To the Editor:


I felt driven to write this response to the abovementioned CJPH editorial.

Research into population health did not begin and end with the publication of Why Are Some People Healthy and Others Not? The book did precisely what it was intended to do – stimulate research into the social, physical and psychological correlates of health and away from healthcare as the only predictor of health. The authors admit that health was defined as “not ill”, but the real issue is that no matter what the measure of health/illness and no matter what the measure of social stratification, there is a gradient in health or, as Michael Marmot likes to describe it, “a joint association” between health and social strata.

Implying that income inequality is the only population health variable of interest slights the ongoing world-wide research being conducted by researchers inside and outside the CIAR. Works such as that of Ichiro Kawachi on social cohesion, Richard Wilkinson on social hierarchy, Lisa Berkman on social networks or Alvin Tarlov’s examination of the effect of non-health policy on society, examine how economic and social forces operate and provide hypotheses by which researchers in a wide variety of disciplines can examine the non-healthcare determinants of health. What all of these researchers understand is that health has a social gradient. It is not a case of poverty vs. others or of the “haves” and “have-nots”.

And, perhaps more importantly, all these researchers understand that in the current political structure, social change occurs when the majority of the population is engaged in an issue – in Canada this means engaging the middle class. Policy change occurs at the governmental level when the middle class is engaged in the debate. When the middle class understands that they are not as healthy as the class(es) above them, they will have a vested interest in changing the status quo. When they understand that the factors that are associated with (the cause of?) the gradients in health are not simply cut-off at the poverty line, wherever it is set, but extend up through the social strata of the population, then change can occur. Since the concept of population health is understandable to the general public, it is an excellent avenue for promoting a social change towards greater equality in Canadian society. It should not be swept aside, as the authors of the editorial seem to suggest, because, in Canada, it had its roots with a specific research group.

Population health is an excellent model for social change, not a recipe for acceptance of the status quo.

Shona J. Kelly
Research Scientist
Dept. Health Care & Epidemiology
University of British Columbia

Authors’ response

Shona Kelly misses the point concerning our critique of population health. Population health researchers correctly describe system-level factors such as economic inequality and social cohesion – among others – that impact upon population health. What population health does not do is provide a means by which we can come to understand: a) the forces that create and maintain health inequalities; b) how these forces translate into poor health through government actions; and c) how to devise means by which individuals within their communities can strive to identify and reverse these factors that impact upon their health. Its neglect of any role for human agency outside of a nebulous belief that middle-class people will be envious of the very-well-off having better health is also part of our critique.

As important perhaps as the inability of population health to consider the political, economic, and social forces that create health inequalities is its blind spot for the material insults that poverty inflicts upon an ever-increasing proportion of Canadians. The suggestion that the health futures of poor people depend upon the middle class rising up over living a few months less than the wealthy consigns an entire generation of Canadians to ill health. Bertolt Brecht, in The World’s One Hope stated: “All those who have thought about the bad state of things refuse to appeal to the compassion of one group of people for another. But the compassion of the oppressed for the oppressed is indispensable. It is the world’s one hope.”

Health promotion has the potential to place the futures of low-income people in their own hands; population health does not.

Toba Bryant
Dennis Raphael
University of Toronto
marijuana to rapidly excreted drugs like cocaine and heroine. There are complex reasons why people choose a particular drug as their substance of choice. The switch to a different drug among addicts has more to do with availability rather than fear of positive urine drug screening.

This article also highlights the need for more understanding and training in Addiction Medicine on the part of researchers in this field.

Raju Hajela
Addictionist
President, Canadian Society of Addiction Medicine

Authors’ response

Dr. Hajela misses the point of the article. Drug testing in Canadian jails was not initiated in order to collect evidence of patterns in drug use. CSC officials knew that drug use was rampant and argued before the courts that testing was justified in order to stop drug use and its associated violence. It has done neither. I agree with Dr. Hajela that more treatment should be available in jails (and outside them) to respond to the chronic relapsing condition of substance dependence. CSC has recently implemented methadone maintenance for some opiate-addicted inmates. More and broader treatment modalities are needed, as are harm-reducing interventions for those who are presently treatment resistant. Our suggestion, that the $2 million currently being spent on an ineffective intervention be redirected to more effective modalities, seems eminently justifiable and far from naive.

Perry Kendall
Provincial Health Officer
Victoria, BC

Explain how the futures approach can be used to support long-term planning, strategic management, and policy-making in the health sector. Now established as a well-defined discipline, the futures approach uses a range of tools to construct a scenario of the future — whether probable, desirable, feasible, or a “worst-case” disaster — in order to give current policy options a long-range perspective. The approach has proved especially useful in developing countries, where health conditions are undergoing rapid transition, new problems are emerging, and scarce resources demand careful priority setting.

Addressed to health professionals in the public sector, the book aims to demystify the concepts and methods of futures research while also demonstrating its many practical advantages as a strategic planning tool. With this goal in mind, the book explains how projects can be designed to anticipate the impact of demographic trends, new health care technologies, global climate change, newly emerging diseases, the HIV/AIDS epidemic, the effect of market forces on access to essential drugs, and many other events.

The handbook has nine chapters. The first introduces the concept of futures research and explains the many applications of futures exercises in the health sector. Chapter two uses a series of questions and answers to show how futures projects can address a range of problems in national health systems, mainly in the developing world.

Chapter three offers practical advice on how to initiate and conduct a futures exercise. Chapter four describes the basic components from which futures projects are typically constructed, and shows how these components can be combined in the design of a hypothetical project in a country concerned about trends in the availability of pharmaceutical products and essential drugs.

To illustrate the flexibility and versatility of health futures, chapter five outlines more than 30 different project designs that can be put together using the basic components. Chapter six provides a survey of techniques and devices applicable to futures work, guidelines for selecting the most appropriate tools, and advice on the use of specific methods at different steps in a futures exercise. The application of futures techniques to health is considered in chapter seven. The remaining chapters describe printed and on-line information sources, and list relevant organizations, networks, training programmes, and funders.

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