSN website)

Target for Action[3]

The population health approach focuses action on a whole population or a sub-population. The aim is to reduce inequalities in health status between population groups. This approach fits well with the reality of English-speaking communities, which are sub-groups of regional populations. The population health approach supports strategies directed at correcting social and income inequalities as these relate to health status. But action can also extend beyond improving health outcomes. The population health approach includes attaining a sustainable health system and strengthened social cohesion. This last aspect of population health resonates with many English-speaking communities striving to improve access to services and maintain demographic vitality.

Maximizing Potential Benefit[4]

The population health approach directs action at root causes to increase the potential benefits for health outcomes. "Investing Upstream" means directing actions in those areas that have the greatest potential to improve health outcomes – "The earlier in the causal stream action is taken, the greater the potential for population health gains". For example, actions aimed at improving food security and eating habits in families with children may reduce the incidence of diabetes, obesity or hypertension in a community. When these situations develop, they result in a diminished quality of life for individuals and families, reducing the productivity of the communities in which they live. These problems can lead to other serious health issues that require solutions that are costly for the health system.

Improving Effectiveness[5]

One important dimension to the population health approach is the development of new sources of evidence on the determinants health. For example, there is a growing understanding of how income, education and social status affect health outcomes. There is evidence that social inclusion has an impact on mental and physical health. We are developing our understanding of how culture and language can act as barriers to accessing the health and social services system.

The use of population health surveys is supporting development of new knowledge on population health. We will demonstrate how the Quebec population health survey used in conjunction with other demographic and survey information can be a valuable tool for assessing the range of health determinants affecting English-speaking communities.

Multiple Strategies and Shared Responsibility[6]

The health of a population is affected by factors that fall outside the health sector. Social, economic and environmental factors interplay and affect community health. In economic terms, these can range from dramatic events such as industry closures to longer-term changes causing economic and population decline in a region. Environmental influences may manifest themselves in increased incidences of diseases such as asthma and other respiratory ailments. Environmental issues such as agricultural practices and protection of water resources have both an economic and health implication. Social factors such as alcohol consumption, drug use and gambling can impact individual health, family relations and community well-being.

The population health approach recognizes that strategies must be innovative and inter-connected to encompass action addressing the full range of social, economic and environmental health determinants. Multiple strategies developed in this manner will have the greatest impact on health risks and conditions. An example on a broad level is informed public policy that directs resources to supporting families with young children, identifies the education system for social and health intervention, regulates working conditions to promote healthy child development, and facilitates access to primary health care.

Multiple strategies work at the community level as well. An initiative to reduce incidence of alcohol consumption in a community can include coordinated strategies involving the justice system, the education system, the health system, business and community organizations, and political leaders.

The population health approach calls for shared responsibility and accountability for health outcomes. Joint actions between health and other sectors are encouraged. Communities can identify and solicit many different stakeholders that can become partners in initiatives to promote population health.

Community and Citizen Empowerment[7]

The population health approach promotes the participation of communities in strategies to improve health. The aim is to build public confidence in decision-making regarding population health priorities, and to increase information sharing.

The population approach promotes strategies to empower communities as stakeholders in the health and social services system. For example, it would support the actions of English-speaking communities working to increase their participation in the health and social services system to ensure it adapts to community needs.

Developing a perspective on what determines good health in a community can be a mobilizing experience. It can engage more community and institutional actors in promoting health and establish the community organisation as knowledge-based in its approach to advocating change. As a stakeholder, the community organization gains respect from other players in the health care system if it becomes an expert at mapping the health determinants of the community.

Promoting health information is an excellent community empowerment strategy because health care providers are very sensitive about communities knowing about their services. Also, the system is placing more and more emphasis on health promotion to reduce healthcare costs. More government funding programs are favouring communities taking charge of their own health. This is a natural lever for communities to use to build their stake in the health system. The Health Canada Diabetes Strategy is a good example, where some of our English-speaking communities have applied for grants to run diabetes prevention programs and build partnerships with healthcare providers.

Notes

[1] http://www.hc-sc.gc.ca/hppb/phdd/approach/approach.html#health, “What is Population Health?”
[2] Idem, “Key Elements of a Population Health Approach”
[3] Idem, “Focus on the Health of Populations”
[4] Idem, “Investing Upstream”
[5] Idem, “Base Decisions on Evidence”
[6] Idem, “Apply Multiple Strategies to Act On the Determinants of Health”
[7] Idem, “Employ Mechanisms to Engage Citizens”

SECTION TWO

Mapping Health Determinants in English-speaking communities

Introduction

Developing an understanding of what contributes to good health and vitality of English-speaking communities requires assessment of key health determinants. Only with this step can organizations identify the conditions necessary to attain the best possible health outcomes for their communities. Mapping health determinants lays the groundwork for the development of effective population health promotion strategies.

We will look at twelve key determinants and identify the underlying premises and evidence that supports them. We will also cite what we know about health determinants in English-speaking communities.[1]

Key Determinant 1: Income and Social Status

Underlying Premise

Health status improves at each step up the income and social ladder. Higher incomes promote optimal living conditions, which include safe housing and good food. The degree of control people have over life circumstances and the ability to adapt to stressful situations are key influences. Higher income and social status generally result in more control and more resources to adapt. Studies are showing that limited options due to limited means and poor coping skills for dealing with stress increase a person's vulnerability to a range of diseases.

Evidence

There is strong evidence that higher social and economic status is associated with better health. These two factors are considered to be the most important determinants of health.

Evidence from *the Second Report on the Health of Canadians*[2]

- Only 47% of Canadians in the lowest income bracket rate their health as very good or excellent, compared to 73% of Canadians in the highest income group.

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes.
- Studies show that large differences in income distribution (the gap between rich and the poor) are a more important health determinant than the total income that a population generates. Income gaps within and between groups increase social problems and poor health.

What we know about English-speaking communities

Evidence from Community Health and Social Services Data Model[3]

- 27% of English-speaking Quebecers (English is the first official language spoken) live below the Statistics Canada low-income cut-offs. The rate is greater than that of French-speaking Quebecers (22%). This means that over 250,000 members of our communities are vulnerable.
- 48% of unattached individuals in English-speaking communities live below the low-income cut-off.
- 49% of those in English-speaking communities living in single-parent families are low-income
- There are high rates of low-income in the English-speaking communities of Mauricie et Centre-du-Québec, Gaspésie-Îles-de-la-Madeleine, Bas-Saint-Laurent, and parts of Montréal-Centre,
- English-speaking communities are less well off all regions except for Montréal-Centre. But even here, over 30% of English-speaking people live below the low-income cut-offs.
- Income gaps between English and French speaking people are the most dramatic in the regions of Gaspésie-Îles-de-la-Madeleine (30% versus 20%) Abitibi-Témiscamingue (25% versus 18%), Mauricie et Centre-du-Québec (31% versus 20%), Bas-Saint-Laurent (28% versus 19%).

Evidence from the 1998 Quebec social and health survey[4]

- Poor and very poor income levels are linked to factors such as higher incidence of drug use, average to poor eating habits, food insecurity including incapacity to offer balanced meals to children, lack of recreational physical activity, excessive weight, lack of breast examinations, long-term health problems, high level of psychological distress, presence of suicidal ideas, and limitations on activity.

Comment

The 1998 Quebec Social and Health Survey showed that English-speaking people (by mother tongue) perceived their economic situation to be poor or very poor to the same degree as French-speakers. When combined with the regional profiles according to the Statistics Canada Low-income cut-offs, the 1998 survey provides a rich portrait of health determinants in English-speaking as these relate to income adequacy.

These data can allow organizations to identify vulnerable English-speaking communities in many regions and groups at risk such as unattached individuals (the elderly) and children in single-parent families. The information shows that there are health status inequalities between English-speaking communities and regional populations, and between groups within English-speaking communities.

<u>Key Determinant 2: Social Support Networks</u>

Support from families, friends and communities is associated with better health. Support networks are important in helping people solve problems and deal with adversity. They contribute to an individual's sense of control over life circumstances. Support networks support a feeling of well-being and act as a buffer against health problems.

Evidence

- In the 1996-97 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for.

Evidence from *Investing in the Health of Canadians*[5]

- Some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure.

What we know about English-speaking communities

Evidence from the *Report to the federal Minister of Health*[6]

- English-speakers are much more likely than French-speakers to say that they would turn to family first in case of illness; French-speakers would turn to public services first.
- English-speakers are far less likely than French speakers to have a family member living nearby.
- In 8 of 16 of administrative health regions, the ratio of caregivers to the seniors in English-speaking communities was less than the provincial average of 2.3 to 1. This ratio is the number of English-speaking persons aged 35 to 64, compared to those aged 65 and over.

Evidence from the Missisquoi Institute[7]

- English-speaking communities in 14 of 17 administrative health regions in Quebec experienced a population decline from 1996 to 2001.
- There was a decline of greater than 10% in English-speaking communities in Mauricie, Centre-du-Québec, Chaudière-Appalaches, Abitibi-Témiscamingue, Québec, Bas-Saint-Laurent.
- There were declines in 8 other regions: Gaspésie-Îles-de-la-Madeleine, Lanaudière, Côte-Nord, Estrie, Montérégie, Laurentides and Saguenay-Lac-Saint-Jean.

Key Determinant 3: Education

Health status improves with level of education. Education is closely tied to income and social status and provides knowledge and skills for problem solving. It helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. Education improves people's ability to access and understand information to help keep them healthy.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy
- People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods.
- In the 1996-97 National Population Health Survey (NPHS), only 19% of respondents with less than a high school education rated their health as "excellent" compared with 30% of university graduates.

Evidence from *Investing in the Health of Canadians*

- The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven work days per year due to illness, injury or disability, while those with university education lose fewer than four days per year.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- The 1998 Quebec Social and Health Survey shows that Quebecers (including English-speaking Quebecers) with very low scolarity perceive their health status to average or poor compared to those with more education.
- The Quebec survey also shows that Quebecers (including English-speakers) have higher levels of psychological stress and activity limitations compared with those with higher education. Those with low scolarity are more likely to consider their eating habits as average or poor and have problems offering balanced meals to their children.

Key Determinant 4: Employment and Working Conditions

Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job.
- Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being.

Evidence from *Investing in the Health of Canadians*

- A major review done for the World Health Organization found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities.

What we know about English-speaking communities

Evidence from the *Report to the federal Minister of Health*

- English-speaking communities in 9 of 16 administrative health regions experienced unemployment levels greater than the provincial average for English-speaking people (13.2% in 1996).
- The rate was 42.2% in the English-speaking community of Côte-Nord and 35.8% in Gaspésie-Îles-de-la-Madeleine.
- The unemployment greater among Anglophones than among Francophones in 15 out 16 regions.

Evidence from the 1998 Quebec social and health survey

- The survey (with a representative sample of anglophones) links unemployment with other factors of health vulnerability such as food insecurity, poor perception of health status,

increased number and duration of health problems, high levels of psychological stress, increased presence of suicidal ideas, physical limitations on activity, lack of social intimacy, lack of coverage by private health insurance plans,

Key Determinant 5: Social Environments

The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community issue. Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- In the U.S., high levels of trust and group membership were found to be associated with reduced mortality rates.
- Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24% of all assaults against children; among very young children, the proportion was much higher.
- Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80% of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend.
- Since peaking in 1991, the national crime rate declined 19% by 1997. However, this national rate is still more than double what it was three decades ago.

What we know about English-speaking communities

Evidence from the *Report to the federal Minister of Health*

- Social environments are affected by community vitality. English-speaking communities in 9 of 16 administrative health regions are considered to have very low or low demographic vitality. Demographic vitality is an aggregate of community characteristics including rate of ageing, unemployment, proportion of caregivers to seniors, population size, and level of bilingualism.
- English-speakers are far less likely than French-speakers to have a family member living nearby, yet English-speakers are more likely than their French-speaking neighbours to say they would turn to family first in the case of illness.

Evidence from Missisquoi Institute

- Some 2,600 English-speaking women experience domestic violence in Quebec on an annual basis, as calculated by applying the incidence projections provided by the Ministry of Public Security to the numbers of women in each region who speak English as their first official language spoken (1996).

Key Determinant 6: Physical Environments

The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13% of boys and 11% of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 1996-97.
- Children and outdoor workers may be especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts.

Evidence from *Investing in the Health of Canadians*

- Air pollution, including exposure to second hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- 35% of Quebec anglophones, by mother tongue, are exposed to second-hand smoke at home every day, or nearly every day. 24% are exposed to second-hand smoke outside the home every day, or nearly every day.
- The incidence of asthma in Quebec children has risen dramatically between 1987 and 1998 (from 3.4% to 6.6% of the population up to 14 years).
- The incidence of allergies has risen from 6.5% to 10.3% of the total Quebec population between 1987 and 1998.

Key Determinant 7: Personal Health Practices and Coping Skills

Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health.

Definitions of lifestyle include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play.

These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- In Canada, smoking is estimated to be responsible for at least one-quarter of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole.

- Multiple risk-taking behaviours, including such hazardous combinations as alcohol, drug use and driving, and alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men.
- Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 1996-97 from 22% to 34% among men and from 14% to 23% among women.

Evidence from *Investing in the Health of Canadians*

- Coping skills, which seem to be acquired primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day-to-day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- About 30% of Quebec anglophones, by mother tongue, currently smoke. 40% of members of English-speaking communities started to smoke before the age of 16.
- 42% of Quebecers (including a representative sample of anglophones) aged 15 to 24 consumed 5 drinks or more on a single occasion, and repeated this at least five times in the last twelve months. This compares to 25% of adults aged 45 to 64.
- 44% of Quebec males aged 15 to 24 have used one or several drugs over a 12-month period, compared to 35% of females the same age. The incidence of drug use drops to 8% of the population aged 45 to 64.
- Almost one-third of Quebecers who consider their diet to be average or poor also consider their state of health to be average or poor as well.
- 42% of Quebec men and 49% of Quebec women over the age of 65 never engage in recreational physical activity.
- Over 40% of Quebec men and 31% of Quebec women aged 45 to 64 are considered to carry excessive weight. Obesity is more likely to affect Quebecers who are poor or very poor and who have low or very low scolarity.
- Of those Quebecers having had more than one sexual partner over a twelve-month period, 55% of the males and 63% of the females engaged in at least one incidence of risky sexual behaviour.
- In Quebec, the incidence of high blood pressure among men aged 65 and over climbed from 19.2% in 1987 to 30.8% in 1998. The rate of diabetes jumped from 5.6% to 10.6%. A similar large increase occurred in women over 65 for these two diseases.

<u>Key Determinant 8: Health Child Development</u>

New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- 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 improves learning, behaviour and health into adulthood.
- Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 1996-97 National Population Health Survey, about 36% of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy.
- A loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life.
- Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death.

Evidence from *Investing in the Health of Canadians*

- A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play.

What we know about English-speaking communities

Evidence from Community Health and Social Services Data Model

- 49% of those in English-speaking communities living in single-parent families are low-income.

Evidence from the 1998 Quebec social and health survey

- In Quebec, a single parent heads 20% of families.
- The 1998 Quebec Social and Health Survey links poor and very poor income levels to high level of psychological distress and food insecurity including incapacity to offer balanced meals to children.

<u>Key determinant 9: Biology and Genetic Endowment</u>

The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime.
- Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive

capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- The incidence of disease in English-speaking communities caused in part by biological and genetic factors is mirrored in the occurrence of such diseases and conditions in the general population. The 1998 Quebec Health and Social Survey is a good source of information on diseases and conditions linked to biological and genetic factors. Other information using language variables can be obtained through online access to the Canadian Community Health Survey.[8]

Key Determinant 10 Health Services

Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health, contribute to population health. The health services continuum of care includes treatment and secondary prevention.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained.
- There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services.
- Access to universally insured care remains largely unrelated to income; however, many low and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- In Quebec, about 27% of persons in the central administrative health regions saw a health professional in a period of two weeks, while 21% of those in distant regions saw one.
- While 6% of the Quebec population in the central regions saw specialist in two-week period, the rate was almost half that for those living in distant regions.
- In the central regions, trips greater than 20 km to see a general physician are the reality for about 3% of the population, while this is the case for 17% of the population living in the distant regions. Trips greater than 20 km to see a specialist affects 6.5% of the population of central regions and 39.3% in distant regions.
- Quebecers in distant regions are more likely to find delays to see a general physician or a specialist a little long or too long compared to those living in the central regions. One in four Quebecers considers delays for day surgery a little long or too long.
- While Quebecers with higher incomes are more likely to be hospitalized for three days or less, those who are poor or very poor are more likely than higher income groups to spend 8 days or more in hospital. The poor or very poor are more likely to be hospitalized more than once in a twelve-month period.

- Quebecers aged 65 and over are much more likely to consider their length of stay in hospital to be insufficient, compared to other age groups. This is also the case with those who consider their state of health to be poor.
- For Quebecers treated with day surgery, 58% rely on family and friends for post-operative care; and 36% use the CLSC, a private resource or a community organization. In case of hospitalization, 15% rely on family and friends for post-hospital care, and 69% on the CLSC, private resource or community organization.
- The 1998 Quebec Social and Health Survey found that 78% of francophones knew about Info-Santé, while only 59% of anglophones did. While 31% of francophones have used Info-Santé, only 19% of anglophones have.
- While over 70% of those with upper middle or very high incomes are covered by some type of private health insurance plan, only 8% of the very poor are. 89% of those covered are under group plans linked to employment or professional activity.

Evidence from the *Report to the federal Minister of Health*

- Regions where the English-speaking community forms 2.4% or less of the regional population score very low with respect to ability to obtain a range of health and social services in English (Bas-Saint-Laurent, Saguenay-Lac-Saint-Jean, Québec, Mauricie, Chaudière-Appalaches and Laurentides).
- About 6 out of 10 English-speaking people who use Info-Santé receive the service in English. About 66% of Anglophones have received primary care in English.
- There are 9 administrative health regions where less than half of anglophones have received primary care in English.
- There are 9 administrative health regions where less than half of anglophones who have used hospital emergency services or outpatient clinics obtained them in English.
- There are 4 regions where entitled access to statutory services in English for youth in difficulty is limited, extremely limited or non-existent.
- Eleven regions are considered to have limited, extremely limited or non-existent access to entitled English-language services provided by rehabilitation centres serving those with physical or intellectual disabilities, youth in difficulty, or persons with drug or alcohol addiction.
- Half of the administrative health regions are in deficit with respect to having moderate to substantial access to entitled English-language services provided by long-term care centres for the elderly.
- Seven of the regions are considered to have limited, extremely limited or non-existent access to entitled English-language general and specialized medical services delivered by hospitals.

Key Determinant 11: Gender

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.

Evidence

Evidence from the *Second Report on the Health of Canadians*

- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34.
- While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence.

- While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb.

What we know about English-speaking communities

Evidence from the 1998 Quebec social and health survey

- In Quebec, the overwhelming majority of heads of single-parent families are women (83%).
- 22.5% of the Quebec population living in a single-parent family experiences food insecurity, including restriction on food availability and inability to offer balanced meals to children. This compares to 5.9% of those in two-parent families.
- Young Quebec women aged 15 to 24 are more inclined than any other age group of either sex to consider their mental health as poor or average.
- Quebec women experience a higher level of psychological stress compared to men (22.8% compared to 17.3%). Almost 34% of women aged 15 to 24 experience a high level of psychological stress.

Evidence from Community Health and Social Services Data Model

- 49% of those in English-speaking communities living in single-parent families have incomes below the Statistics Canada low-income cut-offs.

Key Determinant 12: Culture

Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

What we know about English-speaking communities

Evidence from the Missisquoi Institute

- English-speaking communities in 14 of 17 administrative health regions in Quebec experienced a population decline from 1996 to 2001.
- There was a decline of greater than 10% in English-speaking communities in Mauricie, Centre-du-Québec, Chaudière-Appalaches, Abitibi-Témiscamingue, Québec, Bas-Saint-Laurent.

Evidence from the *Report to the federal Minister of Health*

- Social environments are affected by community vitality. English-speaking communities in 9 of 16 administrative health regions are considered to have very low or low demographic vitality. Demographic vitality is an aggregate of community characteristics including rate of ageing, unemployment, proportion of caregivers to seniors, population size, and level of bilingualism.
- In 7 of the 16 administrative health regions, English-speaking communities comprise less than 5% of the regional population.
- A number of studies have confirmed that language is a health determinant and that language barriers create inequalities in health status. They conclude that problems in communication and understanding reduce the use of preventative services, increase the amount of time spent in consultations and diagnostic tests, influence the quality of services in areas where language is an essential tool such as mental health services, social services, physiotherapy and occupational therapy. Language barriers also reduce the probability of compliance with treatment and diminish the level of satisfaction with the care and services received.[9]

Notes

[1] http://www.hc-sc.gc.ca/hppb/phdd/determinants/index.html, The sections “Underlying Premises” and “Evidence” are substantial citations from the Health Canada presentation of key determinants .The section “What we know about English-speaking communities” is derived from several data sources describing health determinants of these communities.
[2] http://www.hc-sc.gc.ca/hppb/phdd/report/subin.html, *Toward a Healthy Future: Second Report on the Health of Canadians*, 1999.
[3] Community Health and Social Services Network Data Model, *Persons in Families and Unattached Individuals Below the Statistics Canada Low-Income Cut-Offs (1996 Census)*
[4] Institut de la statistique du Québec, *Enquête social et de santé 1998.*
[5] Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*, 1994.
[6] Health Canada Consultative Committee for English-Speaking Minority Communities, *Report to the federal Minister of Health,* July 2002.
[7] Missisquoi Institute, *Percentage Change in Size of the Population with English as the First Official Language Spoken, 1996-2001, by region,* March 2003.
[8] The Canadian Community Health Survey provides health profiles in Quebec according to mother tongue and first official language spoken, http://www.statcan.ca/english/freepub/82-576-XIE/free.html.
[9] Sarah Bowen, *Language Barriers in Access to Health Care,* Health Canada, 2001.

SECTION THREE

Taking Action on Health Promotion and Prevention

- Introduction
- Health Promotion Strategies
- Prevention
- Entry Points for Action
- Objectives and Activities of Population Health Promotion
- The Patient and Community Support Network: A Case Study
- Guide to Project Evaluation: A Participatory Approach

Introduction

The population health approach moves away from the traditional focus on the individual's health, disease management and emphasis on direct patient care. We have learned that population health attempts to address a range of factors that contribute to health; and how these factors interact in the population as a whole and in sub-groups such as minority language communities.

Health promotion is way to take action on population health. We will look at health promotion strategies, prevention, and entry points for community action. We will cite examples of projects already at work in our communities implementing the population health approach. And finally, we will identify the objectives and activities that can form the basis for development of population health initiatives in English-speaking communities.

Health Promotion Strategies

Health promotion strategies are based on values that foster empowerment and community development, increase the learning capacity of individuals and promote change and adaptation of health systems to meet new needs.

There are five main strategies used to promote health that reflect these values.[1]

Building healthy public policy

Building healthy public policy means encouraging all policymakers and planners to weigh the health impact of their policies at all levels, from communities, schools and the workplace to the regional, provincial and federal levels. This means health promotion initiatives that span different sectors.

An example of this is the Community Animation Program, which is co-administered by Health Canada and Environment Canada. This funding program recognizes the link between environment and health. The Coasters Association has developed a project addressing issues of food safety and unhealthy eating habits in its communities. Because of isolation and the transportation system, there are issues of food costs, improper food storing, and poor eating habits to avoid the high cost of purchase and storage. This impacts children who are not exposed to healthy diets in early childhood development. Unhealthy diet leads to problems of behaviour in the school environment. In adults, unhealthy diet creates a host of health problems. The strategy to address this crosses sectors and affects transportation, food security and public health, education and business. Building healthy public policy would mean that decision makers in each sector integrate health promotion approaches into their policies.

Creating supportive environments

This is a broad health promotion strategy that encompasses social, political and economic dimensions that interact and exert an influence over health. Many of our community organizations are already engaged in strategies to create supportive environments as they address issues of youth retention in regions, sustainable economic development, strengthening social networks and promoting community participation in decision making in bodies that affect life at the local, regional, provincial and national levels.

One approach our community organizations can examine is linking the social economy with creation of supportive environments. This strategy combines economic development with creation of health resources such as homecare programs to support English-speaking communities. Social economy is a recognized economic sector in Quebec that receives resources from the government.

Strengthening community action

The community links individuals with the broader institutions that affect their lives. A healthy community can mobilize resources to deal with problems affecting individuals. This reinforces a sense of belonging and identity. Population health promotion can strengthen community action by supporting groups in

- Developing the skills they need
- Learning how to access resources
- Building an effective infrastructure
- Developing strong social networks
- Evaluating and learning from their efforts

The successes of our own communities in strengthening community action stem from actions that 'start where people are at' and build on community strengths.

An example of 'developing skills' is the Palliative Care Project sponsored by the Quebec Association for Adult Learning and being given in different regions of Quebec. The project provides valuable information for families looking after a member in the final stage of life. Another example is the CAMI Diabetes Project through which Magdalen Islanders are learning about prevention of diabetes and the value of early detection.

An example of 'learning how to access resources' is the CASA Information Line Project. This project completed study of availability of English-language resources on the Gaspé coast. In the process, the organization developed a detailed inventory of available services and increased awareness among community resources of the needs of English-speaking people.

An example of 'building an effective infrastructure' is the Holland Centre in Quebec City, which has developed partnerships with public institutions and community resources to deliver primary health care and social services to the English-speaking communities in the Québec region.

An example of 'developing strong social networks' is the Townshippers' Association, which has organized health and social services committees in the different areas of the historic Townships. Townshippers' Association has successfully promoted participation of English-speaking communities in the public health and social services system. It has also sponsored many programs supporting volunteer organizations.

An example of 'evaluating and learning from their efforts' is Coasters Association Youth Drug and Alcohol Awareness Project. The project promoted partnerships involving health and social service providers, municipal leaders and the justice system in order to develop strategies to reduce abuse of alcohol and other substances by English-speaking youth on the Coast. With what was learned in the project, partners are now developing new initiatives in the area of health promotion.

Developing personal skills

Individuals require access to information about health and opportunities to develop skills to enable them to control their lives and alter their environment. For health promotion strategies, these include decision making, problem solving, creative thinking, critical thinking, self-awareness, empathy, communications skills, interpersonal relationship skills, coping with emotions and managing stress. Individuals also require access to health and social services that meet their needs, including linguistic and cultural. Population health promotion includes educating people on a one-to-one basis, in groups, through the media; and provides skills training and supportive services.

An example of this is a project of the Center for Literacy of Quebec to meet the information and education needs of hard-to-reach patients at the Montreal General Hospital, part of the McGill University Health Centre. The purpose is to improve the health education process and information given to patients with low literacy, those who face language and cultural barriers, and those who cannot process health information because of physical or cognitive learning disabilities. The project also aims to improve how health professionals communicate with such patients. This is a health promotion initiative that develops skills in order to improve the capacity to act independently and motivate individuals to act on health advice received.

Reorienting health services

One of the goals of recent health reform is to broaden the perspective of the health system beyond just service delivery to include enhancement of health at the individual and population levels. A reformed system also emphasizes services located closer to communities and responding to local needs.

Quebec's plan to renew the health and social services system reflects these goals.[2] It places more emphasis on prevention programs and improving the primary care system. Quebec is attempting to base its system on population health objectives laid out in its policy for health and well-being. It is clear that collaboration of many partners, including English-speaking communities, will be required if the desired transformation is to be achieved.

A community example of reorienting health services is the Patient and Community Support Network Project of Holland Centre. The project tested the use of videoconferencing as a means to extend services to isolated English-speaking clientele faced with barriers to access to services. The project demonstrated that videoconferencing is a viable means to provide services. The results support Quebec's assertion that communications technology allows an improved response to needs and promotes a more efficient use of resources. Through the project, the community sponsors have demonstrated an option for reorienting health services which would not only meet minority language community needs, but also contribute to the overall goal of improving services in an efficient cost-effective manner.

A second example is the project of the Canadian Deafness Research and Training Institute: Minority within a Minority. This initiative tested videoconferencing to provide distance signing services for English-speaking deaf located in remote or isolated regions where there are no English-language interpreters. This technology will help hearing-impaired persons who face major obstacles communicating with health care providers. It can help the health system reorient itself to comply with a Supreme Court decision declaring that sign language interpretation must be provided to all hearing-impaired persons as a service insured under the Canada Health Act.

Prevention[3]

Prevention of health problems is another key dimension to applying the population health approach. Prevention of health problems such as disease or injury occurs at three levels:

- Primary prevention involves activities aimed at reducing the factors leading to health problems.
- Secondary prevention activities involve early detection of and intervention in the potential development or occurrence of a health problem.
- Tertiary prevention is focused on treatment of health problem to lessen its effects and to prevent further deterioration and recurrence.

Injury, chronic illness, infectious diseases, acute trauma and other health problems can significantly impact a population. Prevention strategies can promote community partnerships with government and health care providers to ensure English-speaking communities benefit from Quebec's new orientations to increase resources in prevention programs.

Entry points for action[4]

The World Health Organization has identified entry points for application of health promotion strategies.

- We can work within specific settings such as workplaces, schools, or whole communities, taking into account the health determinants we want to influence.
- We can focus on meeting particular needs of population sub-groups, like the elderly, youth, children, or a special needs group such as deaf persons or those with an intellectual disability.
- We can target specific health issues, such as diabetes, tobacco use, drug or alcohol use, cancer, depression and others.

A community health promotion strategy may include a combination of these entry points. For example, a community dealing with *a specific health issue*, diabetes, may target a community and a school as *the setting* to address a *vulnerable sub-group*, children or youth with poor eating habits. The project might develop *personal skills* through education on diet and health; promote *community action* through public information meetings on diabetes prevention and early detection (primary and secondary levels of prevention); institute *healthy public policies* such as promoting good food offering in school cafeterias, provide *health services* with community-adapted campaign strategies to extend prevention programs to English-speaking people. This latter action would also contribute to a *more supportive environment* to reinforce healthy behaviours related to diet and health.

Objectives and Activities of Population Health Promotion[5]

To help community organizations get started developing project proposals, there are defined objectives that are compatible with health promotion initiatives. There are also specific activities that support them.

Objective	*Activity Type*
• Identify barriers to health and potential strategies to reduce barriers	• Needs assessments
Objective	*Activity Type*
• Raise awareness, increase knowledge and promote attitudes and practices that contribute to improved health	• Education and awareness

Objective	*Activity Type*
• Build the capacity of individuals, groups and communities to reduce the barriers to health	• Skills development
Objective	*Activity Type*
• Contribute to the development of knowledge about alternative health action initiatives that lead to a more flexible, responsive and cost-effective health system	• Developing innovative models
Objective	*Activity Type*

• Empower individuals, groups and communities to reduce or overcome barriers to health through
  ○ Broadening access to health information, practices and care for specific populations
  ○ Developing and enhancing coalitions and partnerships
  ○ Promoting healthy public policy
	• Reducing barriers to health

The Patient and Community Support Network: A Case Study[6]

The Patient and Community Support Network (PCSN) is a project of the Holland Resources Development Corporation (also known as Holland Centre). The Holland Centre is a community organisation that has created partnerships with the public sector to provide front-line health and social services to the English-speaking communities of the Québec and Chaudière-Appalaches regions.

The goal of the PCSN project is to apply information and communication technology in order to improve the health determinants of English-speaking people in rural and distant regions, as well as those facing special barriers to access to services.

The PCSN project tested the use of videoconferencing as a means to extend services to isolated English-speaking communities and individuals faced with barriers to access to services. Five pilot projects used videoconferencing technology to provide distance services including: support group sessions, specialized counselling, information sessions, consultation for professional support and rehabilitation services.

What health promotion strategies were engaged? What objectives and activities of population health promotion were involved?

The PCSN project involved primarily strategies of *strengthening community action, developing personal skills* and *reorienting the health system*.

The project strengthened community action by linking communities to services. It helped groups develop skills to connect services and to access resources.

- The Fraser Recovery Program is a drug and alcohol addictions program for English-speaking youth up to 25 years old that operates primarily in the Quebec City region. Its participation in the PCSN project consisted of linking participants in support groups in the Quebec City area with program graduates who have moved to the Montreal region and have continued participating in the support groups located there. The objective was to offer Fraser participants in Quebec the opportunity to talk with graduates from the program in a mentoring capacity, and for project graduates to maintain contact with their counsellors.
- Professionals of the McGill University Health Centre and volunteers used videoconferencing to give information sessions on three topics: Adolescents and Suicide, Diabetes and Breast Cancer. The three community organisations (CASA, CAMI and Holland Centre) organised groups of interested individuals to participate in the sessions. Some sessions involved two sites: Gaspé and the videoconferencing centre at MUHC in Montreal. Others used three sites simultaneously: Gaspé, the Magdalen Islands and the MUHC. The information programs were advertised in local papers and on radio. However, soliciting individuals directly was by far the most effective means of promoting participation. Twenty-seven people participated in the initiative. There were five sessions: two on diabetes, two on breast cancer and one on adolescents and suicide. The community groups involved learned how to use technology to gain to access to resources in another region and to mobilize community members to benefit from them.

The project aimed to develop personal skills of prevention and health promotion through programs provided through videoconferencing.

- The McGill School of Social Work offered counselling services of its Loss and Bereavement Program to two clients of Holland Centre. The psychosocial interventions took place over eight sessions. Service providers used the McGill Videoconferencing Centre and clients received services in a videoconferencing studio at Holland Centre in Quebec City.
- The participants in the information sessions on adolescents and suicide, diabetes and breast cancer received health information to reinforce skills to cope with difficult health or social issues.
- The project supported professionals in their efforts to improve counselling skills for certain problems. A social worker in Montreal, referred by the McGill School of Social Work, was engaged as a consultant to provide advice to Holland Centre professionals on the subject of psychosocial intervention with difficult clients. A majority of Holland Centre staff had identified the need for professional support in this area. Three sessions involving eighteen participants from Holland Centre teams were conducted.

The project involved a strategy to reorient the health system.

- The Patient and Community Support Network Project has demonstrated that videoconferencing is a viable means to extend services to distant English-speaking communities and those facing special barriers to access.
- Application of communications technology can extend Quebec's new service orientations in the area of prevention and primary care to communities in regions where the critical mass of English-speaking people and limitations of the system may not permit provision of these services in English.
- Extension of videoconferencing conforms to the Ministry's assertion that communications technology allows an improved response to needs and promotes more efficient use of resources.
- The capability and cost-efficiency of Quebec's emerging telecommunications network make it feasible to introduce videoconferencing as an integral part of service delivery to distant regions.

- A legislative framework exists to introduce videoconferencing into the development of plans of access to health and social services in the English language.

The PCSN project involved 5 health promotion objectives and activities:

Objective	*Activity Type*	*Patient and Community Support Network*
• Identify barriers to health and potential strategies to reduce barriers	• Needs assessments	• In the feasibility phase, PCSN identified needs in 3 regions • PCSN identified health determinants including demographics and information from the Quebec Social and Health Survey 1992-1993
Objective • Raise awareness, increase knowledge and promote attitudes and practices that contribute to improved health	*Activity Type* • Education and awareness	*Patient and Community Support Network* • MUHC information programs on adolescents and suicide, diabetes and breast cancer
Objective • Build the capacity of individuals, groups and communities to reduce the barriers to health	*Activity Type* • Skills development	*Patient and Community Support Network* • Fraser Recovery Program • MUHC information programs • Loss and bereavement counselling: Holland Centre and McGill School of Social Work
Objective • Contribute to the development of knowledge about alternative health action initiatives that lead to a more flexible, responsive and cost-effective health system	*Activity Type* • Developing innovative models	*Patient and Community Support Network* • Videoconferencing as a means to provide services to distant English-speaking communities • Demonstration of capability and cost-efficiency of Quebec's telecommunications network to support videoconferencing as a integral part of service delivery to distant regions
Objective • Empower individuals, groups and communities to reduce or overcome barriers to health through o Broadening access to health information, practices and care for specific populations o Developing and enhancing coalitions and partnerships o Promoting healthy public policy	*Activity Type* • Reducing barriers to health	*Patient and Community Support Network* • All five pilot projects providing support group sessions, specialized counselling, information sessions, consultation for professional support and rehabilitation services • Partnerships formed with Fraser Recovery Program, McGill University School of Social Work, Holland Centre, McGill University Health Centre, Committee for Anglophone Social Action, Council for Anglophone Magdalen Islanders, Constance Lethbridge Rehabilitation Centre and CHSLD Bayview Center

Guide to Project Evaluation: A Participatory Approach[7]

Project evaluation is an important knowledge development tool. Health Canada has produced an excellent evaluation guide that is practical, easy to use and demonstrates how to promote participation of all the key stakeholders in a community health promotion project.

Establishing an evaluation framework before implementing a project ensures groups can:

- Account for what has been accomplished through project funding
- Promote learning about which health promotion strategies work in communities and which do not
- Provide feedback to inform decision-making at all levels: community, regional, provincial and national
- Contribute to the body of knowledge about health promotion
- Assess the cost-effectiveness of different health promotion strategies
- Position high quality projects for future funding opportunities
- Increase the effectiveness of project and program management

Before you start planning a project take a tour of the Guide to Project Evaluation: A Participatory Approach (http://www.hc-sc.gc.ca/hppb/phdd/implement/linked.html). Not only will it provide direction to your work in planning and implementing effective project evaluation, it will also help you define the project work.

The guide is very practical and includes:

- A framework to guide the step-by-step process of developing effective evaluations
- Activities to introduce and plan for project evaluation
- Examples demonstrating the application of the evaluation framework to health promotion projects
- An annotated bibliography of a selected number of useful evaluation resources

The five steps in the project evaluation process are:

- Defining the project work
- Developing success indicators and their measures
- Collecting the evaluation data
- Analyzing and interpreting the data
- Using the results

Evaluation is not something that happens at the end of the project. It is a process that begins when the project begins, usually when the goals and objectives are being defined. When you have completed your tour of the guide, use Chapter 4, Defining Project Work to guide your project design.

This section provides a valuable guide to:

- Developing project goals and objectives
- Writing project objectives
- Identifying key areas for change

Then visit Chapter 5, Developing Success Indicators. This section provides important information on the purpose of success indicators and their measures. It provides guidelines for developing success indicators.

Notes

[1] Saskatchewan Health, *A Population Health Promotion Framework for Saskatchewan Health Districts*, 1999. The five strategies in this section are drawn from this guide, which has acted as a resource for health districts, community organizations and other agencies concerned with improving health determinants. Saskatchewan has been a leader in health reform and health promotion, placing special emphasis on the role that communities can play in influencing the factors that affect health.
Also, visit http://www.hc-sc.gc.ca/hppb/phdd/implement/implementation.html.
[2] Quebec, Ministère de la Santé et des Services sociaux, *Making the Right Choices,* 2002.
[3]http://www.hc-sc.gc.ca/hppb/phdd/implement/implementation.html#prevention, Prevention.
[4] Saskatchewan Health, *A Population Health Promotion Framework for Saskatchewan Health Districts*, 1999.
[5] http://www.hc-sc.gc.ca/hppb/phdd/implement/linked.html, Health Canada *Guide to Project Evaluation: A Participatory Approach.*
[6] Jennifer Johnson, Jim Carter, *Patient and Community Support Network: Using videoconferencing to improve access to health and social services for English-speaking minority communities in Quebec,* March 2003.
[7] Health Canada *Guide to Project Evaluation: A Participatory Approach*

SECTION FOUR

Population Health Initiatives for 2004-2005: Getting Started Now

- Introduction
- Context
- CHSSN Role and Mandate
- Health Canada Consultative Committee
- The Action Plan for Official Languages
- Quebec's Priorities in Primary Health Care
- Federal Initiatives and Quebec's Jurisdiction
- Coordinating Community Action

Introduction

Health Canada is planning to introduce a new funding program in population health for 2004-2005. Now is the time for interested community groups to get started. In this section we look at the population health context for English-speaking communities, which can set the stage for community initiatives. The role and mandate of the Community Health and Social Services Network (CHSSN) is explained.

Population health initiatives being considered for funding by Health Canada will have to take into account the federal government's new plan with respect to official language communities. We look at the Action Plan for Official Languages and explain the role of the Health Canada Consultative Committee on English-speaking Minority Communities.

Any population health projects will necessarily operate within Quebec's jurisdiction in the area of health. We will examine Quebec's priorities regarding primary health care renewal and new rules that will govern federal spending initiatives in Quebec.

And finally, we propose coordinated actions with community groups developing projects to maximize the chances for success.

Context

English-speaking communities experience inequalities in health status due to variations in health determinants linked to community well being. The Quebec population health and social survey has confirmed that factors such as income level, social support networks, education, employment status, social and physical environment, health practices, gender, culture and access to health services influence health outcomes.[1] English-speaking communities are vulnerable in a number of these areas.

A number of studies have confirmed that language is a health determinant and that language barriers create inequalities in health status. They conclude that problems in communication and understanding reduce the use of preventative services, increase the amount of time spent in consultations and diagnostic tests, influence the quality of services in areas where language is an essential tool such as mental health services, social services, physiotherapy and occupational therapy. Language barriers also reduce the probability of compliance with treatment and diminish the level of satisfaction with the care and services received.

Rationalisation of the health and social services system has reduced the role of institutional networks and placed more pressure on communities to meet needs. The Health Canada Consultative Committee on English-speaking Minority Communities has determined that nine regions are experiencing demographic distress within this context. Their report has documented

gaps in access to entitled services in several regions in the areas of primary care, general and specialized medical services, long-term care, youth protection, and rehabilitation programs. In addition, measures to promote access to English-language services have declined at a time when the system is undergoing major change.

English-speaking communities have been surveyed and determined that access to health and social services in English is a key priority.

CHSSN Role and Mandate

The CHSSN is a network of 48 organizations from across Quebec dedicated to supporting English-speaking communities in their efforts to improve access to services. One of our objectives is to foster projects and initiatives to promote access to English-language health and social services.

The CHSSN promotes knowledge-based community development as a means for communities to direct their future. We believe the population health approach we have presented reflects this orientation. It will guide our support for communities working to define needs, priorities and the actions required to promote community health and well-being.

Health Canada Consultative Committee

Health Canada Consultative Committee for English-speaking Minority Communities was created in 2000 to provide advice to the federal Minister of Health on ways to enhance the vitality of English-speaking communities in Quebec and to support their development.

In its recent report to the Minister, the Committee has recommended concerted government and community actions to improve access to the range of health and social services in English. The Committee believes that communities must have the capacity to mobilize resources, and the system must respond with sufficient resources and with service delivery approaches adapted to regional and community realities.[2]

Within its mandate, Health Canada has recognized it has a role to play in carrying out the federal government's commitment to actively support the development and vitality of Quebec's English-speaking communities.

Consequently, the Consultative Committee has an interest in being informed of population health initiatives being developed by English-speaking communities.

The Action Plan for Official Languages

Recently, the federal government released its action plan for official languages. Among other objectives, the plan aims to reinforce the commitment of the Government of Canada to support minority official language communities. One orientation is community development in which measures are defined to enhance communities' access to public services such as health.[3]

In this context, Health Canada is preparing to contribute to initiatives of both Quebec and English-speaking communities in the area of primary health care. Application of the population health approach to identifying community needs, priorities and actions will help English-speaking communities take full advantage of the commitment made in the federal Action Plan.

Quebec's Priorities in Primary Health Care

Quebec's Health and Social Services Plan 'Making the Right Choices', is a plan to renew the primary health care system. It presents an approach consistent with the goals of promoting population health. For example, it aims to offer first level health and social services, including

psychosocial intervention and rehabilitation, closer to the population. It also calls for an orientation towards prevention to reduce pressure on costly services.[4]

It will be important for community organizations to be familiar with the Quebec plan and develop project proposals consistent with its orientations. This will ensure that proposed population health initiatives will involve the partners of Quebec's health and social services system

Federal Initiatives and Quebec's Jurisdiction

In December 2002, Quebec adopted new legislation governing the application of federal spending initiatives in the province. The provisions affect any programs of Health Canada that touch on Quebec's jurisdiction in the area of health. In this regard, projects being considered for funding by Health Canada will go through a process of selection and approval involving representatives of Quebec's Ministry of Health and Social Services.[5]

In addition, public institutions or other public bodies such as regional health and social services boards that become partners in a federally funded community project will have to have authorization to do so.

Coordinating Community Action

The purpose of this presentation is to introduce community organizations to the population health approach to defining need, priorities and action to improve the health determinants affecting English-speaking communities.

Health Canada is a partner in this initiative in the context of its mandate to provide information on its funding programs and its commitment support the vitality of our communities, recognizing that the provincial government is primarily responsible for delivering health and social services within its jurisdiction.

The CHSSN invites community organizations to make full use of the resources contained in this presentation to develop projects to promote the health of English-speaking communities.

The CHSSN will act to coordinate access to resources persons who can assist groups in preparing projects.

The CHSSN will act to coordinate the presentation of project proposals to officials of Health Canada before the end of 2003, in order that projects can be considered for funding in 2004-2005.

Notes

[1] Institut de la statistique du Québec, *Enquête social et de santé 1998.*
[2] Health Canada Consultative Committee for English-Speaking Minority Communities, *Report to the federal Minister of Health,* July 2002.
[3] Government of Canada, Privy Council Office, *The Next Act: New Momentum for Canada's Linguistic Duality: The Action Plan for Official Language Communities,* 2003.
[4] Quebec, Ministère de la Santé et des Services sociaux, *Making the Right Choices,* 2002.
[5] *Loi sur le Conseil exécutif,* L.R.Q., C-60.