Health Policies and Trends for Selected Target Groups in Canada

An Overview Report for the Canadian Association of Occupational Therapists (CAOT)

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Contents

Tables

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1. Introduction

The purpose of this report, commissioned by the Canadian Association of Occupational Therapists (CAOT), is to provide an overview of key health and social development policy areas and to describe emerging trends affecting health policy. While this report addresses some issues directly related to occupational therapy, it mainly provides contextual information to enable the CAOT to identify opportunities and challenges facing the profession of occupational therapy in the next five to ten years.

The report highlights current health policies and key global and national trends on health issues that may have an impact on the following federal and provincial/territorial policy areas:

- Aboriginal Health

- Canadian Forces

- Veterans Affairs

- Obesity and Health

- Persons with Disabilities

The report attempts to identify patterns that may have implications for public policies that can further develop, support and sustain initiatives relevant to these populations. It is based on reviews of the pertinent literature and of key government websites, as well as telephone interviews.

Before outlining health and social policy developments affecting the target groups, we provide an overview of major global and national trends in health issues and health policy.

2. Context: Key Global and National Health and Health Policy Trends

The planning and delivery of health service in Canada is influenced by a wide range of broader trends. Decisions about and planning for public health, primary health care service, acute care, the management of chronic disease, palliative care, are continuous and ongoing and are influenced by a diverse set of forces some that extend well beyond the realm of health care per se.

Some of these trends are global, some are common to many countries, and a few are unique to Canada. What follows is by no means a comprehensive account of these global trends – it is in fact highly selective. It draws on efforts by health care policy experts to identify and describe some broad forces that will shape health care in Canada in the short, medium and long-term.

2.1 Pandemic Planning

From a truly global perspective one of the most compelling realities facing health care planning and delivery is the continuing reality that sooner or later we will be faced with an influenza pandemic, quite possibly of considerable size and impact, which will have a major impact on the health of people all over the world. From a strategic planning perspective what is perhaps more important is the ongoing efforts devoted to planning for, preventing, and as required, mitigating the eventual influenza pandemic. In Canada the legacy of the arrival of SARS on our shores demonstrated that infectious disease can spread quickly from one part of the world to another (Epstein et al., 2007).

Notwithstanding the increased public attention, as a percentage of total spending on health, funding for public health in general and pandemic planning in particular, remains very, very small.[1] Therefore, the most important impact of pandemic planning is not that it diverts resources away from other parts of the health care system. Rather, the greatest impact of pandemic planning may be the extent to which it reinforces our collective sense of vulnerability, the globalized nature of the threats to health, and the fact, despite necessary and critical ongoing efforts at disease prevention, some of us will inevitably experience illness and injury. In other words, pandemic planning underlines the fact that each of us is at some risk of disease and we therefore all have a stake in the health care system.

2.2 Immigration and Diversity

Another global trend that will shape health care in Canada is immigration. As should be well known, with some notable exceptions,[2] the birth rate in Canada is very low (10.75 births/1,000 population). The result is that population growth in Canada is increasingly the result of immigration.[3] This long term trend has a number of important implications for health care.

First, the labour force in general and the health care labour force in particular will increasingly be made up of people who were not born in Canada or whose parents are foreign born. To the extent that people migrate not so much to Canada as to three or four large Canadian cities (i.e., Vancouver and the lower mainland of B.C.; the Edmonton-Calgary corridor; the Greater Toronto Area; and, to a lesser extent, Montreal), this will serve to reinforce the challenges of matching

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[1]   The Public Health Agency of Canada (PHAC) spends approximately $100 million per year on disease-specific strategies including a possible influenza pandemic *(PHAC, 2005-2006 Performance Report)* and the 2006 federal budget announced $1 billion over five years to improve pandemic preparedness *(PHAC, Report on Plans and Priorities, 2006-2007)*. While these are large numbers and do not include provincial and territorial spending on pandemic planning, recall that Canada spent an estimated $148 billion on health services in 2006. See *Canadian Institute for Health Information, Health Care in Canada 2007*. 2007. Ottawa: CIHI.

[2]   While the birth rate overall is low, the birth rate among some Aboriginal peoples and some recent immigrants is comparatively higher. Specifically, the current Aboriginal birth rate is about 1.5 times the overall Canadian rate (Statistics Canada, "Canada's Aboriginal Population in 2017," *The Daily*, June 28, 2007) although this masks variation between different Aboriginal groups. For immigrants, "studies have shown that immigrants have higher fertility rates compared with Canadian-born women, but those rates decline to Canadian levels with the second-generation" (Statistics Canada, "Births," *The Daily*, July 31, 2006).

[3]   According to Statistics Canada, "Net international migration continues to be the main engine of population growth in Canada, accounting for about two-thirds of the annual increase in 2005/2006." Statistics Canada, "Canada's Population," *The Daily*, September 27, 2006.

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supply and demand in the labour force in general and the health care labour force in particular. This may mean, for example, a reinforcing of the trend whereby Canadians in rural areas must travel to (if not relocate) to larger centres to receive health care (the promise of telehealth notwithstanding) (Nagarajan, 2004).

Second, immigration and the linked challenges of credential recognition and the ethical dilemmas associated with the migration[4] will be a critical part of how we address the continuing shortages of health care professionals. Finally, health care is a labour intensive exercise – it is about people serving people. As the Canadian people become more diverse, the health care workplace will also become more diverse. Necessarily, many of the broader societal debates about integration and respect for cultural and religious differences[5] manifest themselves in the delivery of health care (Spector, 2004).

2.3 Ageing and Consumerism

Canadians are getting older. The average age of Canadians is rising; the number of seniors is growing, and on average Canadians are living longer. However, ageing itself is changing. That is to say that the experience of elderly Canadians of today is increasingly different from that of elderly Canadians that came before. Increasingly, Canadians over the age of 65 are more likely to be working (at least part-time), more likely to travel and, most importantly perhaps, more likely to be in relative good health. While elderly people do make more demands on the health care system, patterns of care are changing (Hogan and Hogan, 2002). The baby boomers are not going to age like their parents and grandparents (Chen and Millar, 2000). They will live longer, be in better health, consume more over-the-counter and prescription drugs (and less hospital-based care), and do so in comparatively large numbers. However, because they will die later, baby boomers will bring to the health care system lengthier experiences of chronic disease that will require careful management. In other words, just as the baby boom generation reshaped popular culture and the world of work, they will exert a powerful influence on how we understand ageing. The sheer size of the baby boom generation will also mean that their approach to ageing, how they redefine what it means to be "old" will be very influential for a long time (Ricard, 1992).

Equally important, the baby boomers bring with them an increasingly strong consumer orientation to health care. To the extent that the boomers will continue to define our culture, including our health care culture, this consumer orientation will have a powerful effect on how we frame health care. As the Ontario Medical Association (OMA) Discussion paper put it, this

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[4]   In the face of world-wide shortages, highly trained health professionals are increasingly able to migrate which can and does create shortages in "source" countries. The highest profile Canadian example is perhaps physicians from South Africa. For an introduction to the challenges associated with international migration of health care professionals, see Tom McIntosh, Renée Torgerson and Nathan Klassen. 2007. *The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada.* CPRN Research Report H|11. Ottawa: Canadian Policy Research Networks.

[5]   The challenges associated with balancing integration and respect for cultural and religious differences are canvassed in a recent discussion document release by the Quebec Consultation Commission on Accommodation Practices Related to Cultural Differences led by Charles Taylor and Gérard Bouchard. See, *Accommodation and Differences. Seeking Common Ground: Quebecers Speak Out, Consultation Document.* Quebec: Gouvernement du Québec, 2007).

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consumer orientation means that "We are individualistic in our decision making. We demand greater timeliness, quality and choice. We are open-minded about alternative approaches to health care …We bring our individual culture to the clinic and seek to integrate that culture with science-based health and wellness management" (OMA, 2006).

In effect, a large group of relatively healthy and relatively wealthy health care consumers with a less deferential attitude to health care providers is almost certainly to have a profound impact on the delivery of health care services over the next 25 years or so.

2.4   New Biology, Advances in Genetics, and the Prospect of Individualized Health Care

In a recent speech to the Canadian Club, the President of the Canadian Institutes of Health Research (CIHR) argued that biology today has become the most exciting and fast-moving of all the sciences. As Bernstein put it, "Insights from biology are leading to new therapies, new diagnostics, [and] individualized medicine, including the identification of at-risk individuals" (Bernstein, 2007: 3). This theme is echoed in the OMA Discussion paper which suggests that how we define a "patient" is changing, "in part because illnesses we used to start thinking about at age 50 are now predictable as early as birth" (OMA, 2006).

One of the many effects of this shift in our understanding of illness and of patients is that we increasingly have the ability to tailor treatments to individuals based on very specific information about the nature of what ails them. Medicine and indeed health care is likely to become individualized. As the OMA Discussion paper put it: "Even if the promise of modern genetics is only partly realized, each of us will be able to identify our risks from the womb, and will face decisions about when and how to intervene from our earliest days" (OMA, 2006: 17).

Trends towards individualized medicine will be accentuated by two other phenomena – advances in pharmacogenomics and continuing innovations in information and communications technologies (ICTs). In the case of pharmaceuticals, our current model is based on the production of large amounts of the same drug or class of drugs to treat large groups of patients who are classified as having the same disease. This matching of large-scale drug therapy with large-scale groups of patients also makes it easier for the government to offset the costs of drugs if only because the cost of drug treatment can be reasonably predicted and the benefits are spread widely across the population. However, in the future we will speak less of "patients" who have "cancer" and require "chemotherapy" and much more about "Sayeed" or "Brooke" who has a cancer that requires many pages to describe for which a very specific drug therapy can be devised, albeit with the benefit accruing largely to them alone.

In the case of ICTs, Dr. Bernstein describes a not-too-distant future where we can link our bodies, our electronic health records, our clinics and our hospitals to "smart" homes that can monitor our heart rates, whether we've had a fall, and our blood sugar (Bernstein, 2007: 4).

It is very likely that there will be pressure to individualize and tailor many other aspects of health care delivery, including and perhaps especially "hands on" care. This trend will be amplified and reinforced if and when health care is increasingly understood as a consumer commodity. Hence,

Dr. Bernstein speaks of a "heightened sensitivity of our personal responsibility for our own bodies" that will dramatically change both human health and our health system (Bernstein, 2007).

2.5 Climate Change – Selected Direct and Indirect Effects

It is now all but certain that our climate is changing and the change is the result of choices made by human beings individually and especially collectively. The manifestations of climate change extend well beyond so-called "global warming." While it is true that some parts of the planet and of Canada will be warmer and in some cases drier (southern Alberta, Saskatchewan, Manitoba) what will be perhaps more remarkable will be the increasing variability and intensity of the climate across Canada. We are facing a pattern of increasingly violent storms, dramatic shifts in snowfall and rainfall, increased flooding in some places, extended drought in others.

Climate change will have both direct and indirect effects on human health. As indicated in the table below, the direct effects are various. For example, climate change will lead to increased temperature-related illness and the extreme weather events. This in turn will lead to increased demand for primary care and assistance in managing chronic disease such as asthma. In those places where the climate will be hotter and drier there will be less cloud cover which brings increased cancer risk. In those places where climate change results in higher levels of smog, we are faced with increased incidence of lung-related disease. However, the health care system will also have to deal with the secondary effects of climate change. For example, prairie agriculture, at least in the most southern parts of the prairies, is facing massive change as a result of decreased moisture and more intense weather. Farmers and their families face the prospect of having to take risks with new and different crops; increased risk of crop failure; and continuing pressure to sell to their larger and sometimes corporate neighbours. Larger farms mean fewer people living in rural areas. The net result is a continuing decline in the rural population, a decline in the numbers of rural health professionals while, at least during the transition, rural areas are facing an increased incidence of mental illness and an ageing population (Pickett et al., 2000). Continuing shortages of health professionals will mean continuing if not increasing pressure to deliver health care in innovative ways with a resulting shift in who does what among health professionals. The collapse of the cod fishery off Newfoundland and the decline in the salmon fishery in British Columbia resulted in similar patterns of rural depopulation and pressure to both consolidate and innovate when it comes to the delivery of health services (Davenport et al., 2005).

Table 1. Health and Climate Changes

Selected Health Concerns	Examples of Health Vulnerabilities	Selected Impacts on the Health System (increases in demand)
Temperature-related morbidity and mortality	• Cold and heat related illnesses • Respiratory and cardiovascular illnesses	• Primary care • Chronic disease management
Health effects of extreme weather events	• Injuries and illnesses • Social and mental health stress due to disasters	• Acute care • Rehabilitation
Stratospheric ozone depletion and increased exposure to UV radiation	• Skin damage and skin cancer • Cataracts • Disturbed immune function	• Cataract surgery; possible increase in cataract-related vision loss
Health and Socio-Economic Impacts on Community Health and Well-being	• Changed determinants of health and well-being • Vulnerability of community economies	• Mental health services
Source: Adapted from Health Canada (2001).		

In summary, it is possible that the health effects of climate change will be felt most acutely in rural and remote Canada. However, because these are precisely the areas that are facing the largest challenge recruiting and retaining health professionals, it is plausible to suggest that climate change will be an indirect impetus for even more and extensive regionalization, service consolidation and primary health care reform.

We turn now to the discussion of Canadian health policies in the following areas: Aboriginal Health; Canadian Forces; Veterans Affairs; Obesity and Health; and Persons with Disabilities.

3. Aboriginal Health Policy

3.1 Health Gap

Despite recent improvements in the life expectancy and infant mortality rates of Aboriginal people in Canada, there remains great disparity between Aboriginals and non-Aboriginals in overall health status and the ability to access health care services (HCC, 2007). The health gap is particularly wide on rates of injury, suicide, infectious diseases, heart disease and diabetes (Health Canada, 2003).

The federal government has focused on improving availability and access to health care and providing health programs and services for First Nations on-reserve and Inuit communities. Better access to primary health care services alone will not close the health gap because there are also important cultural, socio-economic determinants of health. Aboriginal people experience lower quality housing, poorer physical environment, lower educational levels, fewer employment opportunities, and weaker community infrastructure, which contribute to their lower health status. Culturally relevant health care programming and Aboriginal holistic healing traditions that address the whole person are important in achieving health and well-being for Aboriginal people and communities (Health Canada, 2003).

3.2 Mandates

Aboriginal peoples, including First Nations, Inuit and Métis, receive the majority of their health care services from the provinces/territories. The federal government contributes funding through the Canada Health Transfer. The federal government also provides some services directly to First Nations and Inuit, through the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The federal government supports the cost of extended health benefits under the Non-Insured Health Benefits Program (NIHB) for Status Indians including off-reserve. Métis and Non-Status people are ineligible for this program.

Through self-government negotiations, transfer agreements, land claim agreements and other mechanisms, the majority of First Nations governments and some Inuit organizations now control the delivery of a variety of health services and programs. Métis and other Aboriginal organizations also deliver a limited number of health programs and services (First Ministers and Leaders of National Aboriginal Organizations, 2005).

Federal/Provincial/Regional jurisdictional debates continue to be a major barrier to service provision to First Nations and other Aboriginal people. Little acknowledgement is given to the barrier those boundaries impose to individuals moving between reserve and urban life (Smye and Mussell, 2001).

3.3 First Nations Transfers (Federal)

In 1979, a *Federal Indian Health Policy* was announced that recognized the need for community development, a strong relationship between Indian people, the federal government, and the Canadian health system. This shifted the policy focus and started the trend towards increased involvement of First Nations and Inuit communities in the delivery of health services (Health Canada, 2003). In the mid-1980s, the Medical Services Branch of the Department of National Health and Welfare started to work towards transferring control of health services to First Nations and Inuit communities and organizations.

In 1989, a Tribal Council in Quebec signed the first Health Services Transfer Agreement whereby control of community-based health programs south of the 60th parallel is transferred to Aboriginal communities. Many Tribal Councils have since followed suit. However, findings from the 2005 National Evaluation of the Health Transfer Policy show that First Nations organizations that transferred in the early 1990s now have access to fewer resources on a per capita basis than those that transferred more recently (Lavoie et al., 2007).

3.4 Territorial Transfers (Federal)

The territories have all signed Final Transfer Agreements which devolved responsibility for Universal Health Programs to the territory governments. The Northwest Territories signed in 1988, Yukon in 1997, and Nunavut in1999, a condition when it was created (Health Canada, 2003). Although the transfer agreements stated that First Nations and Inuit communities in the territories would continue to have access to any new federal programs, this has not always been the case. Health Canada's policy regarding funding of health programs to First Nations in the territories includes a provision that new programs which duplicate areas of responsibility already transferred to the territorial governments should not be funded, to prevent "double dipping." However, First Nations in Yukon, for example, assert that they do not receive comparable funding from the Yukon Government for the delivery of programs and services otherwise meant to be provided through federal enhancements (Lemchuk-Favel, 2007).

3.5 Changing Government Policy

Under the past Liberal minority government, the policy environment on Aboriginal Health emphasized collaboration between the federal, provincial/territorial governments, and the leaders of Aboriginal organizations to eliminate the disparity between Aboriginal and non-Aboriginal Canadians' health.

The First Ministers and Aboriginal leaders met in 2004 to address the need for an action plan and specific measures to close the gap between the health status of Aboriginal peoples and the Canadian public (CICS, 2004). The creation of the Aboriginal Health Transition Fund was agreed upon at this meeting, a $200 million investment over 5 years to improve availability, responsiveness, integration and quality of health programs and services to Aboriginal people (HCC, 2007). It was also determined that the Federal, Provincial/Territorial Ministers responsible for health and Aboriginal affairs were to work in partnership with Aboriginal leaders to develop a blueprint for action, with specific roles and responsibilities, and to report back within one year (CICS, 2004).

Over $2 million was invested on the development of this blueprint, presented in the report entitled, *Blueprint on Aboriginal Health: A 10-year transformative plan*, which was tabled at the First Ministers' Meeting on Aboriginal Issues in Kelowna, BC in November 2005 (AFN, 2007). This *Blueprint* was to serve as a framework for collaborative action. Its goals were to guide the attainment of the same level of health and health care services for Aboriginal peoples as other Canadians experience, and to increase the number of Aboriginal health care practitioners (HCC, 2007). After this meeting, the Liberal government announced what is commonly referred to as the "Kelowna Accord" with more than $5 billion to be invested over the next 5 years to close the gap between Aboriginal people and other Canadians in education, health, housing and economic opportunities (Privy Council Office, 2005).

The Conservatives won the federal election in January 2006 and the new minority government issued a statement that they supported the objectives, targets and principles of the Kelowna communiqué but would not commit to the $5 billion previously promised (CICS, 2004). The previous federal government had committed to using the *Blueprint* as a framework in creating Aboriginal health programs but no funding has been committed thus far. The federal government has not been clear on what their plans are regarding Aboriginal health programs. Without further discussion and clarification to settle the funding arrangements for implementing the *Blueprint*, the provinces and territories cannot move forward with the plans committed to in Kelowna (HCC, 2007).

3.6 Priority Areas, Programs and Services

3.6.1 Aboriginal Persons with Disabilities

It is estimated that 31% of Aboriginal people have a disability. Depending on the source, definition of disability, and variables used, Aboriginal rates of disability are between 2 to 3 times that of the Canadian population (HRSDC, 2006). Aboriginal women elders have one of the highest rates of disabilities of all groups in the country (MacDougall, 2006).

Indian and Northern Affairs Canada (INAC) supports disability initiatives through the Western Economic Diversification Program. The Program funds individual projects that benefit people with disabilities by enhancing economic well-being through activities that assist entrepreneurial growth, improve quality of life through research and development, increase access to community facilities, and enhance the capacity of organizations that serve the disability community. For example, the Program has provided funding to the First Nations Disability Association of Manitoba to enhance its capacity to provide peer support, advocacy and referral services designed to improve the quality of life for Aboriginal persons living with disabilities in Winnipeg (HRSDC, 2006).

Human Resources and Social Development Canada (HRSDC), through its Aboriginal Affairs Directorate (AAD) is responsible for the policy and program design of Aboriginal labour market programming. This includes the Aboriginal Human Resources Development Strategy (AHRDS), which helps strengthen the ability of Aboriginal people to compete in the Canadian job market. It includes a disability component. HRSDC encourages other partners and organizations to include people with disabilities in all services and activities. The Aboriginal Skills Employment

Partnership (ASEP) provides Aboriginal people with jobs in major economic development ventures in the mining, oil and gas, construction, forestry, and hydroelectric industry (HRSDC, 2007).

However, there is no home department for Aboriginal disability issues in the federal or provincial governments. Because no one is clearly responsible for Aboriginal persons with disabilities, the programs and services are uneven and sometimes non existent across and within provinces (MacDougall, 2006).

3.6.2 Home Care

The First Nations and Inuit Home and Community Care (FNIHCC) program was launched by Health Canada in 1999. The program provides various health-related home care services such as case management, nursing care, in-home respite care and personal care. However, there are indications that the services are not always those that respond to the needs of the community. Areas that continue to have gaps in suitable services are palliative care, rehabilitative care, respite care and mental health services (AFN, 2005).

3.6.3 Residential Schools

The federal government of Canada was involved in administering residential schools from 1874 to 1996 (Indian and Northern Affairs Canada, 2004). Children were systematically removed from their parents' care to be educated in residential school, a policy which the Government of Canada has admitted was intended to "remove Aboriginal people from their homelands, suppress Aboriginal nations and their governments, undermine Aboriginal cultures, [and] stifle Aboriginal identity" (Chandler et al., 2003: 39). Many former students have come forth with cases of sexual and physical abuse. The residential school system has left a tragic legacy for many former students, and their communities. They continue to struggle with the many issues that have resulted, such as family violence, and alcohol and drug abuse (Indian and Northern Affairs Canada, 2004).

The Aboriginal Healing Foundation (AHF) is an Aboriginally-run, non-profit corporation that administers federal funding to community-based initiatives across Canada to help those affected by the legacy of physical abuse and sexual abuse experienced in residential school. These healing initiatives address issues such as cycles of physical and sexual abuse, family violence, drug and alcohol abuse, and parenting skills. They provide support for survivors and their descendents in the healing process through counselling and traditional ceremonies.

3.6.4 Alcohol and Substance Abuse

The National Native Alcohol and Drug Abuse Program (NNADAP) is a Health Canada program largely controlled by First Nations communities and organizations. NNADAP was created because of the "urgent and visible nature of alcohol and drug abuse among First Nations people and Inuit." NNADAP provides over 550 prevention programs with over 700 workers - almost all employed by First Nations and Inuit communities. Program activities vary, based on the size and needs of each community and the availability of skilled workers, but they generally fall into three key areas: 1) Prevention activities, aimed at preventing serious alcohol and other drug abuse

problems; 2) Intervention activities, aimed at dealing with existing abuse problems at the earliest possible stage; 3) Aftercare activities, aimed at preventing alcohol and drug abuse problems from reoccurring (FNIHB, 2006).

3.6.5 Suicide Prevention

The Aboriginal suicide rate is two to three times higher than the non-Aboriginal rate for Canada, and for youth the Aboriginal suicide rate is estimated to be five to six times higher than that of non-Aboriginal Canadian youth (FNIHB, 2005). The Advisory Group on Suicide Prevention was an independent panel appointed by the federal Minister of Health and the National Chief of the Assembly of First Nations in 2001. The result of their analysis was the *Acting on What We Know: Preventing Youth Suicide in First Nations* report. The Suicide Prevention Training Programs, at the Centre for Suicide Prevention, work with Aboriginal communities to provide support and training in suicide prevention and bereavement. Their training and workshops take place all across Canada, and include Aboriginal youth suicide prevention training for youth educators, applied suicide intervention skills training, and counselling the bereaved (Centre for Suicide Prevention, 2007).

3.6.6 Unintentional and Intentional Injuries

Injuries are the leading cause of disability and death among First Nations people and Inuit aged 44 and under (FNIHB, 2007). Twenty-six percent of all deaths among First Nations people are caused by injuries, compared to six percent of deaths in the Canadian population. In both the First Nations and total Canadian populations, mortality rates from injury are far higher among men than women. As is the case for the Canadian population in general, unintentional injury death rates in First Nations have fallen substantially over time, however this is not the case for intentional injuries such as suicide and violence.

Health Canada works with First Nations and Inuit organizations and communities to develop activities and programs to prevent injuries. Injury prevention education is taught at the Aboriginal Head Start program and the Brighter Futures program to help First Nation and Inuit children understand the importance of injury prevention from an early age (FNIHB, 2007).

3.7 Gaps and Opportunities

A sizeable gap remains between the health of Aboriginal peoples and the rest of Canadians with regard to health status and the availability and access to health care services. An important factor in access to health care services for Aboriginal peoples is the supply and distribution of health care providers (Romanow, 2002).

There are disproportionately few Aboriginal health care workers in Canada compared to the percentage of Aboriginal peoples in the Canadian population. There have been efforts to increase the number of Aboriginal health care providers through funding, training, and partnerships. In Saskatchewan a quarter of all nursing bursaries are awarded to Aboriginal students (Government of Saskatchewan, 2006), and the government of British Columbia recently announced $500,000 to recruit Aboriginal youth into nursing programs and increase the number

of nurses in Aboriginal communities in BC (Government of British Columbia, 2007). The Aboriginal Nurses Association of Canada (ANAC) conducts research, supports training, and spreads awareness, among other things, to increase Aboriginal control and access to culturally appropriate health services. The Aboriginal Nutrition Network (ANN) encourages Aboriginal peoples to pursue a career in nutrition and supports dieticians working in Aboriginal communities.

There have also been initiatives to expand training for non-Aboriginal health care providers so that they have the cultural awareness to work in Aboriginal communities and address their specific needs. For example, the Eskasoni Health Centre in Cape Breton has brought Dalhousie University physicians into Mi'kmaq communities to deliver services, and has reported positive results from the training and experience (Romanow, 2002).

These are examples of efforts by health care professionals to help close the gap in health status and service provision for Aboriginal peoples. Health care professional associations that form partnerships to promote, recruit and train health care practitioners have an important role in helping to increase the number of Aboriginal and non-Aboriginal health care providers in Aboriginal communities and working with urban Aboriginal populations.

4. Canadian Forces and Access to Health Care[6]

4.1 The CFHS

The delivery of health care services to military personnel falls under the auspices of the Canadian Forces Health Services (CFHS) (National Defence, 2007). The CFHS delivers medical and dental services to military installations both at home in Canada and overseas, and is comprised of the Medical and Dental branches that provide a continuum of health care services. Unlike provincial and territorial partners who are constrained by geographical boundaries, the CFHS exists to support the men and women of the Canadian Forces (CF) whenever and wherever they serve.

4.2 Constitutional and Legislative Framework

The Constitution Act of 1867 assigns sole responsibility for all military matters, including military health care, to the Federal government. The 1984 *Canada Health Act* excludes CF members from the definition of 'insured persons' under the *Act*. CF members are also excluded from insurance coverage under the Public Service Health Care and Dental Care Plans. However, through the CFHS, CF members receive the same care and publicly funded benefits and services that Canadians receive under their provincial health care plans. The Canadian Forces Spectrum of Care document describes health benefits and services for CF members and defines a standard of health care.

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[6]   This section is based on and contains excerpts from the National Defence website and provides an overview and summary of relevant existing programs, services and funding models relevant to how enlisted personnel access medical care. See in particular the Force Health Protection website at www.forces.gc.ca/health/news_pubs/ hs_factsheets/engraph/sheet-06_e.asp?Lev1=4&Lev2=9&Lev3=7.

4.3 Scope and Delivery of Health Care

The CFHS provides health care and services to 83 000 Regular and Reserve Forces personnel both at home ("in-garrison") and on deployment. In Canada, CF members receive non-emergency, outpatient medical and dental care at base clinics, health care centres and support units at 77 military installations across Canada. Staff at CF clinics provides health care services similar to those found in community clinics – diagnosing and treating non-life threatening illnesses and injuries, performing minor surgical procedures, and promoting wellness. Most clinics will have a primary care service, basic laboratory and diagnostic imaging capabilities, an out-patient pharmacy, an optical services section, and a physiotherapy service. Some of the larger clinics will incorporate a number of specialty services such as, mental health, internal medicine, cardiology, and dermatology. Usually secondary, tertiary and quaternary care, as well as after-hours primary care, is provided in civilian health care facilities.

Health services are provided overseas when and where CF personnel are deployed through a variety of arrangements ranging from locally purchased services to partnerships with other military health Clinic staff also functions as the "company doctors" for the Canadian Forces. In this role they perform a unique occupational health and safety function that ensures military personnel have no medical limitation that would preclude them from carrying out their military task at peak performance."

The closure of military hospitals throughout the 1980s and 1990s, coupled with a significant reduction in military medical personnel, has resulted in the CF becoming increasingly reliant on the civilian health care sector, both for the provision of medical services to CF members and as sites for CFHS military personnel to maintain their clinical skills.

4.4 Unique Challenges

In addition to the expertise required to run primary health care clinics across CF bases and stations, the CFHS must also function in the challenging and distinctly different Maritime, Aerospace and Field environments. This requires a multi-disciplinary team approach and extensive specialty operational training. The CFHS is currently implementing a health care reform process to develop a patient-oriented health service that better meets the needs of CF members (National Defence, 2007).

4.5 The Health Care Team

The Health Care team includes traditional health care professionals (clinical specialists, physicians, dentists, nurses, pharmacists, physiotherapists, health care administrators, and various technicians), and other health care providers unique to the military, namely Physician Assistants and Medical Technicians.

4.6 Force Health Protection

Force Health Protection (FHP) is a large prevention and health promotion initiative within the Canadian Forces Health Services (CFHS) designed to protect Canadian Forces (CF) members from preventable illnesses and unnecessary casualties – in garrison and on deployment – while helping them achieve and maintain a healthy lifestyle.

FHP has a staff of 35 dedicated civilian and military health professionals, including medical and health promotion specialists, industrial hygienists, public health physicians and nurses, senior preventive medicine technicians and epidemiologists generating people-oriented, proactive preventive programs which provide tangible benefits for CF personnel. FHP encompasses four functional areas: Health Promotion, Occupational and Environmental Health, Communicable Disease Control, and Epidemiology.

4.7 Health Promotion

Strengthening the Forces (STF) is the national health promotion program managed by the CFHS. It delivers military-specific programs such as helping personnel to cope with deployment stress, as well as general health programs including weight wellness and smoking cessation. A new and revitalized STF program was launched at CF bases in November, 2002 in association with the CF Personnel Support Agency. Using the World Health Organization's definition of health promotion, the program encourages members to make informed health choices in four main areas:

- Social Wellness, including suicide prevention, stress management and anger management, family violence prevention, healthy families and spiritual health;

- Addiction Free, including drug and alcohol, smoking, gambling and other addictions;

- Nutritional Wellness, including nutrition, healthy weight and heart health; and

- Active Living and Injury Prevention.

STF program's other objectives include injury prevention research, base safety, special nutrition needs and chronic disease risk reduction.

4.8 Occupational and Environmental Health

This section establishes policies and programs to protect CF members from occupational and environmental health hazards. This includes the application of national workplace health standards and the establishment of a capability to identify, quantify and conduct risk assessments for occupational and environmental health hazards on deployed operations. Deployable Health Hazard Assessment Teams (DHHAT) provide commanders with quantitative health risk assessments and risk mitigation advice. This capability was deployed to Afghanistan in early 2002. DHHAT also provides the data necessary for CFHS staff to objectively address potential future exposure-related health concerns and to alleviate unnecessary worry among deployed members.

4.9 Training and Professional Development

Because of the relatively modest size of the Canadian Forces Health Services (CFHS), it is impractical to conduct certain levels or specialized areas of medical and dental training within CFHS resources. For this reason, a significant volume of activity is out-sourced to educational establishments throughout the country. All CF physicians, dentists, nurses, physiotherapists, pharmacists, social workers, and bio scientists are graduates of accredited schools in Canada. In other cases, focused education such as, paramedic and health care administration programs are achieved through contracted delivery of curricula coordinated through CFHS training establishments. Where requirements of this nature have a uniquely military component, advantage is taken of the facilities of other nations' military health care services, particularly the United States, where both an operational dimension to the training is imparted, and inter-operability with allies in the medical and dental domains is enhanced.

With the closure of Canadian Forces Hospitals, it is no longer possible to expose CFHS clinical personnel to a broad enough spectrum of patient-care challenges in military settings alone. In order for them to remain prepared for the uncertain demands of operational deployments and to maintain and enhance their skill sets in support of in-garrison care and deployed care, many are now placed in civilian health care settings. Throughout Canada a significant number of military clinicians have become integral members of health service agencies, including hospitals, through an exclusive Maintenance of Clinical Skills Program (MCSP). This program hones professional skills through every-day practice and makes a valued contribution to community health care while at the same time, provides an experienced cadre from which to draw when the exigencies of operations demand it. Some Physician Assistants and Medical Technicians are placed in regional trauma facilities or ambulance services, consistent with their equivalency qualifications, in order to rigorously exercise their skills and advance their expertise. Additionally, other Health Service Technicians, such as Medical Laboratory, Operating Room and X-Ray are placed in civilian facilities in their respective fields of practice.

4.10 Gaps and Challenges

According to a health expert at the Canadian Department of Defence Hospital in Ottawa, the main challenge facing the Canadian Military currently is centered on the needs of causalities returning from deployment in Afghanistan. The need for appropriate and cost-effective services to aid in the re-integration of these persons into the Canadian health care system may increase in scope depending on the numbers of causalities.[7] In an interview, Major Robert Crispo, Physiotherapy Branch Advisor, expressed the view that it would financially strain the current CF health delivery model should we see a substantive increase in the numbers of injured personnel returning to Canada in need of rehabilitative services. It is conceivable that a shift from the current third-party contract system to one where more Occupational Therapists (OT) are staffed on-site would be considered in light of a convincing economic case.

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[7] From a phone interview with Physiotherapy Branch Advisor Major Robert Crispo on October 3, 2007.

In another interview, Elaine Somers, Acting Program Manager for the CF Case Management Program, indicated that the services of Occupational Therapists would be most advantageous in reintegrating military personnel back into productive work in the Forces after deployment (according to Somers, roughly 60,000 enlisted are in uniform and 5,000 are deployed).[8]

4.10.1 Rx2000 Project

In 2000, the Primary Care Renewal Initiative (PCRI) established the Rx2000 program as a means to address the issues stemming from inconsistencies in health care service delivery in the Canadian Forces. Many initiatives stemming from this program have been the drivers for change in policies, management structures and frameworks of accountability within the CFHS.

The Rx2000 Project is built upon four distinct, integrated and equally important pillars or streams:

- Continuity of Care;

- Accountability Framework;

- Health Protection; and

- Sustainability of CF Health Services Human Resources.

Each pillar addresses a number of the 359 recommendations arising from seven military reports that commented on the state of health care in the CF.

Rx2000 employs an integrated approach to its reform process – bringing together health care resources under one command or administration, developing an interdisciplinary approach to health care delivery and building partnerships with the civilian health care sector. [By 2004] the *Rx2000* Project has addressed over half of the 359 recommendations from the various reports.

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[8]   From a phone interview with Elaine Somers, Acting Program Manager, CF Case Management Program on October 9, 2007.

Table 2. 359 Recommendations

Rx2000 4 Pillars			
Continuity of Care	**Accountability Framework**	**Health Protection**	**Sustainability of CFHS HR**
Case Manager Primary Care Renewal Initiative Standing Committee on Operational Medicine Review Pre Hospital Care Third Party Contract Material Management Mental Health Physiotherapy	Accreditation – Continuous quality Improvement Command and Control Health Policy Performance Management Modern Management Review	Force Health Protection	Health Services Reserves Human Resources Capability Enhancement Civilian – Military Cooperation
<u>Source</u>: Adapted from National Defence's website, www.forces.gc.ca. Accessed December 2007.			

5. Veterans Affairs

This section is excerpted and adapted from the Veterans Affairs Canada website.

5.1 Recent Federal Policy Initiatives

5.1.1 Veterans Charter

The Canadian Forces Members and Veterans Re-establishment and Compensation Act, known as the New Veterans Charter was launched in April 2006 and is a comprehensive wellness package for CF members, Veterans and their families (VAC, 2006). The programs of the New Veterans Charter include rehabilitation, disability awards, health benefits, financial benefits, and job placement assistance.

5.1.2 Veterans Bill of Rights

The Veterans Bill of Rights is a comprehensive declaration of rights for all war-service Veterans, Veterans and serving members of the Canadian Forces (Regular and Reserve), members of the Royal Canadian Mounted Police, spouses, common-law partners, survivors and primary caregivers, other eligible dependants and family members, and other eligible clients. It sets out the rights of Veterans and clients in accessing Veterans Affairs' programs and services (VAC, 2007).

5.1.3 Veterans Ombudsman

It was announced in April, 2007 that a Veterans Ombudsman position would be created as an impartial, arms-length and independent officer responsible for advancing Veterans issues. A Veterans Ombudsman will uphold the Veterans Bill of Rights, and review individual and systemic issues related to the Bill of Rights. An Ombudsman is an effective means of maintaining transparency and accountability, and will play an important role in raising awareness of the needs and concerns of the Veterans.

5.2 Policy Priorities

The Policy Planning and Liaison Division of Veterans Affairs Canada (VAC) provides policy advice and coordinates services between the Department and the Minister's Office, central agencies and other federal departments. The policy priorities are structured around two strategic objectives: Integrity of programs and service improvement; and organizational effectiveness. Under the first strategic objective, the policy priorities are to improve and expand services for Canadian Forces Veterans and still-serving members, to partner to serve the RCMP and eligible civilians, to transform service delivery, and to promote innovation and strength capacity in policies and practices.

5.3 Health Services for Veterans

Veterans Affairs Canada (VAC) provides a range of programs and services to more than 150,000 aging Canadian veterans and members of the Canadian Forces. The Health Care Program is designed to enhance the quality of life of VAC clients, promote independence, and assist in keeping clients at home and in their own communities by providing a continuum of care. VAC provides treatment and other health-related benefits, long-term care in its one remaining departmental facility, as well as community or contract facilities to veterans and other eligible persons (e.g. through regular public hospitals and referrals to registered medical service providers that bill directly to VAC).

Veterans' health needs are handled by a team composed of a client service team manager, an area counselor, a district nursing officer, a medical officer, a district office occupational therapist that advises on the report submitted by the private therapist, and finally a client service agent. All these members review the case and make appropriate recommendations. Across the country there are 32 district offices. In most cases, services of occupational therapists are available (primarily through contractual arrangements).[9] There is also the Veterans Independence Program (VIP), which is a national home care program.

Eligible veterans and other qualified clients are entitled to health care benefits under the *Veterans Health Care Regulations*. These benefits include medical, surgical and dental care, prosthetic devices, home adaptations, supplementary benefits such as travel costs for examinations or treatment and other community health care services and benefits. Under the Health Benefits Programs of Choice, occupational therapy services are covered, although requiring a referral from a physician.

Disability pensioners are provided with treatment benefits, such as prescription drugs directly related to their pensioned conditions. Treatment benefits may also be provided to clients for non-pensioned conditions when these are not covered by a provincial health plan and the VAC client is receiving services under the Veterans Independence Program, or when the veteran or eligible civilian is within the income limits defined by the War Veterans Allowance Act.

5.4 Client-Centred Service Approach

VAC's Client Services have shifted from a program-centred to a Client-Centred Service Approach (CCSA). Under CCSA:

- the individual needs of the client are identified and then it is determined how best to provide assistance, through internal or a coordination of departmental and community resources;

- a partnership exists between the client and the Department as demonstrated through direct client involvement in all aspects of their case planning decisions;

- staff work with the client to meet all their needs, not just to determine their eligibility for Departmental services and benefits; and

- delivery of services with or without VAC benefits is legitimized.

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[9] From a phone call with Marjorie Hackett, Regional Occupational Therapy Coordinator, Veterans Affairs on October 17, 2007.

The Research Directorate at VAC develops, procures and transfers applied health research and information in support of evidence-based decision making.

5.5 Assistive Devices

Assistive devices are products designed to help people with health issues to live independently. They include wheelchairs, canes, grab bars, slip-resistant flooring or mats, as well as aids to help persons dress, prepare food or live safely within their home.

Veterans Affairs Canada offers financial assistance to eligible clients who need to purchase assistive devices. Access to these benefits depends on a person's eligibility status and their specific health needs.

5.6 Mental Health – Operational Stress Injury

An Operational Stress Injury (OSI) is any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian military, such as anxiety disorders, depression and Post-Traumatic Stress Disorder (PTSD) as well as less severe conditions that interfere with daily functioning.

PTSD is a psychological response that can happen when a person experiences one or more intense traumatic events - particularly ones that threaten life or that of someone else. Symptoms can include: distressing memories, images, nightmares or flashbacks of the event(s); gaps in memory; feelings of being cut-off or detached from loved ones; less control over impulses; problems concentrating; sleep disturbances; and/or anger and irritability.

To help veterans and still-serving CF clients who may be suffering from PTSD, VAC has published a booklet, *Post-Traumatic Stress Disorder (PTSD) and War-Related Stress* that describes common symptoms of PTSD, offers practical advice on how to cope with it, and discusses treatment options. Third location decompression is a strategy used by the CF to ease the reintegration of military personnel from deployment overseas to life at home. For example, for the current operations in Afghanistan military personnel returning to Canada spend around 5 days in Cyprus taking part in at least two of the five mental injury sessions offered (Standing Committee on Veterans Affairs, 2007: 4).

The Operational Stress Injury Social Support (OSISS) Program provides confidential peer support and social support to CF personnel, Veterans, and their families, affected by an operational stress injury like anxiety, depression, or PTSD resulting from military service.

5.7 Gaps and Challenges

In the departmental review in February 2007, the Standing Committee on Veterans Affairs found that the advancing age of veterans of the Second World War and the Korean War presents a new challenge for health services. As the needs of these ageing veterans evolve, the health services provided by VAC require concurrent updating.

While many new positions have been created for occupational therapists at the regional level, there are none at the national level, and furthermore, they tend to get relegated to a minor role, that of equipment specialist.[10] There is currently a missed opportunity to involve occupational therapists more widely and productively in the area of chronic pain management, and better reintegration into society after deployment. With the growing numbers of younger veterans needing a gamut of services to aid in the reintegration process, medical services that encompass a wide scope of practice would be advantageous for a number of reasons. The challenges are centered on how to better utilize the expertise of occupational therapists for veterans of all ages, how to enable these professionals to have a more prominent role in Veterans Affairs as health care providers with permanent employee status, and how to position them to hold more sway in health care policy at Veterans Affairs.

Another challenge for VAC is how to deal most effectively with the increasing number of Canadian Forces veterans with Post Traumatic Stress Disorder (PTSD) and other operational stress related injuries. Although programs are in place to address these issues, such as the third location decompression and OSISS programs mentioned above, cases may still go undetected and untreated. The challenge is how to reach and help individuals dealing with PTSD who are not yet clients of VAC or who are not seeking treatment or disability benefits.

6. Obesity Health Policy

6.1 A Growing Health Problem

Of troubling concern to the public and health professionals alike is the increasing rate of obesity in the general Canadian population. For the past twenty years the rate of obesity and overweight in Canada has been steadily increasing to what health professionals now refer to as an epidemic, and for the first time in over a century, Canada's children may be the first generation who can expect worse health than their parents. According to the June 2007 Conference Board Report *How Canada Performs, A Report Card on Canada* people who are overweight or obese constitute 57.5% of the general population (Conference Board of Canada, 2007: 8).

In 2004, approximately 6.8 million Canadian adults between 20 and 64 were overweight, and an additional 4.5 million were obese. Roughly speaking an adult male is considered overweight when his body weight exceeds the maximum desirable weight for his height, and obese when his body weight is 20% or more over this desirable weight. A similar guideline holds true for women, but a threshold of 25% rather than 20% (Starky, 2005: 1).

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[10] From a phone call with Marjorie Hackett, Regional Occupational Therapy Coordinator, Veterans Affairs on October 17, 2007.

6.2 Obesity and Other Health Risks

According to the World Health Organization (WHO) the "impact of the obesity epidemic on non-communicable diseases such as cardiovascular disease, type 2 diabetes, and cancer threatens to overwhelm health systems; the need for prevention and control is clear" (Raine, 2004: v). Obesity and overweight pose a major risk for serious diet-related diseases, with serious consequences to health that range from chronic conditions that reduce overall quality of life to increased risk of premature death. Given available evidence, the economic implications of obesity on the Canadian health system could be considerable. Obesity poses morbidity and quality of life issues akin to those associated with smoking, poverty, and problem drinking (CIHR, 2003: 5).

The health problems that stem from obesity of course go far beyond the ones we usually hear about, like diabetes and heart disease. Obesity can also affect a person's joints, breathing, sleep, mood, and energy levels, thus it has a negative impact on a person's entire quality of life.

Obese individuals have to strain more to do simple things. Sporting activities are often avoided, which excludes them from many social activities. Most cannot buy clothes easily of their size and find difficulty getting in and out of cars, into the seats in buses or cinema theatres. Flexibility gets reduced. The toes become progressively out of reach and personal hygiene can become a problem. Physical activity of any sort can be quite difficult due to shortness of breath and easy fatigue, so that even housework or continuous employment is a challenge.

There are several abnormalities in pulmonary function in obese individuals. There is a fairly uniform decrease in expiratory reserve volume and a tendency to reduced lung capacity, which makes the individual gasping on few steps.

6.3 Health Promotion Policies

Health Canada and the Public Health Agency of Canada develop ongoing national policies and programs that encourage healthy eating, physical activity and healthy weights. They include:

- *Canada's* Food Guide to Healthy Eating, Canada's Physical Activity Guide to Active Living, and a combination of the two, Canada's Guide to Healthy Eating and Physical Activity;[11]

- new nutrition labelling regulations, combined with education on their use, to allow Canadians to compare products more easily, assess the energy value of and nutritional value of more foods and better manage special diets;

- the establishment of six National Collaborating Centres to focus on knowledge translation in six priority areas of public health that include the determinants of health, public policy and Aboriginal Health;

- support for the annual **WinterActive** and **SummerActive** initiatives, which encourage Canadians to get involved in community-based healthy living activities across Canada; and

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[11] Health Canada has recently revised the *Food Guide to Healthy Eating*, which was released in 2006. It has also published the first-ever version tailored to the needs of First Nations, Inuit and Métis.

- a new website, www.healthycanadians.gc.ca, which provides Canadians with a one-stop shop for healthy living information.

The federal government is providing $5 million to help fund the renewal of **ParticipACTION**. This funding will support a renewed national public awareness campaign to encourage Canadians to maintain an active lifestyle.

As of January 1, 2007, parents have been able to claim a **Children's Fitness Tax Credit** of up to $500 of eligible expenses from sport and physical activity programs for each child under the age of 16, promoting physical fitness, including sport, among children.

The **Pan-Canadian Healthy Living Strategy (PCHLS)** provides a forum for multiple partners to work collaboratively in addressing common risk factors, with an emphasis on physical activity and the importance of a healthy diet. It is through this forum that the Federal/Provincial/ Territorial (FPT) Ministers of Health and Health Promotion set targets for physical activity, healthy eating and healthy weights. Collaboration on physical activity policy and programs also take place through the **FPT forum on Sport, Physical Activity and Recreation.** Similarly, the **FPT Group on Nutrition** offers a mechanism for collaboration on healthy eating policies and programs. The federal government, through **the Knowledge Development and Exchange** component of the federal Healthy Living and Chronic Disease Initiative, invests in FPT initiatives, including $875,000 in the Physical Activity and Sport Benchmarks/Monitoring Program.

The **Canadian Best Practices Portal** is a centralized access point for the exchange of evidence of effectiveness for best practices related to chronic disease prevention and the promotion of healthy lifestyle practices.

6.4 Community-Based Programming and Community Capacity Building

According to the Government Response to the Seventh Report of the Standing Committee on Health (Government of Canada, 2007) the evidence on policy applications favours integrated and community-level interventions for a variety of health-related issues. This multi-faceted, community-based approach has proven more successful than independent, unlinked initiatives. Among these community-based programs are:

The **Maternal Child Health Program** which ensures that a home visit to First Nations families on reserves during pregnancy, infancy, and early childhood. The home visits provide support, information and linkages to other services.

The **Aboriginal Head Start Program** (AHS) promotes the health and well-being of children through a comprehensive program that encompasses health promotion, nutrition, parental involvement, Aboriginal culture and language, social support, and education.

The **Community Action Program for Children** (CAPC) provides funding for organizations working with children up to the age of six who may be at risk for social, health and developmental problems.

The **Canada Prenatal Nutrition Program** aims to improve the health of infants and mothers both by supporting healthy diets in pregnancy, breastfeeding support and education and counselling on health and lifestyle issues. Healthy weight gain during pregnancy and breastfeeding are known to protect against obesity for mother and child later in life.

The **Aboriginal Diabetes Initiative** funds obesity prevention projects for children that include healthy school policies that place emphasis on healthy snacks, and children's camps that focus on preventing obesity through education on healthy lifestyles.

All these programs endeavour to reduce health inequities by addressing the *determinants of health*, which Health Canada identifies as the twelve following: income and social status, employment, education, social environments, physical environments, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowment, gender and culture.

6.4.1 Funding Strategies

The Healthy Living and Chronic Disease initiative supports other community-based programs. The **Healthy Living Fund is** a fund designed to support organizations at the national level, through the **Physical Activity and Healthy Eating Contribution Program,** and in the regions through agreements with the provinces and territories. The regional stream of the Fund will be administered in collaboration with provincial and territorial partners, who will jointly determine priorities and co-fund the organizations.

The **Canadian Diabetes Strategy** targets populations at high risk of developing diabetes, and aims to prevent complications among those with diabetes.
Building Canada, a $33 billion infrastructure plan announced in Budget 2007 aimed at providing long-term, predictable and reliable funding to help provinces, territories and municipalities meet their infrastructure needs, includes funding to support sports infrastructure and active transportation projects such as bike and rollerblading paths. Municipalities also continue to benefit from the 100 per cent GST rebate which they can apply to any infrastructure project, including those promoting a healthy lifestyle.

The federal government has a long track record of intervening in public health issues such as smoking and injury prevention. In light of what we know about the effects of obesity on the short and long-term health of individuals, public expectations will only likely build in anticipation of the government's actions surrounding the problem of obesity.

6.5 Obesity in Canada: Identifying Policy Priorities

Developing policies to prevent obesity requires the ability to identify existing gaps in the research as well as identifying policy priorities. Listed below are key priorities for policy-relevant research identified in a report on a roundtable intended to promote cross-sectoral linkages among stakeholders on the issue of obesity (CIHR, 2003). The following are salient issues highlighted by experts from the roundtable that would enable policy-makers to stem the tide of obesity.

- Evidence and surveillance: Concern was raised on the state of evidence on obesity in Canada, specifically over the quality and quantity of population-level data.

- School health: It was agreed that the school setting can be used as a community's prime location for health promotion. After-school programs could be more conducive to health promotion, education, health, justice and sports. A school health program could be developed modeled on a program developed by the Council of Ministers of Education Canada (CMEC) called the Pan-Canadian Curriculum. Participants suggested that Health Canada work with the CMEC to develop a similar program.

- Urban design and transportation: More research is needed to better understand the relationship between urban design, transportation, obesity, and obesity prevention. It was noted that more studies are needed to link obesity to housing, mixed-use neighborhoods, walking patterns, amenities, and car use and transportation options.

- Policy-related research: funding and design: More funding is needed for "less traditional" areas of policy-related research, such as historical research, research on values, and the synthesis of findings were suggested. Better integration across governmental sectors and policy makers was also deemed important.

- Evaluation of policy tools and interventions: More work is needed to assess the value of interventions; those that are effective ought to be funded over longer terms and better mechanisms are needed to evaluate, monitor and review them regularly.

- Social inequities as determinants of obesity: It is known that certain population groups have higher rates of obesity in Canada, notably, Aboriginals, many immigrant groups, those in rural and remote areas, those living in the Atlantic region and those with a lower socio-economic status. Factors that lead to obesity in these populations are related to food insecurity and inequitable access to physical activities. More research is needed on other mechanisms that can lead to increased risk of obesity, such as poverty and income inequality.

6.6 Gaps and Opportunities

Many health officials are referring to obesity as an "epidemic." In an effort to coordinate research and recommendations, the Canadian Obesity Network (CON) facilitates partnerships amongst university researchers, the private sector as well as the public. Their goal is to enable Canada to strengthen its capacities to effectively address the myriad personal health and societal challenges posed by obesity.[12] Specifically, they have identified the following opportunities for policy makers to bridge the gaps in knowledge of the problem of obesity: partnerships with industry, partnerships with not-for-profit and non-governmental organizations, and partnerships with governments and policy makers.

Experts from a national roundtable to identify policy priorities also pointed out gaps in research on obesity and suggested that quality environmental scans of existing policy instruments be conducted to facilitate longer-term strategies (CIHI:2003). Furthermore, they advocated funding of research of international comparisons of nutrition policy from a historical perspective as well as closely working with municipalities on creating environments more conducive to walking and

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[12]   For more information about the network, see www.obesitynetwork.ca/.

physical activity. Finally, they recommended that obesity issues area raised at all levels of government and that citizens talk with the federal minister of health in their home riding about obesity. Clearly there is much work to be done in mitigating the causes of obesity in the Canadian population.

7. Persons with Disabilities

7.1 Status

Approximately 1 in 8 Canadians live with disabilities. The disability rate increases with age, and seniors are also more likely to have severe rather than mild or moderate disabilities. Common types of disabilities include hearing, seeing, speech, mobility, agility, pain, learning, memory, developmental, and psychological disabilities (PHAC, 2006). Statistics Canada defines a person with a disability to be someone who experiences any restriction or lack of ability, resulting from an impairment, to perform an activity in the matter or within the range considered normal for an able-bodied person. Those that have a technical aid that completely eliminates the limitation are not considered to have a disability. An impairment that limits everyday activities can have a profound impact on peoples' lives; their mobility, agility, independence, the ability to find and hold a job, income levels, leisure activities, and psychological well-being (Statistics Canada, 2001: 3). Despite progress in the status of Canadians with disabilities, many still face exclusion, poverty and isolation (Gordon, 2006: 1). The Canadian public policy trend, across all orders of jurisdiction, has been to address these issues by eliminating barriers and promoting the full integration of people with disabilities into Canadian society.

7.2 Mandates

Policies concerning people with disabilities fall under federal, provincial, and municipal jurisdictions. Several federal departments and agencies work on disability issues for example, Service Canada, Industry Canada, Transportation Canada, and the Office for Disability Issues at Human Resources and Social Development Canada. However, the Disability Advisory Committee of the Canada Revenue Agency (CRA) was cut, along with all other advisory committees of the CRA, in September 2006 due to the Government of Canada's decision to reduce program expenditures (CRA, 2006: 1). The Government of Canada works across orders of government with provincial and municipal jurisdictions and with national organizations of people with disabilities to try to integrate services for people with disabilities (HRSDC, 2006: 6).

Table 3. Federal, Provincial/Territorial and Non-Governmental Programs and Services

Government of Canada	Provinces and Territories	Other Partners
The Government of Canada supports persons with disabilities through **financial support** programs such as: - Earnings replacement (e.g. Employment Insurance – Sickness Benefits) - Pensions (e.g. Canada Pension Plan – Disability) - Federal tax credits to offset costs related to a disability (e.g. Disability tax credit) The Government of Canada invests in: - **Learning** (e.g. Canada Student Loans Program) - **Employment** (e.g. transfers of money to provincial and territorial employment programs) - Communities by funding **disability organizations** The Government of Canada also sets **standards for accessibility** (e.g. building accessibility) and provides limited funding for making homes accessible.	Provincial and territorial governments are primarily responsible for programs and services related to: - **Health care** - **Social services** (e.g. social assistance) - **Education** (e.g. Provincial student loans) - **Employment** Provincial and territorial governments also provide support through: - Provincial **Workers Compensation** - Provincial **tax credits** and deductions - **Home care** and attendant care - Regulation of private disability insurance Provincial and territorial governments also provide services related to: - **Housing** (e.g. low-income housing) - Barrier-free **transportation**	Other partners include: **- Non-governmental organizations**, which provide advocacy, support, training, and some program delivery. **- Employers**, which provide work leave and benefits, workplace accommodations, and hiring/training **-** The **insurance industry**, which provides disability and liability insurance **- Consumer industries**, which provide standards, and accommodation for accessing goods/services
Source: Social Development Canada (2004: iii).		

7.3 Policy

At the 1995 Annual Premiers' Conference, the Premiers' agreed to make social policy reform and renewal a shared priority and established the Ministerial Council to do so. The report to the Premiers by the Provincial/Territorial Ministerial Council on Social Policy Renewal followed in 1996. In 1999, the *Social Union Framework Agreement* (SUFA) was signed to further collaboration between orders of government (Provincial/Territorial Council on Social Policy Renewal, 2001: 1, 6). At the June 1996 First Ministers' Meeting, persons with disabilities were identified as a collective priority in the pursuit of social policy renewal. This was reaffirmed in December 1997.

The federal, provincial and territorial policy direction for disability issues is guided by the report *In Unison: A Canadian Approach to Disability Issues*, which was released in 1998 by federal, provincial and territorial ministers responsible for social services, as a blueprint for promoting the integration of persons with disabilities in Canada. The report states that federal, provincial and territorial governments recognize that an integrated approach is necessary to address the main concerns identified: income support, citizenship, disability supports and employment issues for persons with disabilities. *In Unison* describes the vision and outlines the long term policy directions aimed at promoting full citizenship of people with disabilities in all aspects of Canadian society, based on the values of equality, inclusion and independence (Federal/ Provincial/Territorial Ministers Responsible for Social Services, 1998).

Building on the *In Unison* blueprint document, the follow up report *In Unison 2000: Person with Disabilities in Canada*, provides a broad view of how adults with disabilities have been faring in comparison to those without disabilities. Likewise, the 2002, 2004, 2005 federal reports *Advancing the Inclusion of People with Disabilities* provide an overview of key initiatives that different federal departments and agencies have implemented, individually or in collaboration.

In the 2006 *Advancing the Inclusion of Persons with Disabilities* report, it is stated that the Government of Canada will be seeking to develop a National Disability Act to improve accessibility and inclusion for all Canadians with disabilities, as was outlined in the 2005-2006 Conservative election platform. The United States passed such an act in 1990, as did the province of Ontario in 2005 (Disability-Related Policy in Canada, 2007). However there is debate among the Canadian disability community as to whether a National Disability Act is necessary given that mechanisms do exist, such as *The Charter of Rights and Freedoms* and federal statutes that should be respected with due jurisprudence (Gordon, 2006: 1).

Building on the *In Unison* policy outline, the government of Canada has set priorities for action within its departments and agencies, with provinces and territories, and with partners in the disability community to ensure sustained progress towards full citizenship for people with disabilities. The Government of Canada Disability Agenda is based on a commitment to work towards the full participation and inclusion of persons with disabilities; engaging the disability community and all sectors of Canadian society in action on disability issues; recognition that achieving real progress requires shared responsibility and a commitment to action; and a commitment to work towards clear outcomes, linked to significant priorities (HRSDC, 2007).

7.4 Priority Areas, Programs and Supports

7.4.1 Accessibility

"Accessibility is about creating an environment in which systemic barriers to the full participation of people with disabilities are reduced or eliminated so that these people have equal access" (HRSDC, 2006: 13). Federal government policy, programs and services on accessibility issues for people with disabilities are centred on the following key areas: transportation, housing, sport, electoral system, library system, internet and computer technology, and telecommunications.

As mentioned above, Ontario has legislation (passed in June 2005) to promote participation of people with disabilities, called the *Accessibility for Ontarians with Disabilities Act*. This *Disabilities Act* is the first of its kind in Canada. The goal is to make Ontario equally accessible for people with disabilities by 2025. This means that people with disabilities should have equal opportunity to partake in everyday activities, such as going to work or school, shopping, going to the movies, etc. Businesses and organizations that provide goods and services to people in Ontario will have to meet certain accessibility standards in five areas:

- Customer service
- Transportation
- Information and Communications
- Built Environment
- Employment

The Customer Service Standard comes into effect January 1, 2008. Businesses and organizations that provide goods or services to people in Ontario will be legally required to make their customer service operations accessible to people with disabilities. The legal requirements of the standard are set out in two Ontario Regulations under the *Disabilities Act*. A committee is currently working on developing an Accessible Transportation Standard, which should be completed by early 2008 (Ministry of Community and Social Services, Government of Ontario, 2007).

The Canadian Standards Association (CSA) sets standards, although it is not a government organization, to help make communities more accessible to people with disabilities. Some of these standards are: *Accessible Design for the Built Environment*, which explains how to make buildings accessible and safe for people with disabilities; *Customer Service Standard for People with Disabilities*, which explains how organizations can provide customer service to people with disabilities equivalent to the quality of service they provide everyone else; and *Design for Aging*, which provides principles, guidelines and tools for designing products and providing services for people whose abilities are affected by aging (Government of Canada, 2006: 17).

7.4.2 Disability Supports

Disability supports are technical aids and devices, and programs and services that help people living with a disability actively participate at home, at work, at school and in the community (Fawcett et al., 2004: 1). They include special equipment; homemaker, attendant or interpreter services; physiotherapy and occupational therapy; and respite care that responds to individual needs (HRSDC, 2006: 13).

The Industry Portfolio programs of Industry Canada provide help related to a variety of areas, such as Aboriginal business, consumers, industry, regions, small business, research, science and youth (Industry Canada, 2007). Industry Canada works to ensure that Industry Portfolio programs and services are accessible to Canadians with disabilities through the Assistive Devices Industry Office (ADIO) (HRSDC, 2006: 34). ADIO works with Canadian assistive device developers, producers, vendors, and service providers, giving them advice, support, and market intelligence. The Advisory Committee of Persons with Disabilities (ACPD) makes sure that employee needs influence departmental policy.

7.4.3 Employment

People with disabilities have much lower levels of employment than other working-age Canadians. This is because of barriers to training, education, transportation and other workplace accommodation needs for disabled people. There are also a myriad of demographic factors that affect employment such as age, gender, visible minority status, province/territory of residence, and level of education. For example, young people with disabilities are more likely than their older counterparts to be employed. Also, women with disabilities are less likely to be employed than men with disabilities. The nature, duration and severity of the disability are also important factors in employment. People with a severe degree or multiple disabilities are less likely to be employed than people with a lesser degree of disability. For example, people with hearing disabilities fare relatively well in terms of employment level when compared to others with disabilities, but still far below people without disabilities (Crawford, 2004: 8).

The Opportunities Fund for Persons with Disabilities is a federal program through Human Resources and Social Development Canada. The objective is to assist persons with disabilities who do not qualify for assistance under Employment Insurance, to prepare for, obtain and keep employment, or become self-employed (Crawford, 2004: 22).

Employability Assistance for People with Disabilities (EAPD) is a jointly funded initiative between the Government of Canada and the provinces/territories, which focuses on employment and labour market intervention for people with disabilities. Some examples of interventions provinces and territories may choose to jointly fund through the EAPD are: employment counseling and assessment, pre-employment training and skills development, post-secondary education support, and assistive aids and devices (Crawford, 2004: 23).

In Canada, there are three types of publicly-funded vocational rehabilitation coverage: provincial workers' compensation programs, provincial programs previously funded under federal-provincial Vocational Rehabilitation of Disabled Persons but now financed under federal-provincial Employability Assistance accords, and coverage provided through the Canada Pension Plan's (CPP) Vocational Rehabilitation Program for CPP Disability Benefit recipients to move back into the labour force (Crawford, 2004: 23).

7.5 Gaps and Opportunities

Despite programs and services through the federal, provincial and territorial governments to help integrate people with disabilities into all aspects of Canadian society, studies show that Canadians with disabilities have many unmet needs. Their unmet needs relate to aids, devices, support with activities of daily living, specialized features within the home, educational supports and supports in the workplace. Those most likely to have unmet needs are people with severe disabilities, those with low incomes, those of working age, and those who require high cost items such as electric wheelchairs, scooters, and lifts. Cost is a predominant factor in unmet need, as is lack of information (Fawcett et al., 2004: 3).

There is a very large requirement for support with activities of daily living, and these supports are being provided primarily through informal sources, such as family and friends. Approximately a quarter of supports with activities of daily living is provided by an organization

or agency. Therefore there is a gap in the health care system's formal infrastructure for the provision of supports for daily living. This problem will only be exacerbated by the ageing population of baby boomers (Fawcett et al., 2004: 64). This health care gap needs to be addressed with more formal infrastructure and better supports for people with disabilities.

Likewise, work supports are a vital part of getting a job, keeping a job, and advancing in a job for persons with disabilities. There are two important types of work supports: infrastructure support, such as modified structures in the workplace; and personal supports, such as work aids or devices and job modification (Fawcett et al., 2004: 52). These supports are lacking for employed disabled people and a leading factor in unemployment for disabled people. Two of the specific supports most required are job redesign and modified hours, which are largely controlled by the employer (Fawcett et al., 2004: 66). Thus, programs for these types of supports are limited. Programs need to be redesigned and implemented to address the barriers to, and supports for employment of people with disabilities.

These gaps in health care services for persons with disabilities are leaving many needs unmet for Canadians living with disabilities. Many non-governmental organizations exist across the country that advocate for better accessibility and services for persons with disabilities. The Canadian Association for Community Living (CACL), for example, works with other disability rights organizations and with the federal government to provide information as well as policy research and recommendations, and to facilitate awareness-building activities. The Canadian Association of Independent Living Centres (CAICL) has responded to the unmet needs of Canadians living with disabilities through its national network of Independent Living Resource Centres (ILRC). ILRCs provide access to employment training, disability supports, income support, housing, and transportation. They are part of a movement to help remove barriers to empower and enable people with disabilities to live independently and exercise full citizenship. There are many other provincial/territorial and national disability-related organizations that are far too numerous to mention here. Their work raising public and political awareness of disability issues is important in giving voice to the disability community and addressing their unmet needs.

8. Conclusion

Some of the longer-term trends affecting health policy in Canada include:

- the need for citizens to be adequately prepared in the event of a pandemic;

- the health impacts resulting from global climate change;

- the continuing shift of employment and population from rural areas to cities so that Canadians in rural areas must increasingly travel to larger centres to receive health care (a problem that may be compounded as the health effects of climate change are felt most acutely in rural and remote Canada);

- a growing challenge of recognition of credentials of immigrant health care professionals;

- the ageing of the population and the likelihood of increased incidence of chronic illness; and

- the individualization of health care.

These trends are likely to be associated with increasing strain on health care resources and a growing need to find innovative ways to improve and maintain population health more efficiently. For example, better integration of the health care system with social supports that promote healthy living, will allow more people with health issues to live independently.

A look at Canadian health policies for Aboriginals, Canadian Forces and Veterans, and Persons with Disabilities, as well as policies to address the growing incidence of obesity, reveals a number of current or emerging gaps in health programs. These include:

- inadequate access to health services for Aboriginal peoples, on reserve and in the North;

- the (potentially) increasing need to assist injured deployed personnel to reintegrate into the Forces in a timely and cost-efficient manner;

- an emerging need for more services to help Canadian veterans who were injured in service to integrate into their communities;

- the need for more research on best practices in preventing obesity and obesity-related diseases and effective measures to implement them; and

- numerous unmet needs of Canadians with disabilities, including access to assistive devices, support with activities of daily living, specialized features within the home, educational supports, and supports in the workplace.

Examining Canadian health policies in these areas has also revealed that there are opportunities for new partnerships with health care associations, such as the CAOT. For example, there appear to be opportunities to:

- increase the number Aboriginal and non-Aboriginal health care providers in Aboriginal communities on reserve as well as to improve health care for urban Aboriginal populations;

- make an economic case to the Canadian Forces that OTs can play a more central role both in the delivery of health services to the Forces;

- assist in facilitating the integration of veterans into society after service;

- conduct research on the prevention of obesity and the optimum coping strategies for obese persons for every segment of the population, across the entire lifespan; and

- address the unmet needs of Canadians with disabilities regarding assistive devices and supports in the home, education and work spheres.

Further research is required for an in-depth analysis of policy issues in each of these target groups in order to be able to make well founded recommendations regarding issues that may affect the field of occupational therapy.

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