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Message from the Scientific Director

Two important IPPH activities are converging this fall. The first is completion of our report for the international review of CIHR. This is providing an exciting and informative retrospective on the work of the Institute over the last 10 years and will help guide future directions. The second involves contributions to a number of international meetings and symposia where some of Canada's best public and population health scientists are showcasing their work.

As is the case for all CIHR's Institutes, our report summarizes key outcomes and takes stock on our achievements, which in many cases have involved other partners. The IPPH report describes our role in public health renewal, our contributions to research on health disparities, and to building the field of population health intervention research. It reflects the tireless efforts of CIHR-funded researchers. I want to thank our talented and committed staff who have each made substantial contributions to the preparation of this report.

Our Institute Advisory Board members have also provided very helpful input on the evaluation report. I would also like to take this opportunity to acknowledge the substantial contributions of "retiring" IAB members. Kristan Aronson has chaired our IAB since 2009 bringing superb facilitation skills to this role. We are going to miss her many contributions as a board member over the past five years. We are very pleased to announce that Richard Massé has now taken over the helm as Chair and to also welcome Susan Kirkland to the role of Vice Chair. In August, we bid adieu to two IAB members. We want to thank Slim Haddad who provided particularly strong leadership in the realm of global health. Penny Hawe is also moving on, having made her mark on the Board in the domain of population health interventions and having served as co-Chair of the PHIRIC Planning Committee. We want to remind all who may be interested in serving on the board, that applications for this role can be submitted at any time.

Dr. Nancy Edwards
Scientific Director

Building on our participation in the June 2010 CPHA conference, the Institute continues to fuel critical discussions on population health interventions. In July, I spoke at the invitational AHRQ conference in Washington, D.C. presenting key findings from a position paper on scaling-up in public health. Erica Di Ruggiero ably represented IPPH at the International Union of Health Promotion Research Conference in Geneva, where she presented at a session also involving an IPPH-funded Chair and Centre. In a third important meeting, Erica and Jeannie Shoveller (incoming PHIRIC co-chair) joined Penny Hawe for discussions with CDC to share learnings from PHIRIC. This fall, I will participate in a workshop led by the Global Alliance for Chronic Disease in Beijing and present at both the European Union of Public Health Associations Conference in Amsterdam and the Global Health Systems Strengthening Conference in Montreux, Switzerland. Three of our Chairs will be featured at the EUPHA conference, where we are hosting a moderated workshop with a focus on population health intervention research. Each of these venues provides opportunities to showcase leading Canadian scientists and work related to foundational building blocks for population health interventions including population health ethics,

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Inside this Issue:

Invited Book Review
This is Public Health: A Canadian History

This is Public Health: A Canadian History

By Christopher Rutty, PhD, and Sue C. Sullivan

Canadian Public Health Association: 2010

Reviewed by Trevor Hancock, Public Health Consultant, BC Ministry of Healthy Living and Sport, Chair, Core Public Health Functions Steering Committee and Co-chair, Population Health Promotion Expert Group, Public Health Network of Canada

First, what a grand thing it is that the Canadian Public Health Association (CPHA) is 100 years old, and how important it is to be reminded by them of the history of public health in Canada. I know it is a stale aphorism, but those who do not know their history are doomed to repeat it, and history is often an important guide to – or forewarning of - the future. As a health futurist I firmly believe that all good futurists are also good historians, and there are important lessons for us here. So, kudos to the authors especially, and the many others who contributed to this book!

Before I get to the future, a bit about the book itself. It's an interactive e-book, which, as the website says, is "engaging, richly illustrated, suitable for a broad audience and available as a free download" – but the full text is only available in English for now, with plans underway for a French version. The interactive and downloadable nature makes it easy to recommend as a text for students. I have always believed that the history and philosophy of health and medicine should be a required introductory course for ALL health sciences/studies students, as it might engender some sense of proportion about clinical medicine's relative unimportance to population health, as Thomas McKeown so powerfully pointed out in "The Role of Medicine" back in 1979.

The book begins with an introductory section on health in the first few centuries of European settlement and a chapter summarising the health issues from Confederation in 1867 to 1910, when CPHA was founded. From there, it tells the story of public health decade by decade until 1986, where it stops with the Ottawa Charter for Health Promotion, although there is an epilogue by John Last which summarises key issues and events since then and looks to the future. (In the interest of full disclosure, I had some input to this section.)

One of the strengths of the book is that it is richly endowed with short profiles of important public health figures of the day, which gives us some insight into the challenges they faced and the dedication and passion – and long-term commitment – they brought to their work; it is inspiring stuff. It is thus a very personal history, although there is at the same time a lot of material about public health organisations, both governmental and non-governmental, and the challenges they faced. It is also, incidentally, a useful source of dates for upcoming centennials; the first public health nurses hired in Toronto in 1911, in Manitoba in 1916, in BC in 1917, the first full-time county health unit (Saanich, BC) in 1921 and so on – go find your favourite one.

Another of the book's strengths is the constant reference, in every decade of that history, to the appalling health problems faced by – and created for – Aboriginal people. The Introduction reminds us that European expansion across North America brought with it a host of diseases that "destroyed many indigenous lives". This process continued well into the 20th century; smallpox brought from California during the Gold Rush in the 1860s devastated BC's First Nations, as did the 'Spanish' 'flu in 1918/19, wiping out entire settlements among the Haida. In the 1930s the combination of poor living conditions and neglect meant the mortality rate for TB among the Aboriginal people of Saskatchewan was 20 times the national rate; by the 1940s, death rates from TB among Aboriginal people were "among the highest ever reported in a human population" – at a time when the national mortality rate for TB was rapidly declining. By 1986, when the story stops, it was still the case – and still is today – that the relatively poor health of Aboriginal people is a stain upon the nation.

In a review this short of a book this large, it is difficult

to do full justice to all that can be gleaned. But here are a couple of other points I noted which have application today:

- The leaders in public health in the 19th and early 20th century – arguably the high point of the history of public health – brilliantly combined solid research and the application of science with education, strong communication skills and a commitment, indeed a passion, for reform and fearless advocacy. We have seen that same combination of the development and use of good research with passionate advocacy be effective in the fight against tobacco, and we need it more than ever today if we are to fully address the broad determinants of health and reduce the unacceptable inequalities in health that still exist today.

- Our current concerns with the low status of public health are nothing new. In the late 1940s shortages of public health professionals were linked to the low pay of public health physicians compared to GPs or specialists, and to "a legacy of undervaluing public health work"; in 1959, an American Public Health Dean lamented in the Canadian Journal of Public Health (CJPH) that public health seemed to be 'losing ground' and 'falling into disrepute', while in 1966 John Hastings strongly criticised the Hall Report that laid the groundwork for Medicare for its lack of attention to preventive medicine, health promotion and community health programs. But he also "added that the field had to shoulder much of the responsibility for its poor showing" because of its timidity, its failure to live up to its predecessors, who were "crusading, dedicated, militant people".

I think that is still the case today, in spite of the best efforts of many of our leaders, whose commitment and passion is clear. But we have not made the case for public health forcefully enough. When I lecture to medical students, I tell them that public health is not only more important to the health of the population than clinical medicine, but it is in fact the most complex, challenging, sophisticated and difficult of all the specialties. This is because we not only have to know biology and medicine, but anthropology, sociology and other social sciences as well as engineering, urban planning, ecology and other natural sciences, in addition to epidemiology and health administration! But we don't act as if that were the case. Given the depth and breadth of population and public health, we should invest at least as much in research in these areas as we do in basic and applied clinical research, but our research budgets tell us that we are a long way from realising that objective.

We are, sadly, still a long way from realising the promise laid out in the CJPH in 1948 by Paul Martin Sr., then Minister of National Health and Welfare, that the new federal philosophy was that "social well-being is an essential and basic consideration of healthful living," and that "Canada is among those countries where public health is shifting its emphasis and broadening its outlook to embrace all that affects human life."

That, of course, is a pretty good definition of population health and human-centred development, and it rather neatly encapsulates the challenge we face as CPHA enters its second century, as do the challenges John Last lays out in the Epilogue:

A focus on maternal health, infant and early child development as part of a long-term investment in human development;

A focus on health and the built environment;

A focus on health equity . . . urgent attention must be given to correcting the iniquitous status of First Nations Canadians;

A focus on the ultimate determinant of human health, ecosystem health;

A focus on appropriate application of scientific discoveries and technical developments.

It is, I suspect, an agenda that our 'crusading, dedicated, militant' predecessors would have embraced.

"The leaders in public health in the 19th and early 20th century ... brilliantly combined solid research and the application of science with education, strong communication skills and a commitment, indeed a passion, for reform and fearless advocacy."

Applied Public Health Chair Feature: Dr. Benedikt Fischer

By Barry Shell

Dr. Benedikt Fischer
Applied Public Health Chair

"Of course public health would be well served if prohibition worked, but Fischer points out the realities: drug use exists and it's not going away."

Cannabis is the most widely used illegal substance, accounting for more arrests than any other drug. Studies show that in many settings, more Canadian teenagers smoke pot than cigarettes, yet unlike tobacco, marijuana is completely absent from any public health campaigns. Dr. Benedikt Fischer, based mainly as a Professor at Simon Fraser University's (SFU) Faculty of Health Sciences and as a Senior Scientist at the Centre for Addiction and Mental Health in Toronto, is tackling this problem with a public health approach. Fischer specializes in psychoactive substance use and public health.

"Forget about the criminalization of substance use. That's an anachronism. The main thing I'm trying to do is think about substance abuse as a health issue," says Fischer. He wants to take morality out of the question. "Forget about sin and losing control. Think of it like we think about nutrition or exercise," he says. "We don't fight diabetes with the police. We deal with it as a health problem, even though many diabetics got that way by making bad lifestyle choices, the same as most drug addicts."

Working with BC provincial health officer Perry Kendall, the Canadian Public Health Association and many others, Fischer is proposing a set of Lower Risk Cannabis Use Guidelines. Based on solid scientific evidence, they will be based on similar models of existing guidelines for tobacco or alcohol use. The focus will be on modifying behaviours to reduce health harms by suggesting changes in use patterns and practices, or by using safer implements.

While Fischer has focused primarily on illicit drugs such as cocaine, heroin and cannabis, increasingly he finds prescription drugs are also being misused. His paper published in the December 2009 *Canadian Medical Association Journal* commented on a substantial increase in number of deaths involving prescription opioids such as Oxycontin and Percocet in Ontario. Those deaths correspond with increased prescribing of these drugs by doctors. "People are getting these drugs from people in white coats," says Fischer. "It's a totally new challenge. These are legal products with a legal supply and legitimate patients, but you still have abuse issues." The solutions are even more complex than safe injection sites for heroin addicts. Pain care is an important and sensitive field. "You can't just outlaw Oxycontin," says Fischer. "You would do more harm than good. The challenge is to find the right balance in the interest of public health."

Yet for some reason Canada is a world leader in painkiller use, with five times the prescription rate per capita as the UK. Fischer thinks these high rates might have something to do with the entrepreneurial nature of Canadian doctors. "If a woman comes into your office in a lot of stress, with four kids, a husband who is out of work, and complains of pain, you can make that go away with a painkiller, but it's a lifestyle problem. You can spend time with her discussing lifestyle change, but writing a 'script is just easier," he says. "Sometimes I wish there was a billing code for avoiding writing a prescription, which actually would make a lot of sense," says Fischer.

Fischer's work attempts to defuse the often volatile relationship between public health and substance abuse. Vancouver's controversial but successful safe-injection site is a typical example. "Why do people generally assume that substance abuse is against public health?" asks Fischer. "They want abstinence and prohibition, but that is not realistic." Of course public health would be well served if prohibition worked, but Fischer points out the realities: drug use exists and it's not going away. And our current system of control and enforcement just doesn't work. Yet he cautions against placing a too heavy expectation on safe injection sites. At a minimum, there are 5,000 drug injectors in Vancouver who inject themselves with street drugs on average about four times a day. That's 20,000 injections per day. The safe injection site can accommodate about 250 per day. "That's just over one percent. Even if all those people change their behaviours, that still doesn't do much," says Fischer. Also, the sites focus on harm reduction and disease prevention. "By limits

of their design, they cannot eliminate the black market for drugs at hugely inflated prices that makes addicts rob cars and turn tricks in the street sex trade," says Fischer.

Is there a way out? According to Fischer it's all about facing up to facts. Bad public policies are often ignored with the burden always placed on users. But repressive laws that force helpless addicts into dark alleys where they are in danger are equally to blame. "The idea is to minimize the impacts of the bad behaviour of both addicts and policy makers," says Fischer, who testified before the Senate Committee on Legal and Constitutional Affairs regarding Bill C15 on minimum mandatory sentencing.

Most drug addicts have mental health issues and they are just self-medicating. Fischer believes that it is time society adopts a more sensible and evidence-based policy perspective for substance use which is guided primarily by public health and not law enforcement.

Barry Shell is a writer in the office of the Vice President, Research at SFU. This article first appeared in 'SFU Research Matters'. It is reproduced here with permission.

2010 IHSPR-IPPH Summer Institute—Primary Health Care

The Summer Institute is co-hosted by the Institute of Population and Public Health and the Institute of Health Services and Policy Research (IHSPR) and focuses on a different topic each year.

Primary health care is the backbone of our health care system. From infants, children and youth to adults and the elderly, most Canadians receive the bulk of their preventative and episodic care, chronic disease management, mental health care, post-hospitalization follow up, and rehabilitation from primary health care providers. Not only does high-quality, effective primary health care reduce overall health care system costs, but it also improves health outcomes, health equity, and the patient experience. But primary health care in Canada can also be inaccessible, fragmented, biased towards cure rather than prevention, and misaligned with patient, family. and community needs. More research and researchers are needed to address these pressing issues, and in this spirit thirty selected trainees and twelve academic researchers came together in Alliston, Ontario for the 9th annual CIHR IHSPR-IPPH Summer Institute: Revisiting the Foundations of Primary Health Care Research.

Chaired by Dr. Peter Norton, Professor Emeritus of Family Medicine at the University of Calgary, the Summer Institute featured a faculty of well-established primary health care researchers from across Canada and the United States. Through interactive presentations, discussions, fireside chats, and small group work, trainees explored key topics in primary health care ranging from participatory research with vulnerable populations to the secondary use of electronic health records for research.

As participants of a unique capacity-building event, trainees with experience and an interest in primary health care research had the rare opportunity to engage with leaders in the field about career and thesis advice and possibilities for future collaboration. Although the Summer Institute took place over just four days, it is hoped that the meaningful partnerships and connections forged will help to strengthen the primary health care research community in a lasting and fruitful way.

For more information about the 2010 CIHR IHSPR-IPPH Summer Institute, please contact Stephanie Soo, Senior Projects Officer, CIHR-IHSPR (stephanie.soo@utoronto.ca, 416-978-8402)

The Summer Institute is an intensive four-day training opportunity that brings together top graduate students, post-doctoral fellows, researchers, and decision makers from across Canada for a unique learning experience complementary to formal academic training.

Student Corner: Turning on the SWITCH

Kate Neufeld, B.Sc. (Hons), MD Candidate
University of Saskatchewan

Kate Neufeld
CIHR IPPH
2010 Summer Student

Many Canadians continue to experience health disparities despite various national, social and economic policies and Canada's universal health system. Low-income families, the elderly, recent immigrants, and many Aboriginal groups are among the most vulnerable (Hayward & Colman, 2003). A study conducted by the Saskatoon Health Region found shocking disparities in health outcomes between residents living within the city's lowest income neighbourhoods and the rest of the city (Lemstra & Neudorf, 2008). Today, unique student-run health clinics across Canada are doing what they can to help.

SWITCH
University of Saskatchewan

As a University of Saskatchewan student, I have had the wonderful opportunity to volunteer with the Student Wellness Initiative Toward Community Health (SWITCH). SWITCH is one of seven interdisciplinary, student-run health and education projects across Canada building health equity by targeting health and social needs of the most vulnerable populations. At SWITCH, university students work alongside health professionals, who act as mentors, to provide after-hour health care and public health services to Saskatoon's five core neighbourhoods. In addition to clinical services, SWITCH offers a wide range of other services including education through health promotion programming, children's health days, immunizations, social services and counselling, dental clinic, Reiki, and a fresh food store.

SWITCH aims to provide holistic care by focusing on the physical, emotional, social and spiritual aspects of each client. For example, an aboriginal cultural advisor is available on shift to interact and assist clients and volunteer staff. Through this work in the community, students gain a broader understanding of the social, cultural and physical determinants of health. This understanding plays a key role in adapting services to fit with the needs of communities.

Not only is SWITCH improving access to health services for underserved populations, it continues to teach students how to respond to the community's health and social needs. "SWITCH allows students to encounter the health and social concerns of people living in the downtown core of Saskatoon in a manner that they do not when working at the University Hospital," commented Dr. Bruce Reeder, SWITCH mentor and professor in the Department of Community Health and Epidemiology, College of Medicine, U of S. "They [students] must grapple with evident health inequities and try to understand their root causes. In doing so, students come to realize the need for not only high-quality interdisciplinary clinical care, but also long-term public health programs". As well, programs like SWITCH provide opportunities for public health research within health settings.

I have learned from SWITCH that building health equity starts by learning directly from those within the community about the unique and local challenges they face. Also, health interventions, such as those provided by SWITCH, are necessary to prevent widening health services access gaps. Turning on the "SWITCH" trains future health providers to face these realities.

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2. Lemstra, M. & Neudorf, C. (2008). *Heath Disparity in Saskatoon: Analysis to intervention Executive Summary*.

The NCCHPP and Public Health Ethics

By Christopher McDougall
Research Officer
NCCHPP

Ethics. Everyone believes they have them (and hopes their colleagues and neighbours act by them), but many find it difficult to say what they are exactly, where they come from, and when and how they can be used to guide our actions.[1] Ethics seem to be based on values, but which ones? Ethics are often expressed as principles that help guide us toward right decisions, but which principles are the most important, and how do we know that in any given situation?

Public health ethics. Public health is replete with moral issues and dilemmas. From health inequalities to needle-exchange to infectious disease control, and from water contamination to bio-banking to taxation schemes, public health practice, policy, and research requires ethical decision-making, frequently under circumstances of empirical uncertainty, and not infrequently in the face of significant material scarcity, social panic or political opposition.

Until recently, public health borrowed its ethics from medicine. However, with its distinctive focus on prevention and on communities, public health is now widely viewed as being in need of its own distinct ethics and principles. The result has been a surge of interest that has included the development of theoretical frameworks, empirical research agendas, and practical decision-making tools, in addition to (at least in the US if not yet in Canada) a professional code of ethics,[2] a model course curriculum,[3,4] and a web-based training course.

The National Collaborating Centre (NCC) for Healthy Public Policy, one of six NCCs, has begun to develop documents, training modules tailored to Canadian contexts and cases, and resource collections to support the integration of public health ethics tools into policy and practices across the country. These include the following documents:

Proceedings of a Workshop on Public Health Ethics in Practice: Impact and relevance of ethical frameworks on decision-making during the H1N1 pandemic.

Case Studies of Ethics During a Pandemic. A collection of pandemic and infectious disease control scenarios.

List of Public Health Ethics Researchers and Instructors across Canada: A preliminary inventory of individuals engaged in public health ethics-related research and teaching across the country.

In association with our colleagues within the Public Health Ethics Stream of the QPHRN, at the PHAC's Public Health Law and Ethics Program , and the CIHR-IPPH, the NCCHPP is aiming to further advance public health ethics across the country by engaging with researchers, educators, professional associations, and local and regional practitioners in order to:

- increase awareness of new and existing work in public health ethics;
- identify and help to connect interested individuals and organizations; and
- identify gaps in knowledge and relevant applied research.

All three of these aims will animate, for example, an NCCHPP workshop at the upcoming JASP, Public Health Ethics : A Tool for Deliberation and for the Development of Healthy Public Policies. Through historical overviews, case studies and group discussion, this full-day event (in Quebec City, November 24, 2010) will provide participants with a better understanding of how ethics can provide both the space and the language for a more thoughtful, democratic, and just process of public policy making.

"[W]ith its distinctive focus on prevention and on communities, public health is now widely viewed as being in need of its own distinct ethics and principles."

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2. *Principles of the Ethical Practice of Public Health*. (2002). New Orleans, LA: Public Health Leadership Society.

3. Jennings B, Kahn J, Mastroianni A. et al. Eds. (2003). *Ethics and public health*: *model curriculum*. Washington, DC: Association of Schools of Public Health.

4. US Association of Schools of Public Health Model Curriculum in Public Health Ethics.

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(continued from page 1) and knowledge translation for system change. They also provide critical networking opportunities with public and population health funders, scientists and decision-makers who are working globally.

In this newsletter, we invite you to read about some of the outstanding work being conducted by our research community. Behind these short snapshots are many successes and awards. For instance, Benedikt Fischer's book entitled *Drug Policy and the Public Good* won in the Public Health Category of this year's BMA Medical book award. This feature also kicks off our inaugural student corner which will become a standing section in future issues of POP News. In his book review, Trevor Hancock reminds us of the long standing contributions of public health on which we stand. Canada is leading the way in the realm of population health interventions. We are privileged to be among the forces that are actively changing this landscape.

Funding Opportunities

Please visit the IPPH website for a list of current funding opportunities being offered by the Institute

Featured Articles

Please let us know about your recent publications. We would like to profile some of these in future newsletters. Please email Emma Cohen, IPPH Knowledge Translation and Communications Officer. Thank you.

Kirkpatrick SI, McIntyre L, Potestio ML. (2010). Child Hunger and Long-term Adverse Consequences for Health. *Arch Pediatr Adolesc Med.* 164 (8):754-762.

Mohindra KS, Labonté R. (2010). A systematic review of population health interventions and Scheduled Tribes in India. *BMC Public Health*. 10:438.

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Stephen C, Daibes I. (2010). Defining features of the practice of global health research: an examination of 14 global health research teams. *Glob Health Action*. 9(3).