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Remarks to Canadian House of Commons Standing Committee on Health

TOPIC: Health Promotion and Disease Prevention

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We would like to thank the Committee for inviting us to speak today on the very important topic of health promotion and disease prevention.

First, a little bit about who we are. My name is Jane Moloney and I am the Chairperson of the Canadian Alliance of Community Health Centre Associations – CACHCA, for short. My colleague, Scott Wolfe, acts as CACHCA's Federal Coordinator, based in Toronto. CACHCA provides support to Community Health Centres and their provincially-based associations across Canada.

Currently, there are over 300 Community Health Centres across Canada, although they go by several different names from province to province. For instance, they include:

- Québec's CLSCs, such as the CLSC de Côte-des-Neiges, in Montréal, and the CLSC du Fjord in La Baie;
- Saskatchewan's co-operative community clinics, such as the Saskatoon Community Clinic and the Prince Albert Co-operative Health Centre; and
- Ontario's Community Health Centres and Aboriginal Health Access Centres, such as the Oshawa Community Health Centre and Wabano Centre for Aboriginal Health, in Ottawa.

Examples of Community Health Centres can now be found in all provinces and territories. However, only a small fraction of Canadians to date have been given access to this innovative healthcare solution by their federal, provincial and territorial governments.

We'll describe for you in a few moments the main characteristics of Community Health Centres and what unites them across the country. This is important because we know that it is the integration of these core characteristics at the level of frontline primary health care services that provides some of the greatest examples of success in preventing disease and improving health for Canadians, as well as in other countries. In fact, we have known this for decades^{i,ii}.

These innovations and successes in illness prevention and health promotion are especially true for individuals and communities facing complex health issues and barriers in accessing care and support. We believe that expanding the Community Health Centre model offers one of the best opportunities within our health system to improve health promotion, disease prevention and health outcomes across Canada.



The main objective of our association is to work for improved health and healthcare services for individuals and families in communities across the country. One of the main ways we do this is by helping governments and regional health authorities to expand access to Community Health Centres as a cost-effective and successful method for delivering primary health care and improving health outcomes.

In addition to being the current Chairperson of Canada's Community Health Centres Association, I am the Executive Director of one such centre – the North End Community Health Centre in Halifax, Nova Scotia.

In terms of grounding our recommendations to this Committee, we believe that any serious effort to reduce incidence of disease and to improve the health of Canadians must include a three-pronged approach. We see *all* of these three areas as essential. They are:

1) **Investment in social and environmental protections against illness and disease – what are termed the “social determinants of health”.** This includes government policy to:

- reduce poverty across Canada;
- ensure adequate housing and food security for all Canadians, and
- prevent the overwhelming impact of other forms of social inequity on Canadians' health.

Canada's own Chief Public Health Officer, Dr. David Butler-Jones, has clearly and unambiguously described the impact of social inequities on the health of Canadians. He states that:

“...there are Canadians in every corner of the country who continue to experience high rates of injury, chronic or infectious diseases and addictions. These individuals are at a higher risk of poor health and premature death. They are also more likely to need the health-care system for what are largely preventable health issues. Poor health also results in higher rates of absenteeism and lowers productivity in our workplaces...The evidence shows that people with better incomes, better education and better social supports enjoy better health than those with fewer social and economic opportunities.”ⁱⁱⁱ

Dr. Butler-Jones is not alone in his emphasis on the health and economic impacts of inequity. He is among the overwhelming consensus of health experts around the world, including the World Health Organization as a whole, who have identified improved country-level action on the social determinants of health as a top priority to improve health and ensure sustainability of high-quality health care systems.

2) **Improved inter-sectoral collaboration among governments and government agencies.** This would include legislation, structures and processes to ensure that government collaboration occurs across sectors and Ministries, with a view to ensuring that public policy and service planning are considered from the perspective of their potential impact on the health of Canadians. We cite the province of Quebec's health in all policies legislation and the Ontario Government's cabinet-level Poverty Reduction Strategy as two examples of action in this area.



- 3) **A shift in the planning and funding of our federal and provincial health systems to ensure equitable access for all Canadians to appropriate primary health care.** This must include increased and more equitable access to integrated, person-centred Community Health Centres. Community Health Centres provide high-quality, team-based care that is integrated with health promotion programs and community development initiatives. These services offer more than a “build it and they will come” approach to health and health care. They partner with the community to deliver locally-relevant services, programs and supports that address individual, family and community needs. Illness prevention and health promotion are intrinsic to this integrated Community Health Centre approach.

So, again, the three prongs of an effective health promotion and disease prevention approach for Canada would include:

- Investment in addressing the social determinants of health;
- Increased inter-sectoral collaboration; and
- Improving access to equitable and comprehensive primary health care through Community Health Centres.

We would be pleased to help ensure that members of the House of Commons Committee have access to Canadian and global reports providing irrefutable evidence of the importance of action on the social determinants of health. These include the *2008 Annual Report of Canada's Chief Public Health Officer*, and the World Health Organization's *2008 World Health Report* which calls for global commitment to addressing the social determinants of health at local and country levels.

Our association joins Canadians from coast to coast in emphasizing the urgency of action required from the Canadian government in heeding the recommendations contained within these key reports.

In this regard, we would like to remind this Committee that in October of this year, Ministers of Health, researchers, health organizations and civil society groups from around the world convened in Brazil for the *World Conference on Social Determinants of Health* and adopted key country-level and global commitments for action on the social determinants of health.

CACHCA was among the official delegates at this critical global meeting. We were inspired and encouraged by the extent to which there is growing global consensus on the need to increase country-level action on the social determinants of health around the world. We strongly urge this Committee and the Government of Canada to be part of the global community, and to support commitments emerging from the World Conference, using them as guides and indicators by which to plan and evaluate current and future Canadian public policy.

We would now like to dedicate the remainder of our time with you today to the third of the three areas for action that we described just a moment ago. This is the need for federal, provincial and territorial governments to increase equitable access to comprehensive primary health care across Canada through Community Health Centres. This is a key step to improving health promotion and disease prevention.



It is also where our association and our members can share unique insight into what it actually takes, at community level, to truly improve health and prevent illness and injury among Canadians and their families.

While healthy public policy is critical so that we ensure the fundamental *pre-conditions* for Canadians to achieve health, public policy alone is not enough. It is also essential to make sure that our specific health services are designed and coordinated to reach people and families where they are – close to where they live, and in ways that care for the *whole person* rather than only treating one's illness, disease or episodic needs.

This is why the level of the health system referred to as “primary health care” is so important. It is also why the ways in which primary health care services are organized and coordinated can make all the difference.

Community Health Centres bring health care providers like family physicians, nurses, dietitians, therapists and others together to work as a collaborative inter-professional team. This means that people receive comprehensive care from the right providers, and at the right time. Health professionals practice in a supportive, team environment where they are not isolated in making complex care decision.

But more than simply re-organizing these care services, Community Health Centres couple these team-based primary care services with group health promotion programs, social service supports and community programs that emphasize illness prevention, rather than simply treatment.

As a result of this integrated approach, various research studies have found that Community Health Centres provide effective and cost-effective care, achieving better overall outcomes than treatment-focused medical models^{iv,v}. These studies have linked superior performance by Community Health Centres to a number of factors, including:

- the impact of their inter-professional, collaborative care teams;
- their development of tailored programs to meet the local needs of the communities they serve;
- more appropriate and person-centred consultations; and
- superior quality of chronic disease prevention and management, including for diabetes, coronary artery disease, congestive heart failure and hypertension.

In one of the largest ever Canadian studies of primary care models, conducted across Ontario from 2008 to 2010, researchers found remarkable evidence pointing to the impact of this integrated, local Community Health Centre model of care.

On nearly every index measured, people currently under the care and support of Community Health Centres face greater barriers to health, including lower income levels, language and settlement barriers, and a higher number of co-morbid health conditions including chronic diseases, physical disabilities and mental health issues^{vi}. Yet, despite the sheer scale of these “patient complexities” – all of which would typically predict higher rates of health system utilization, such as hospital



emergency room admissions – people cared for by Community Health Centres had the lowest rates of emergency room admissions among all models of frontline primary care in the province^{vii}.

Furthermore, research from the United States, where there is a national network of over 1200 Community Health Centres, underscores the broader health system savings achieved through Community Health Centres.

In the U.S., robust system-level data have shown that Community Health Centres generate major cost savings to the overall health system by providing high-quality, preventive care to the “medically uninsured”, individuals who in addition to facing an insurance/access barrier also typically face other significant social barriers to health.

Statistics from the U.S. show that Community Health Centres save their health system \$1,263 per person annually compared to other primary care providers, such as fee-for-service medicine. Furthermore, local communities with a Community Health Centre have 25% fewer emergency department visits for ambulatory care sensitive conditions than those without a Community Health Centre^{viii}.

Although there are fewer Canadian research studies in this area than in the United States, existing Canadian research from the past four decades further substantiates the cost-effectiveness of Community Health Centres when considered from the overall health system perspective of preventing illness and disease progression, and reducing burdens on more costly health system resources^{ix,x}.

By reducing avoidable burdens on scarce hospital and other services within the health system, those health services become more readily available when they are needed. This means shorter wait-times and a stronger health system for the whole population.

This reform of health services is what Tommy Douglas spoke of in warning us, back in the early days of our Medicare system, that single-tier public health insurance was only the first step on a longer path to a strong health system and improving health outcomes. He urged us to move to a “second stage of Medicare”, placing emphasis on the need to better coordinate and integrate our actual health services, with a focus on keeping people well rather than simply patching people up when they are sick.

The critical health and economic impacts of Community Health Centres, demonstrating this “second stage of Medicare” in action, are among the many reasons why key federal and provincial reports in Canada, including the 1967 Castonguay-Nepveu Report, the 1972 Hastings Report, and the 2002 Report of the Royal Commission on the Future of Health Care in Canada, have consistently recommended expanding Community Health Centres as a solution to our most pressing health and health system challenges.

We also believe that the Community Health Centre solution is exactly the sort of innovation that Canadians are requesting when they indicate their overwhelming preference for governments to find practical solutions *within* Canada’s publicly-funded, publicly-administered health system.



We respectfully remind this Committee that the Canadian public's demand for publicly-funded and publicly-administered health services remains strong and is, in fact, growing.

Just two weeks ago, Nanos Research released the latest findings regarding Canadian attitudes toward health care; 94% of Canadians now state that they want publicly-funded and publicly-administered solutions to health care challenges as opposed to introducing more private, for-profit experimentation within our health system^{xi}.

In conclusion, and in terms of our specific emphasis today on the Community Health Centre solution for improved health promotion and illness prevention, we respectfully request that this Standing Committee adopt the long-standing recommendations found in four decades worth of reports advocating expansion of Community Health Centres across Canada.

Furthermore, we strongly recommend that the Committee encourage the Government of Canada to use its funding and policy levers, including negotiation of the forthcoming 2014 Health Accord, to strengthen public funding and administration of health services across Canada, including expedited implementation and expansion of the Community Health Centre solution throughout the provinces and territories.

These steps will ensure that efforts to better promote health and prevent illness in Canada are well entrenched within our health system, and reach all Canadians. Toward this goal, we remain at your disposal to assist in any way we can.

Thank you.

ⁱ Abelson J and Lomas J. (1990) "Do Health Service Organizations and Community Health Centres Have Higher Disease Prevention and Health Promotion Levels than Fee-for-Service Practices?" *Canadian Medical Association Journal*, 142, (6): 575-581.

ⁱⁱ Battista RN and Spitzer WO (1983). "Adult Cancer Prevention in Primary Care: Contrasts Among Primary Care Practice Settings in Quebec." *American Journal of Public Health*, 73, (9), September: 1040-1041.

ⁱⁱⁱ Butler-Jones, Dr David (2008). "A Few Words from Canada's Chief Public Health Officer". Introduction to *The Chief Public Health Officer's Report on the State of Public Health in Canada 2008*. Available at <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/cpho-aspc01-eng.php>

^{iv} Russell G, Dahrouge S, Tuna M, Hogg W, Geneau R, Gebremichael G (2010). Getting it all done. Organizational factors linked with comprehensive primary care. *Family Practice*. 27(5): 535-541.

^v Russell G, Dahrouge S, Hogg W, Geneau R, Muldoon L, Tuna M (2010). Managing Chronic Disease in Ontario Primary Care: The Impact of Organizational Factors. *Annals of Family Medicine*. 7(4):309-318.

^{vi} Rayner J (2011). *Complexity of Care and Panel-size Studies*. In: Acting Today, Shaping Tomorrow: An International Community Health Conference. June 9-10, 2011. Toronto: Association of Ontario Health Centres.

^{vii} Ibid

^{viii} National Association of Community Health Centres (2011). *Community Health Centres: The Local Prescription for Better Quality and Lower Costs*. NACHC: Washington, DC.

^{ix} Saskatchewan Health (1983). "Community Clinic Study." Policy Research and Management Services Branch.

^x Angus DE and Manga P (1990) "Co-op/Consumer Sponsored Health Delivery Effectiveness." The Canadian Co-operative Association. Ottawa.

^{xi} Canadian Health Coalition (2011). "Support for public health care soars: 94% of Canadians – including Conservatives – choose public over for-profit solution". News Release, November 24, 2011. Available online at <http://bit.ly/ul7INr>