

Health

# Population Health Goals for British Columbia

prepared by  
B.C. Coalition of People with Disabilities  
204-456 W. Broadway  
Vancouver, BC V5Y 1R3  
(604) 875-0188 • fax 875-9227

Nancy

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In reply to the request for written input on the subject of Population Health Goals for British Columbia, we wish to address a number of issues which are of particular concern to the disability community. We believe these must be taken into account if any progress is to be made in improving the health status of the people of B.C.

To begin with, we wish to challenge the underlying assumption that people with disabilities are "sick" and need to be cured or "fixed". The WHO definition of health adopted by the Provincial Health Officer in his 1994 Report describes health as "*a complete state of physical, mental and social well-being*" (our italics). For many people with disabilities, this definition is highly problematic. Can someone who uses a wheelchair from childhood or who sustains an injury be characterized as "sick"? Is a Down Syndrome child by definition unhealthy? Where does a person with Tourette's Syndrome, or someone with a cyclical condition such as MS, fit into the definition?

As the Chairperson of the BC Coalition of People with Disabilities (BCCPD) Health Issues Committee pointed out in her letter to the Provincial Health Officer dated April 7, 1995, the correlation between health and disability is, at best, inaccurate (people with disabilities are not by definition unhealthy); at worst, it is dangerous. It serves to reinforce a medical model of disability which has contributed to the disempowerment of people with disabilities, and to the denial of needs which are not strictly "medical", but which may be vital to their day-to-day well-being.

It also opens the door to a eugenicist approach which equates population health with the eradication of all genetically-determined disabilities. This attitude was displayed by federal Health Minister Diane Marleau who expressed her opposition to sex selection technology, but said nothing against the use of techniques to detect prenatal disabilities. This double standard is justifiably frightening to people with disabilities who are already experiencing stigmatization, a lack of autonomy and exclusion from community life.

From a disability perspective the first and "overarching" goal of the "Draft Population Health Goals for B.C." also raises a number of troubling questions. For example, for some people with disabilities, "enhancing quality of life" may not correlate with increased years of life; some disabilities (for instance those arising from birth trauma or genetic difference) are not preventable in the ordinary sense of the word; and as long as disability is equated with sickness, the very real causes of ill health among people with disabilities may continue to be ignored.

We would also argue that attempts to measure the health of people with disabilities in a quantifiable way using measures such as "Health Adjusted Life Expectancy" or "Disability Adjusted Life Years" (a term proposed by the World Bank) are inappropriate. A more useful (but still limited) concept might be "Quality Adjusted Life Years", but even this is flawed to the extent that it suggests that quality can be expressed in quantitative terms.

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**In our view, the primary goal for the improvement of the health of the whole population, including people with disabilities, should be the second one in the draft paper:**

*Ensure that all British Columbians have adequate income, employment opportunities and education; with a valued role to play in supportive families, workplaces and communities.*

There is now undeniable evidence to support the claim in the Provincial Health Officer's 1994 Report that with respect to population health:

*as well as the usually identified behavioural risk factors associated with the major causes of death, the risk conditions of poverty, injustice, lack of education, unemployment, lack of social supports and inadequate child care play an even more important role. (12)*

**Moreover, the health trends not only in British Columbia, but in the Western world, exhibit the same feature: there is a distinct gradient, persistent over time, reflecting the link between measurable determinants such as life expectancy, disease and other barriers to well-being on the one hand, and socioeconomic status on the other. This gradient is altered very little, if at all, by medical intervention (however sophisticated), by educational campaigns aimed at reducing risk behaviours through the alteration of individual "lifestyles", or even by improved access to health care services. In fact, there appears to be little correlation between population health status and health care spending. Rather, it is now generally acknowledged that:**

*factors in the social environment, external to the health care system, exert a major and potentially modifiable influence on the health of populations, through biological channels that are just now beginning to be understood. (Evans et al. 69-70)*

Such an understanding calls for a radical shift away from the classical epidemiological view which isolates and labels certain diseases or risk factors and attempts to prevent or cure them, but continues to ignore the "vastly more frequent and burdensome causes of human misery that are fundamentally non-medical" (Evans 80).

**In short, improvements in population health in British Columbia cannot be left in the hands of the Ministry of Health and the health care industry. As the Provincial Health Officer pointed out in his 1994 Report:**

*To make real improvements in reducing disparities in health will require addressing the most powerful influences on health: adequacy of income and employment, education, housing, early childhood care, social supports, and the creation of communities free of violence, crime, abuse and discrimination. (69)*

The "Draft Population Health Goals" make reference to some (though not all) of these vitally important health determinants, and to the need to reallocate societal resources to improve population health and to develop "public understanding of the range of factors that determine health". Unfortunately, recent actions by both the provincial and the federal government ignore the massive literature supporting a socioeconomic view of health, and may in fact serve to worsen the problems. We offer the following examples:

- **The abolition of the Canada Assistance Plan.** This does away with even those minimal national standards which ensured that people in need would receive assistance and would not be coerced into "workfare" programs.
- **The massive reduction in federal transfer payments.** The abdication of responsibility by the federal government is then translated by the provincial governments into cuts in education, health and social assistance. The result is an increase in inequality and income disparity at a time when the gap between rich and poor, already much too wide, is growing wider.
- **The failure to implement a national childcare program.** The "latency effect" of early childhood trauma, including experiential deprivation, lack of nurturing and abuse have been shown to have a negative impact on adult health, and may well be a factor in alcoholism, substance abuse (including smoking), educational failure and anti-social behaviour. Some studies suggest that early childhood failure plays a role in mental illness in adults, and may even affect the immune system.
- **Reductions in unemployment insurance eligibility and payments.** Recent studies have indicated a link between unemployment and illness, including heart attack and mental illness, to say nothing of domestic violence.
- **The reduction or withdrawal of funds to non-profit agencies and support groups which offer aid to women experiencing low self-esteem, social isolation, poverty and abuse.** On the evidence, women's equality, education and well-being are powerful health determinants which affect both themselves and their children.
- **The withdrawal of all funding for cooperative and low-income housing, and housing for people with disabilities.** The result is overcrowding, subs-standard conditions and reinstitutionalization of people with disabilities.
- **The continued emphasis and expenditure on "lifestyle" (i.e. victim-blaming) solutions.** These initiatives convey the impression that health is an individual, not a collective responsibility, and which ignore the systemic injustices and inequalities underlying the population health gradient.

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Coupled with this is the continued allocation of resources to high-tech research (the "magic bullet" approach to health) at the expense of more health-productive measures to deal with the socioeconomic determinants of population health.

The actions of the federal government have shifted the burden of social services almost entirely to the provinces, providing the excuse in some areas for ideologically-driven policies such as "workfare" and the slashing of already inadequate welfare payments.

In British Columbia, while the picture is not nearly as bleak as it is in Alberta or Ontario, the government has succumbed to the temptation to attack the poorest and most vulnerable sectors of the population in order to demonstrate its "fiscal responsibility".

We acknowledge that the B.C. Ministry of Health has introduced some positive measures—for example, improvements in reproductive health care for women and the provision of greater access to clinical care, breast cancer screening and STD control. The New Directions program, following on the recommendations of the Seaton Commission, holds out the promise of greater public participation in decisions about health care priorities and the delivery of health care. However, the savings which were expected to accrue from the regionalization of health care delivery—the closing of hospital beds and the consolidation of administrative bodies, for example—have not been used to cover even basic health needs, such as home support. There are also troubling indications that volunteers will be used to achieve cost cuts, while the savings effected are absorbed by new layers of health care administrators, managers and professionals. A thorough audit of the process is needed to address this question.

Of even greater concern is the questionable extent of inter-ministerial collaboration with respect to health goals and objectives, particularly in the implementation phase. It remains to be seen if government knows how to implement these goals. Their track record is one of superficial consultation, often after the fact, and disempowerment of community efforts through under-funding, reliance on outside consultants (at great cost) and top-down directives.

As a result of the determined collective efforts of the disability community, the Ministry of Social Services has taken steps to broaden the regulations regarding eligibility for Handicapped Benefits. However, these measures will not touch the lives of those people with disabilities who still do not meet the eligibility criteria of the "handicapped" designation, and who therefore do not have access to the additional benefits. For people with disabilities, and for able-bodied people who rely on social assistance, the Ministry of Social Services seems bent on implementing policies which run counter to all the evidence regarding population health. Recent changes to the GAIN legislation and regula-

tions, for example, will restrict eligibility for social assistance, limit the power of the appeal system to grant benefits and restrict access to discretionary assistance, such as crisis grants.

In addition, constant publicity about “welfare fraud” contributes to the labelling, stigmatization and marginalization of those on social assistance.

The long term consequences of these policies are painful to contemplate. According to Dr. Elizabeth Whynot, in the Skid Road area of Vancouver, where 8,000 welfare cheques are issued each month:

*most of the people involved in destructive behaviour [such as drug and alcohol abuse and prostitution] were victims of trauma, often at a very young age. Poverty and stress in society are increasing, 'and we're producing a whole generation of people who are going to cause problems in the future'.*

Dr. Whynot goes on to say that in this area,

*'babies have a 30 to 40% chance of prenatal exposure to alcohol or drugs. Of the kids working the streets, endless studies show that 60 to 70% were abused in their homes.'* (Deborah Jones, “Welfare Wednesday”, 60)

In her opinion—and ours—a public backlash against social spending will worsen the problem, and the quality of life, not just for those directly affected, but for everyone, will suffer.

What applies to the able-bodied population is doubly true for people with disabilities who rely on social assistance. Stigmatization, labelling, isolation, the absence of needed personal supports coupled with barriers to education and employment, and the lack of choice or the right to assume control over their own lives are daily experiences. People with disabilities are among the poorest in our society, and among the most vulnerable to physical and emotional abuse. They are often captives of a mechanistic medical model of health care which denies them both autonomy and dignity. They are not sick because of their disabilities, however prolonged or severe, but they may become sick as a result of systemic barriers and inequalities which deprive them of even the basic necessities for a full and healthy life.

**From the perspective of the disability community, then, the “overarching goal” of population health policy must be to achieve a radical paradigm shift in the definition of health and in the understanding of the fundamental determinants of population health.** Instead of the “politically innocuous, inexpensive, highly visible, and relatively ineffective interventions of health education campaigns” (Evans 44) which place the responsibility for health on the individual, or continued spending on the expansion of the health care system, there must be a concerted effort to address the socioeconomic factors which determine health.

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The cost of reducing income disparities and building the community supports which are the necessary underpinnings of population health will not be small. The cost of not doing so will be even greater, not only in dollars, but in terms of social stability and security. This is not a problem only for "some poor deprived minority whose situation can be deplored and ignored" by those who are better off (Evans 45). Health gradients in mortality and morbidity hold "across the whole socioeconomic spectrum" (Evans 45). It is therefore in the interest of the whole population that the broad determinants of health be given the attention that has until now been lacking.

In these mean-spirited times, there is an urgent need for leadership from those who have the power and the status to affect the decision-making process. We believe that the Provincial Health Officer can play a major role by insisting that the primary goal of population health in British Columbia must be to address the socioeconomic disparities which are the major determinants of health status.

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