BOARD REPORT

Friday, September 25, 2015

Medical Officer of Health

REPORT TO THE BOARD

Friday, September 25, 2015

Funding Health

The advance of both clinical and occupational medicine has contributed to the changing morbidity and mortality patterns at a population level over the past several decades. The ability to successfully diagnose and treat heart disease and cancer and prevent injury has helped to increase our population life expectancy and to change the types of diseases that we suffer and from which we will die. There is a continuing move to drive medical research even faster towards what is described as 'precision medicine'; the customization of healthcare tailored to the individual patient that offers a precise diagnosis and the exact cure for that particular individual. This direction is very expensive. Will it make a difference to our wellbeing? What should drive the priorities in looking at the wellbeing of a population, community or country?

The National Health Service (NHS) of the United Kingdom has studied 30 years of health care services being available as a right with no personal cost of care. They had expected the health gradient that was evident and aligned with the social gradient to disappear. However, that has not happened. In fact, people at every income level did better than those the level just below them. *The Report of the Working Group on Inequalities in Health*, [1] also known as the Black Report, identified that "Thirty years of the welfare state and the NHS have achieved little in reducing social inequity in health." They concluded that there was broad consensus the health differences are not driven by clinical care but by the social-structural factors that shape our lives.

In 2013, the National Research Council and Institute of Medicine of the United States published a similar report on the life expectancy and well-being in the U.S. It was called, *Shorter Lives, Poorer Health* [2] and offered the initial theory that lack of access to health care for the uninsured was the cause. The final conclusions in this report paint a different picture: "Even if health care plays some role, decades of research have documented that health is determined by far more than health care... In many ways the American health care system is the most advanced in the world, but whiz-bang technology just cannot fix what ails us."

Government investment in public health infrastructure and attention to the foundational drivers of poor health such as poverty and social isolation should be the major areas of discussion as we work towards achieving a healthier population.

[1] Black *Report: Inequalities in Health: Report of a research working group*; Department of Health and Social Security (DHSS), 1980, accessed at: http://www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/

[2] U.S. *Health in International Perspective: Shorter Lives, Poorer Health;* National Research Council and Institute of Medicine of the National Academies, 2013, accessed at: http://www.nap.edu/catalog/13497/us-health-in-international-perspective-shorter-lives-poorer-health

Hazel Lynn

Addendum to the Board Report:

Funding Announcement 2015

It appears the Ministry's new "equity" funding is not that equitable!

Rural Canadians are one of the sub populations examined in the summary report *Improving the Health of Canadians* as part of the Public Health Agency of Canada's "Canadian Population Health Initiative" and supported by the Canadian Institute for Health Information.

Looking at the health of rural people, the report states; "Generally, rural residents of Canada are less healthy than their urban counterparts. They have higher overall mortality rates and shorter life expectancies and are at elevated risk for death from injuries such as motor vehicle collisions and suicide. They are also disadvantaged for cardiovascular disease and diabetes."

I quote from comments by Dr Richard Schabas,

"One of our basic public health principles is that we target our efforts to address health inequities. We understand that we need to spend disproportionate resources on disadvantaged populations."

So, how does the Ministry's new "equity" funding formula measure up to health inequities?

As you have probably guessed... not well.

To further paraphrase Dr. Schabas... The only health measure considered in the Ministry equity analysis is "preventable mortality" expressed as deaths per 100,000 population per year.

Combined, the population of the eight health units receiving enhanced equity funding has a preventable mortality rate of 79. The overall provincial rate is 91. This while, the population of the 26 health units facing de facto cuts is 111.

Although not specifically acknowledged in the Ministry's funding announcement but easily identified by budget and population, the two biggest beneficiaries from the process (Peel and York) are the two healthiest parts of the province at 71 and 58 respectively.

It would appear that the choice of "equity" criteria and the weighting of those criteria are highly subjective and in this case disproportionally favour large urban-based organizations. A so-called 'equity' process that systematically doles money to the healthiest part of the province at the expense of the most disadvantaged and least healthy parts is inherently suspect.

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We work with the Grey Bruce community to protect and promote health.

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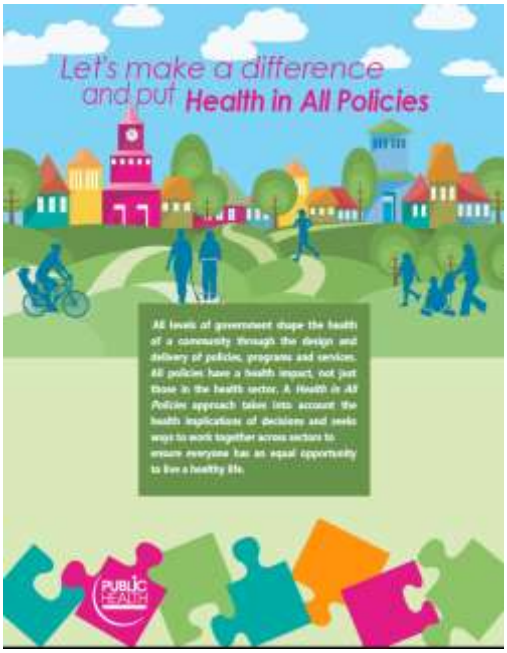
Health in All Policies Federal Election Campaign



All levels of government play a role in shaping the health of a community through the design and delivery of policies, programs and services. Intentional or not, all policies have a health impact.

As part of the 2015 federal election campaign, a mail-out was sent to all candidates in the local ridings with information on the *Health in All Policies* approach to decision making. The material asks candidates to recognize and take into account the health impacts of *ALL* decisions related to policies, programs and services. This strategy aims to:

- Support and advocate for a *Health in All Policies* approach at the federal level
- Seek opportunities to consider the health impacts of policies
- Collaborate with stakeholders to apply a health lens to policies and decisions and build healthy communities together

Feedback from Community Conversations assisted to identify six key priority areas highlighted within the election document:

Income and Employment Security
Environment and Climate Change
Healthy Housing
Healthy Food Systems
Healthy Transportation Networks
Access to Recreation

A cover letter and the election document were sent to candidates in early September. Public Health staff followed-up with each candidate to determine their level of understanding and support of *Health in All Policies*. An awareness strategy included presentations to staff and community partners and a media campaign using both traditional and social media platforms.

***91 Reasons Why 91% of Students Don't Smoke* Campaign**

In June 2015, the Grey Bruce Health Unit Youth Advisor visited Grade 8 classes at the Holy Family School in Hanover and Bruce Peninsula District School in Lion's Head presenting the *91 Reasons Why 91% of Students Don't Smoke* campaign. The goal is to prepare Grade 7/8 students for their transition into high school by letting them know that smoking and tobacco use are not the norm. This is a timely campaign, as these students entered high school this fall.

According to the 2011 Ontario Drug Use Survey, 91% of high school students do not smoke, hence the 91 Reasons; but the common perception holds there is a significantly greater amount of teen smokers. Before the campaign rolled out, the students were asked to participate in a scratch card survey to help understand their level of awareness of rates of tobacco use by teens. Only 4 out of 50 students knew that less than 10% of high school students smoke. One of the campaign objectives is to de-normalize tobacco use among youth and to address the common misconceptions about rates of tobacco use by teens. The survey findings also provide senior students with knowledge to act as positive role models and to set a smoke-free example for younger students.

The top three reasons students chose for being tobacco free were health (39), smoking is gross (25), and the appearance of smoking (16). Other factors that played a minor influence were positive role modelling, cost and the negative impact to animals and the environment.

A posting of student photos and their reasons for being smoke-free helped spread the message to all students in the schools.

***One Health Grey Bruce* at Public Health Inspectors National Conference**

The *One Health Grey Bruce* project was featured in a poster presentation at the Canadian Institute of Public Health Inspectors National Conference in Ottawa earlier this month.

The *One Health* concept considers the relationship between animal and human health. Many diseases affect both. An understanding of how disease can move between species - in food supplies, through vector spread and through other means, can greatly enhance health across the animal/human spectrum.

One Health Grey Bruce was launched in 2012 as part of a provincial pilot. The local project is unique in having the broadest membership base of *One Health* sites in Ontario. Representatives from local veterinary

and medical communities as well as wildlife, agricultural, food safety and Public Health meet regularly to share information and explore opportunities for common action.

Local activities and outcomes include:

- increased mutual understanding and appreciation of members' roles and responsibilities related to animal and human health
- improved information sharing and joint investigation processes related to communicable disease
- joint policy development related to rabies control

Community Conversations Grey Bruce

In 2014, the Grey Bruce Health Unit partnered with the Tamarack Institute for Community Engagement to launch the Community Conversations Grey Bruce. The project is part of a national campaign of conversations that explore the meaning of community, recognize community strengths and challenges and identify future hopes and priorities for shared action.

From June 2014 to April 2015, 47 community conversations were hosted with 407 participants, representing a wide range of sectors and ages. During the conversations, participants were asked to depict a vision of their community in 10 years through words and pictures. The responses reflected the shared hope for healthy, happy, safe and vibrant communities.

From the conversations, six themes were identified:

- **Local Economic Development:** Growth and prosperity, stable jobs, vibrant downtown
- **Affordable Housing:** Safe, accessible and affordable housing options for all
- **Enhanced Resources/Services:** coordinated services, community hubs, education and training, high-speed internet, public transportation
- **Youth Retention:** recreation, employment, sense of belonging, supporting youth to return "home" after education and training
- **Attracting Young Families:** Making our communities welcoming to young families, employment and recreation services
- **Increased Social & Leisure Opportunities**: activities for all ages, trails and parks, theatre and arts, festivals and celebrations, cultural opportunities

Six sessions were held to share highlights from the conversations with 100 participants attending. Additional presentations are planned for this fall including to municipal councils. Community Conversations Grey Bruce was featured in Tamarack's *Engage* magazine and highlighted at the *Neighbours: Policies and Programs* workshop in Hamilton, June 2015. The project will be showcased at the upcoming HCLink Conference in Toronto, November 2015.

Emergency Preparedness

The new *Public Health Emergency Preparedness Protocol, 2015* identifies the minimum expectations for programs and services under the Public Health Standards. The 2015 version supersedes the 2008 protocol.

The purpose, statuary basis and reference to the Standards sections remain unchanged, but there are a number of changes to the body of the document. Many of the changes address omissions in the 2008 document and in those cases we are already complying with the revised wording. There are a couple of new requirements that will affect our systems or documentation.

Several sections throughout the 2015 Protocol identify the need to engage and communicate with partners who have roles in our plan. In the past, we have collaborated at a level in excess of the previous minimum, and as such, are in compliance with the new Protocol. However, our Emergency Response Plan (ERP) will require a minor re-write to ensure these activities are captured as well as provide a means to determine if there is a need for additional action.

The new Protocol also introduces a requirement to identify high-risk populations relevant to specific hazards and assess the potential for disproportionate health impacts to these populations. This has been done in the past during exercises and following emergencies, but we need to add a formal process to our existing Hazard Identification and Risk Assessment (HIRA) document. These changes will be carried out before year end.