



## Natural Allies

*Community Health & the future of CED*

BY KEN HOFFMAN

Ask the new Canadian, the single mother, the street-involved youth, the laid-off factory worker about the thing that is most important to their “health.” You get some interesting answers. They don’t talk about wait times for surgery or diagnostic procedures. They talk about finding a job, completing their education, finding a house or quality childcare they can afford, or living in a safe neighbourhood.

Our society tends to treat all of these as individual issues. “If you can’t get find a job, or a house, or childcare, or get into university then it’s your own fault and you should be trying harder.” While there may be an element of truth to this, the fact that these issues are so widespread in a country as wealthy as Canada says a great deal about what we as a society value (or don’t value). It’s hard to find the job when the factory has closed or the fishery has tanked. It’s hard to get the training when you can’t get the loan to finance it.

These are community issues that require community responses. But who takes the lead to address these issues? Which organizations have the capacity, the resources, and the mandate to look out for the health of *communities* these days?

Not many. Community health centres, or CHCs, do in some areas, but ten years of neo-conservative politics have reduced that role in many parts of the country. A range of community development corporations, nonprofits, and charities attend to portions of the mandate, but many lack the stability, the resources, and the legitimacy to be truly effective.

As someone who has worked in both community health centres and community economic development, I contend that both these sectors can make a substantial contribution to the health of Canada’s communities over the next generation. But the demonstrated capacity of CHCs to earn the trust of their constituents, to serve their well-being, and to help them express their will is of singular importance. To anyone framing a strategy of comprehensive, community-based revitalization, the CHC is a natural

ally. The CED and CHC sectors can really advance the agenda of local communities if they learn how to work together and leverage their mutual strengths.

### CHCs & Community Engagement

Community health centres are organizations that deliver primary health care; they are their clients’ first point of access to the health care system. Several characteristics of CHCs provide them with a unique role and perspective in the health care system. They have a focus on serving a specific community, usually defined by geography, but occasionally by a specific socio-cultural group, such as francophones or Aboriginal people. In Ontario, they also have a specific mandate to serve populations that may have difficulty accessing doctors in private

(above) “Being healthy never tasted so good!” In Toronto, South Riverdale Community Health Centre’s dietician demonstrates food preparation in one of several programs to promote health through wise nutrition. Photocredit: Christopher Dew.



*The increasingly narrow, individualistic view of health & health care propagated by politicians & policy makers has made collaboration between the CED & community health sectors much more challenging in recent years – & more urgent.*

practice, whether because of language, culture, income, age or some other reason.

All CHC staff, including physicians, are paid on salary, rather than fee-for-service. In Ontario, like many places in Canada, CHCs are also community-governed, through boards of directors elected from the community they serve. CHCs still represent a relatively small proportion of the total primary health care picture, serving less than 10% of the population in Ontario; the majority of the population still accesses primary health care through physicians, either practicing solo or in groups.

When I started working in community health in the mid-1980s, community development was a well-recognized strategy of health promotion, and CHCs were leaders and innovators in this area. There are many instances of CHCs that

helped bring their communities together to address broad health issues.

South Riverdale CHC in Toronto mobilized the community to bring about the closure of a lead smelter that was poisoning the children in the area. Sandy Hill CHC in inner-city Ottawa brought together local businesses and social service organizations to create a social enterprise to provide employment opportunities for street youth. In Montréal, the Point St. Charles Clinic has long been a focal point for rallying that neighbourhood to deal with a range of economic and housing issues.

Although this work was never the major or exclusive concern of CHCs, two factors made it essential to their mandate – the focus of each CHC on serving a specific community or neighbourhood, and the CHC commitment to community participation. The community focus enabled the centres to take into consideration a broad range of issues and factors that contribute to health and quality of life, such as physical health, food security, recreation, and employment. Through the participation of community members on boards of directors and various committees, CHCs were able to forge the partnerships necessary to address these issues: partnerships with schools, businesses, social service organizations, churches, recreation programs, the local municipality, and others.

## **Taking the Community Out of Primary Health Care**

Many of Ontario's CHCs retain community development as a component of their

work. The general trend, however, has been to push community development to the sidelines, or to remove it altogether from the realm of primary health care.

Access and wait times have become the mantra of the politicians and the focus for efforts to reform the system. There is no question that access is a huge issue across the entire country – anyone who has tried to find a family doctor lately can tell you that. Over the past three years the federal, provincial, and territorial governments have invested over \$800 million in primary health care reform. A centerpiece of this strategy was a glossy communications campaign of full-page, full-colour ads in major Canadian dailies, as well as TV and radio spots. All talked about getting the “right care at the right time” as well as the importance of teams, information, access, and healthy living. But not a mention anywhere about “community” and its role in health.

In an almost single-minded focus on improving access to primary health care for individuals, governments have created a strategy that leaves communities out of the equation. Primary health care providers are no longer seen as organizations integral to communities but as “one-stop shopping” service outlets with no local roots. It is the “Wal-Mart” approach to primary health care.

Three political factors are driving this transformation. The first is “consumerization.” Since the 1990s, neo-conservative governments have sought to treat everyone using a government-funded service as a consumer, rather than a client or a citizen. This was intended to increase efficiency and accountability for services

(top) These young people were participants in the Youth Employment Apprenticeship Program, a partnership involving Sandy Hill Community Health Centre and a number of other social, health, industry, and education organizations. YEAP enabled street-involved people aged 16-24 to complete their high school and acquire skills and work experience directly related to their occupational interests. Photos courtesy of Sandy Hill CHC, Ottawa, Ont.

(next page) The Little Arrows program of Wabano Centre for Aboriginal Health offers First Nations, Métis, and Inuit children fun and traditional activities while helping them learn more about themselves, relationships, and positive choices. In the top picture, William puts the ribbon and beads on a breach cloth. Below, Wabano's Community Garden teaches people of all ages the life cycle from seed to harvest, and what can be accomplished when the whole community works hard together. Photos courtesy of the Wabano Centre, Ottawa, Ont.

provided, and to make government services operate more like businesses.

The second is “corporatization.” Communities across Canada have seen waves of amalgamations in their municipal governments, in their school boards, and in their hospitals. Once again, in the name of efficiency and effectiveness governments have amalgamated what were seen as small, inefficient operations into large corporate structures serving huge populations and large geographic areas.

The third factor might be called “de-cluttering.” Community participation is messy and uncontrollable. Despite their rhetoric about a greater community voice in decision-making, neo-conservative governments have consistently moved decision-making structures further away from the communities they serve.

## Rise of the RHA

The primary vehicle driving development of the health care system in virtually every part of the country is now the regional health authority (RHA) or its equivalent (in Ontario, Local Health Integration Networks or LHINs). Each has the massive job of co-ordinating all the pieces of the health system for several hundred thousand people, sometimes over an enormous geographic area. My own LHIN in the Ottawa area covers several thousand square kilometers of urban and rural communities across eastern Ontario. Even with the best of intentions, meaningful community participation in such a beast becomes a huge challenge.

These organizations are leaving their mark on primary health care. For example, Alberta RHAs are working to develop clinics to provide primary health care in rapidly-growing suburbs of Edmonton and Calgary. In rural New Brunswick, hospitals are being converted to ambulatory care clinics. Québec, long considered a leader in community-based health care with its network of over 150 *Centres locaux de services communautaires* (CLSCs), rolled all these centres into large, hospital-based *Centres de santé et de services sociaux* (CSSS).

While all these clinics certainly provide a needed service to their communities, they function as neighbourhood points of

service or “branch plants” of the RHAs and CSSSs, not as community-governed organizations with independent boards of directors.

But does any of this really matter? As long as the RHA or LHIN or CSSS or some other alphabet soup creation ensures that we get to see the doctor or nurse when we need to, isn't that enough?

It might be, if doctors and nurses could address all the factors that deeply affect our health. But they can't. Safety, employment, food security, affordable housing, and education – they all have at least as much to do with health status as medical services. Yet they are not just individual issues, but community ones. Certainly, community groups and citizens associations have done amazing jobs to develop initiatives in these areas. The problem is that they are often doing this work in isolation from each other, without resources or any kind of infrastructure, which makes their efforts vulnerable and often transitory. How are these issues to be addressed in a meaningful way without a broadly-based organization providing a focus, staff, and infrastructure at the community level? How are they to be addressed without the assistance of an organization that local people implicitly trust because they know that it (literally) “cares for them”?

In short, when will governments recognize the unique value of a community-based infrastructure like a CHC?

## Cracks in the Facade

Interestingly, events continue to affirm the critical role that CHCs have to play.

The experience of the 1998 ice storm in Québec and eastern Ontario proved how essential health organizations with a community focus can be. In many cases it was CLSCs and CHCs that were able to quickly identify seniors and others who needed help, and get workers out to assist them. They used their partnerships to mobilize other local resources to provide emergency shelter, clothing, and food. They were also there to participate in the clean-up.

Some RHAs are starting to look at the lessons from this experience. In the event



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of a calamity, whether it's a natural disaster or a flu outbreak, who is truly intimate with a community's state of health? Individual physicians, no matter how well-motivated they might be, specialize in addressing the health concerns of the individuals who come through their doors; they do not focus on the community, nor on the reasons why people are coming to them for help.

There are encouraging signs in other places, too. The Winnipeg RHA has an approach to the development of primary health care that may be unique in the country. It specifically recognizes the importance of intersectoral networking and local area development as guiding principles for its work. Meaningful participation in the community's life and governance is seen as a core contributor to health. It is a good example of what RHAs can actually achieve if they honour values of community development and participation in their work.

Aboriginal Health Access Centres, or AHACs, the aboriginal equivalent to CHCs in Ontario, also have a fundamentally different way of working with community. They address health in a holistic way, including its physical, mental, and spiritual components. Community involvement and respect for community values, including the role of elders, is absolutely central to the work of these centres. The mission statement for the Wabano Centre for Aboriginal Health in downtown Ottawa illustrates the broad, comprehensive involvement of

AHACs. It states that Wabano, "engages in clinical, social, economic and cultural initiatives that promote the health of all Aboriginal people."

And Ontario has recently announced that CHCs will be established in several Toronto neighbourhoods that have been identified by the United Way as priorities because of specific social problems, such as youth violence. They are to be established with the active support and participation of the communities they will serve. George Smitherman, the current Minister of Health, knows CHCs well and believes they can play a key role in these neighbourhoods, not only by providing health and social service, but by being a catalyst for community development.

### Natural Allies

One of the great challenges shared by CED practitioners and CHC workers is the need to demonstrate the value of a community-based approach to development. To both groups, people are more than individuals; they are citizens and community members with a shared interest and a shared capacity to work together. Both think about – and work on – the "Big Picture" issues sometimes known as the "social determinants of health": employment, housing, food security, social exclusion.

Yet, despite this common focus on community well-being, there is very little outright collaboration between the CED

and health sectors. For the most part, they seem to work beside, not with one another. The increasingly narrow, individualistic view of health and health care propagated by politicians and policy makers has made such collaboration much more challenging in recent years – and more urgent.

I believe there is a tremendous opportunity right now for CHCs and CED practitioners to forge a national "Community Matters" agenda. It will focus national attention on the structures, approaches, and skills required to support real community development and community participation, not just in health care proper but for the whole range of issues that affect the quality of life in our communities.

We must find the examples and do the research to support this view. It is not a matter of turning back society's clock to some supposed "golden age" of activism. It is a matter of demonstrating why this approach is relevant today, and how it can fit with the new structures that have been developed. We must find the ways to present our stories to decision-makers in ways they will understand. And if there is one thing I know about our sectors – we have some amazing stories to share.



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