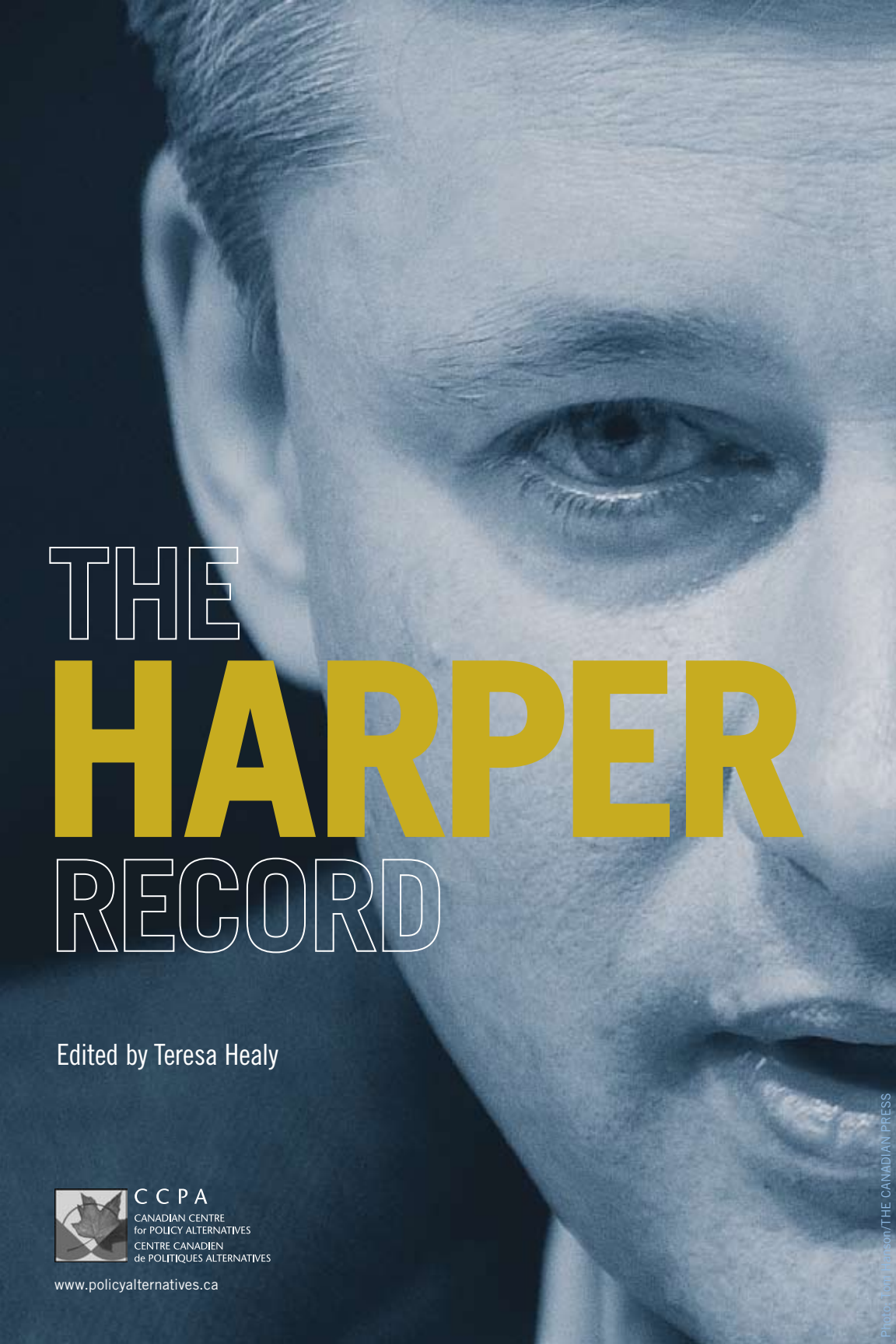

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Harper and Public Health Policy

John Hugh Edwards

IN THE FALL of 2007, almost two years after the Stephen Harper Conservatives came to power, I had the opportunity to sit with a group of public health advocates to discuss the direction of public health care policy in Canada. At the meeting, there was concern about how the Harper government appeared to be shaping a new agenda that centred on a move away from the systemic approach to population health toward a regime placing individual responsibility at the centre of health policy.

Meeting participants had two major concerns. First, people worried about the direct effects of health policy changes. Second, there were worries that the direction of the federal government in a broad range of policy areas, including economic and social development, would have a negative effect on the health of Canadians and their ability to cope with the circumstances affecting their lives.

By the fall of 2007, some of these changes were already clear. As early as August of 2006, in a speech to the Canadian Medical Association, Health Minister Tony Clement signalled the new government's approach by calling for a "get tough on drugs" policy. It appeared that the government was now leaning toward enforcement and incarceration as key elements of its policy on drug addiction.

In the same speech, Clement made it clear that the use of harm reduction programs as part of a range of initiatives, also including treatment, rehabilitation and community support, was no longer acceptable. The subsequent controversy over the federal government's efforts to close Vancouver's safe injection site for drug users showed just how serious this government is in its opposition to harm reduction policies and programs.

In September 2006, nurses in Ontario warned the Harper government about its cutbacks to federally funded programs, including research programs on the health of visible minorities; programs aimed at improving adult literacy and workplace skills; and support for voluntary based programs. Such cutbacks, the nurses warned, would have an adverse effect on the health of Canadians, particularly the poor and most vulnerable.

Since then, people across the country involved in community-based responses to population health issues felt a chill as it became clear that Harper and his government were moving away from a collective response to the root causes of ill-health toward a stance that suggested that health is the responsibility of the individual. And yet, since the 19th century, thousands of studies have shown that health is determined by a series of social and economic factors, including income and social status, social support networks, education and literacy, and working conditions. Simply put, people in more privileged social and economic positions are healthier and live longer than people in lower income classes. Thousands of hours of scholarly studies have been devoted to understanding how class and socioeconomic circumstance determine health outcomes.

These social determinants of health are at the core of most progressive thinking on improving the health of populations. The key is to seek to remove the conditions which serve to make people ill and to promote policies and practices which assist people to remain healthy. While it is clear the current federal government is not convinced of the efficacy of this approach, most progressive public health advocates would contend that the largest increase in improved health outcomes would be achieved by reducing poverty and social exclusion.

In my own work in Cape Breton, I have found that people with little or no formal training in population health have clear understandings of the ways in which poverty can impact health. In 2005, at the request of the Public Health Agency of Canada, I was involved in a community examination of the link between economic and social conditions and chronic disease on Cape Breton Island. The PHAC had found that three areas in Atlantic Canada — Labrador, Northern New Brunswick, and Cape Breton — had a high incidence of chronic disease.

According to recent data, Cape Breton had a very high occurrence of chronic disease, disability, and premature death. It had the highest age standardized mortality rate in the Maritime provinces and a death rate from circulatory disease and heart disease that was 30% higher than the national average. Of the 21 health regions in Atlantic Canada, Cape Breton had the highest death rates from cancer (25% higher than the national average), bronchitis, emphysema, and asthma (more than 50% above the national average). Cape Breton also had the highest rate of high blood pressure in Atlantic Canada, 72% above the national average.

Along with these alarming health outcomes, Cape Breton also records poor performance on a number of economic and social indicators. Over the last several decades, as the coal and steel industries declined and closed, Cape Breton, and specifically the Cape Breton Regional Municipality (CBRM), has experienced a pronounced economic decline. According to the analysis of the planning department of the Regional Municipality, economic indicators have continued to drop in the last inter-census period.

The average income for individuals 15 years and older living in the CBRM, in 2000, was $20,766, while the median income was $15,862. This compares with Nova Scotia's average personal income of $25,297 and median income of $18,735, in the same period. In 1995, the average individual income in the CBRM was $6,892 below the Canadian average. By 2000, the gap between the CBRM and the Canadian average had grown to $9,003. Based on the low-income cut-offs used by Statistics Canada and excluding people who reside in First Nations communities, 24.1% of people residing in the CBRM live in low-income households.

According to the planning department of the CBRM, this is the highest level of low income in any county in Nova Scotia.

Cape Breton clearly suffers from both poor health outcomes and dire economic circumstances. To determine how well the link between the two was understood, I decided to speak directly to two groups of people who had been identified as "at risk" in these communities.

First, with the help of a well-established community organization, focused discussions were organized with a group of young people in one of Cape Breton's poorest urban neighbourhoods. An interesting finding was that these young people, ranging in age from 12 to 17, had a holistic understanding of health and its many dimensions. Rather than speaking of health as simply an absence of illness, these young people spoke to me about the health of their body, mind and spirit. Not only that, but they linked the concepts.

One young man said that "if we don't feed our bodies well, we will not be able to do well in school, and if we don't do well in school, our self-esteem will be injured."

When we discussed the things in their lives that could make them ill, many of the young people mentioned the choices that have to be made by people who are economically disadvantaged. Several mentioned the choice between food and prescription drugs when the family income would not allow for the purchase of both. One young person told such a compelling story about the consequences of being forced to make this kind of choice that it was not difficult to believe that he had lived through the experience himself. He spoke of a family being forced to choose between buying heating oil and other family necessities.

"If you run out of oil, your house gets cold and that could make you sick", he said. "What is worse, if there is no heat in the house, the water pipes will freeze. With no water to wash, bathe, cook, and flush the toilet, your chances of illness increase even further. If your family can't afford a plumber to thaw the pipes, your father might try to do the job with a propane torch, which risks setting the house on fire."

In this young person's lucid narrative we see a descent into chaos, precipitated by choices made because a family had inadequate resources to meet their basic needs. Public policy responses to this bleak scenario would necessarily include the provision of adequate and affordable

housing and a decent living wage. But perhaps these options would constitute too much intervention in the economy and distortion of the market for the neoliberal mindset of our present policy-makers.

A similar description of a spiralling descent into chaos was given to me by a group of young women, several of them lone parents, who were engaged in an employment re-entry program in another neighbourhood in urban Cape Breton. One of these women spoke of her experience as a mother working in a minimum wage job. The family budget is so tight that any unexpected costs can throw the household economy into disarray. A child arriving home from school with a request from the teacher to purchase additional paper or pencils means little to a family with some economic security. But to these young women it can cause high stress. With no available margins, the only way to respond is to juggle other necessities.

Children are frustrated because every request is met with the same negative response, while many of their friends have no such problems. The next day, a doctor prescribes a medication that throws the family budget into further crisis. Just then, the oil truck arrives and the driver demands payment before delivery.

Through these discussions, I came to understand that not only is the link between social and economic circumstances and health firmly established in the clinical and learned literature, but that people who are experiencing the consequences of poverty and ill-health also understand and can often clearly articulate the links.

Healthy public policy

The social determinants of health are well understood. What is missing is an adequate policy response. This response needs to be focused in both the areas of concern identified by the public health advocates at the 2007 meeting. Direct support of programs which prevent disease and promote wellness are essential. Policies which support the kind of community-based programs run by AIDS/HIV organizations across the country should be central to our public health agenda. It is just as important to recognize that programs which alleviate poverty and improve inclusion are key components of healthy public policy.

Consider the taxable $100 per month child care benefit that is central to the present governments social policy. The "benefit" is an obvious move away from a systemic approach to providing quality, affordable child care to the more ideologically acceptable process of placing responsibility for providing care on the individual and the market. The $100 per month will not come close to providing quality child care. It will, in many cases, become part of a still inadequate household budget where it will often be spent on the most pressing need of the day.

The development of a truly affordable system of child care would allow many primary care-givers to play a more active and productive role in the economy, seek education and training to improve their economic lot, and provide their families with increased resources to meet their essential needs. One hundred and fifty years of study in public health confirm that such a policy initiative would positively affect the health outcomes of Canadian families.

The same can be said about a range of social and economic policy issues. Any adequate analysis of the impact of the Harper government on the health of Canadians will have to look beyond direct health policy and into the full spectrum of government action (or inaction) on the social and economic issues which determine health.