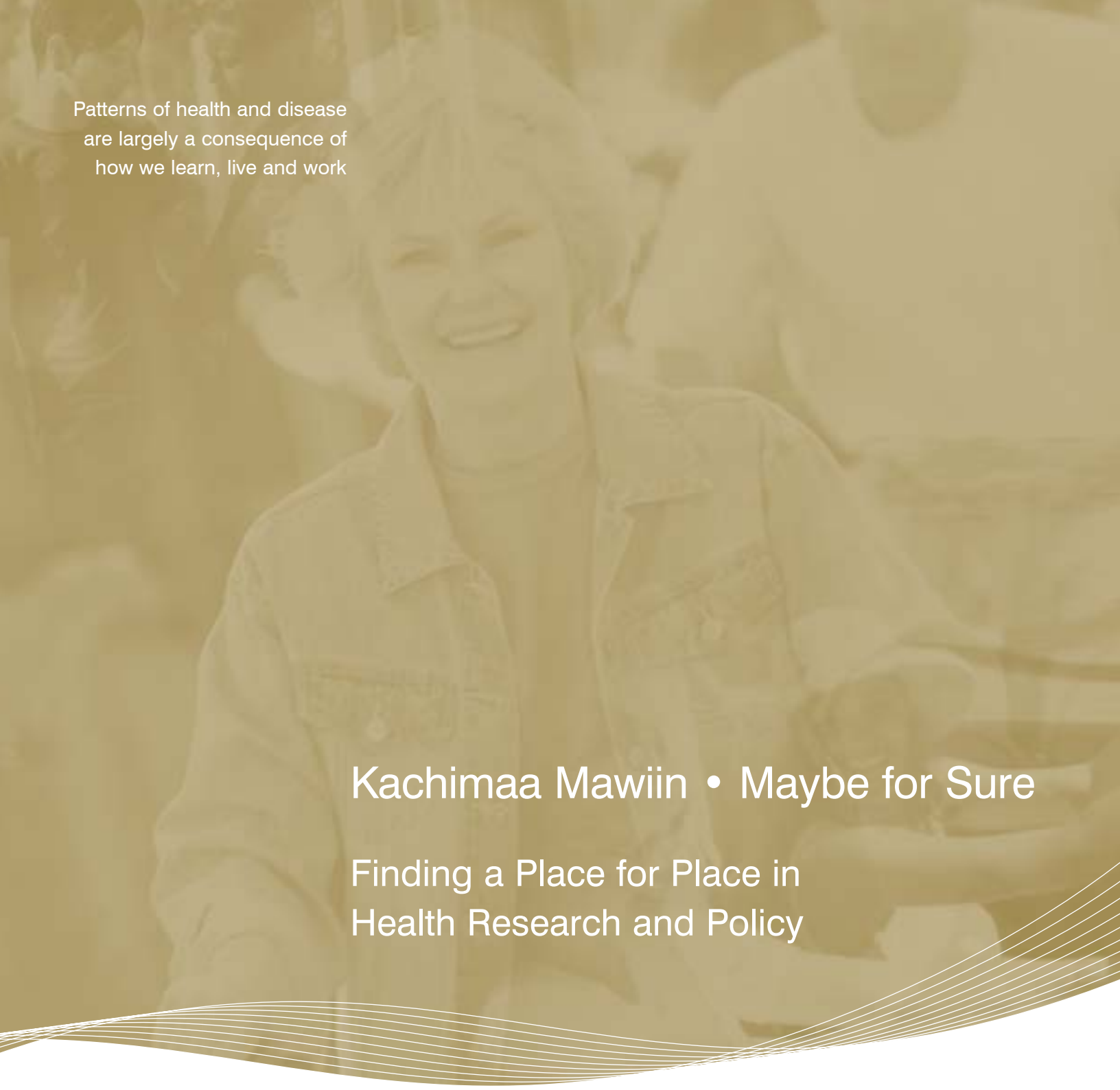

Patterns of health and disease are largely a consequence of how we learn, live and work

# Kachimaa Mawiin • Maybe for Sure

## Finding a Place for Place in Health Research and Policy

Canadian Population Health Initiative

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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## Finding a Place for Place in Health Research and Policy

**Proceedings of Place and Health: Research to Policy Workshop**

A workshop organized by the Canadian Population Health Initiative (CPHI)
in collaboration with the Léa Roback Research Centre
27 to 29 April 2005
La Sapinière, Val David, Quebec

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ISBN 1-55392-720-6 (PDF)



Cette publication est disponible en français sous le titre : *Kachimaa Mawiin — Certitudes possibles : Faire une place au lieu dans le recherche et les politiques en matière de santé*
ISBN 1-55392-721-4 (PDF)

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# Introduction: The Place for Place

There is a place for place in health policy and research.

But what, and where, is that place? How can concepts like "place" and "neighbourhood" be measured or defined? For whom does place matter most, and why? How is health associated with place, and vice versa—and how do the interconnections between place and health inform our understanding of the two? How can researchers from a variety of disciplines understand and conceptualize place as a factor in population health? Further, how can they communicate that understanding and those concepts not only to other researchers from different disciplines but also to policy- and decision-makers? And how do we account for the dynamic nature of place and the effects of time on place and health?

Over the course of three days in April 2005, a group of CPHI-funded researchers met in Val David, Quebec, to discuss and debate the above questions, among others. The "Place and Health: Research to Policy" workshop focused on mobilizing knowledge, envisioning future directions for place and health and linking with policy- and decision-makers. The workshop's objectives were:

- to share research findings and ideas on place and health in Canada;
- to discuss the implications and propose directions for policy development related to place and health issues; and
- to examine future directions for place and health research in Canada.

Following the workshop, objectives included preparing and disseminating a report on the workshop proceedings (this document) and submitting research papers to a theme issue of a relevant journal.

## Background: Banff 2002

In the winter of 2002, a group of CPHI-funded researchers and invited policy- and decision-makers on place and health—many of the same researchers who attended the meeting in Val David—met for a three-day workshop in Banff, Alberta. In addition to briefly presenting their research projects, their purpose was to facilitate the exchange of ideas on place and health and to promote the development of a pan-Canadian research network interested in the spatial analysis of health status in Canadian cities, with a view to using common methods and data-collection tools to facilitate comparisons between studies. They hoped to identify methodological issues they had in common and possible solutions to some of the challenges of conducting research in the area of place and health.

Participants at the Banff workshop identified three key questions to guide their discussion on the complexities of place:

1. **The conceptual question:** How does place affect health? What are the theoretical linkages between neighbourhood context and health? What are the mechanisms by which context produces health?
2. **The scale question**: How is a neighbourhood recognized? What is the relationship between "fuzzy sets" and the ontology of place? What about homogeneity criteria?
3. **The practical question:** What data can we use to research the effects of place on health? What are some creative ways to identify, access and use existing data? Can limitations and opportunities be identified? What about validation of the data and engaging with people who develop the data?

## From Banff to Val David

At the end of the Banff workshop, participants unanimously agreed that they would like to meet again to further the discussion on place and health research. Accordingly, CPHI, with the collaboration of the Léa-Roback Centre de recherche sur les inégalités sociales de santé de Montréal, organized the follow-up workshop at Val David, Quebec, in April 2005.

As researchers from universities and institutions across Canada presented their projects and findings, the Val David meeting reflected the maturing of the state of the Canadian field of place and health research. At the same time, the workshop also raised many practical and conceptual questions about the state of the research and the field—questions that will continue to shape discussion about research into and collaboration within the area of place and health. The Ojibway term *kachimaa mawiin* ("Maybe for sure") arose as an apt way to describe some of the uncertainties inherent in the current state of place and health research, and the potential that the field holds despite—and, perhaps, because of—such uncertainties.

This document provides an overview of the three-day workshop at Val David.

- The workshop was an opportunity for researchers to present their work to a community of colleagues and to policy stakeholders. **Section 2** provides brief summaries of the research projects presented during the first day of the workshop, with responses from a member of the policy- or decision-maker community.
- The various terms used to describe "place," and the great flexibility of the use of those terms, made it clear that there are many different working definitions of this concept—often used interchangeably—that both enrich and complicate the study of place and health and knowledge transfer in the field. **Section 3** summarizes the discussion that took place among workshop participants about the challenges of defining "place."

- One of the workshop's objectives was to discuss implications and propose directions for policy development related to place and health. **Section 4** discusses some of the challenges in translating research to policy and some strategies for bridging the gaps between the research and policy worlds.
- Finally, **Section 5** outlines the discussion on next steps for place and health research, highlighting the importance of interdisciplinary work for the field, the notion of policy-intervention research, and the idea of a research network for place and health to provide continuous quality improvement and help move the field forward.

## About CPHI

The Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI), was created in 1999. CPHI's **mission** is to:

- foster a better understanding of factors that affect the health of individuals and communities; and
- contribute to developing policies that reduce inequities and improve the health and well-being of Canadians.

As a key actor in population health, CPHI:

- provides analysis of Canadian and international population health evidence to inform policies that improve the health of Canadians;
- commissions research and builds research partnerships to enhance understanding of research findings and to promote analysis of strategies that improve population health;
- synthesizes evidence about policy experiences, analyzes evidence on the effectiveness of policy initiatives and develops policy options;
- works to improve public knowledge and understanding of the determinants that affect individual and community health and well-being; and
- works within the Canadian Institute for Health Information to contribute to improvements in Canada's health system and the health of Canadians.

CPHI's **strategic goals** are to:

- build a better understanding of the factors affecting population health (knowledge generation and synthesis);
- contribute to policy development to improve the health and well-being of Canadians (policy synthesis and analysis);
- provide objective and credible information on population health issues (knowledge transfer and reporting); and
- establish collaborative strategies and networks to bring a focus to understanding the determinants of health (knowledge exchange).

For more information and to download CPHI reports, please visit www.cihi.ca/cphi.

## About the Léa-Roback Centre de recherche sur les inégalités sociales de santé de Montréal

The Léa-Roback Research Centre was created to develop a common research agenda and to encourage the development of joint projects. By setting up research infrastructures to meet the needs of researchers, the Centre encourages the realization of projects and the development of a critical mass of researchers interested in issues related to social health inequalities. Moreover, the Centre ensures that knowledge and experience are shared more efficiently between individuals involved in different research, decision-making and intervention environments so that informed actions can be proposed.

The Centre is funded by the Institute of Population and Public Health, as part of a strategic initiative of the Canadian Institutes of Health Research (CIHR) to create research development centres.

### Research Program

The Léa-Roback Research Centre brings together 26 researchers from diverse disciplines and with different perspectives. Each researcher is engaged in a research program corresponding to one of the Centre's four broad questions that reflect different research perspectives and form a more comprehensive vision of research:

- How do social inequalities become health inequalities?
- How can we reduce social inequalities in health?
- How can we diminish the impact of social inequalities on health?
- How can we minimize the contribution of health problems to widening social inequalities?

### Research Infrastructures

The Léa-Roback Research Centre plans to reach its objectives by providing researchers with infrastructures that can match their needs.

### An Infrastructure for Exchange and Knowledge Development

… to document what has been accomplished in our own environments and elsewhere in the field of social inequalities in health, and to provide a solid base for new collaborations that will be implemented to better answer research questions.

### An Infrastructure for Population-Based Data

… to facilitate access to databases that include characteristics of individuals, their families and the contexts in which they live. It is anticipated that new databases will be created, including the establishment of a longitudinal survey that will study the effects of Montréal's contextual features on health status.

### An Infrastructure for Knowledge Transfer

… to encourage exchange among all partners involved in the reduction of social inequalities in health and to develop research projects that correspond to the analytical requirements for effective policy or intervention development.

# Mobilizing Knowledge: Presentations on CPHI-funded Research

The first day of the "Place and Health: Research to Policy" workshop focused on mobilizing knowledge. Researchers presented their projects and results to date. A discussant from a municipal, provincial or federal policy environment then responded to each presentation. In this chapter, summaries are presented of research reports and policy responses.[1]

Research paper presentations were framed by the following headings:

- **Research question and method**
- **Rationale:** Why was this research needed? What problem(s) was it seeking to address?
- **Key findings:** Highlighting policy-relevant findings: What does the knowledge generated contribute to the understanding or management of the "problem(s)" identified?

Discussants' commentaries were framed by the following headings:

- **Key policy-relevant findings:** What do you see as the key policy-relevant findings from the paper?
- **Key policy- and decision-maker audiences:** Who will be interested in these findings and why?
- **Key applications:** How might key audiences apply these findings?
- **Outstanding policy questions**: What related policy questions or major issues have not been addressed? What related research and/or knowledge gaps still exist?

The discussion that followed the presentation of the research reports was framed by the following questions:

- What is the policy relevance of the research presented?
- How might the research papers presented be improved in terms of the clarity and persuasiveness of the research and policy-relevant findings?
- How might the research results be applied?
- What strategies might be employed to "translate" or mobilize the research generated?
- What makes this issue relevant both from a research and policy-making perspective?
- How can engaging in a dialogue between policy-makers and researchers provide an innovative approach to this issue?

The major themes of this discussion are captured in the sections that follow.

1. The opinions and recommendations expressed are those of researchers and discussants and do not necessarily reflect those of the Canadian Population Health Initiative.

## Predictors of Psychological Distress and Quality of Life In Low Income Populations of Montréal

Jean Caron, *Centre de recherche de l'Hôpital Douglas, Université McGill*

### Research Question and Method

Caron discussed that socio-economic level is considered to be the best predictor of mental health, and poor populations are the groups most vulnerable to mental health problems. It appears that having a social support network plays a role in protecting against the chronic psychological stress resulting from conditions such as poverty. Although some studies have found a lack of available social support within the disadvantaged population, is this a characteristic of this entire population or, rather, of the portion of that population experiencing difficulty adapting? Which components of social support have a protective effect?

Five groups of people in southwest Montréal were studied: social assistance recipients experiencing or not experiencing psychological distress; people who were also receiving income security benefits and mental health services; and two groups drawn at random from the general population: one in distress, the other not.

In addition to collecting data using standardized tools, researchers conducted semi-directed interviews. Multivariate quantitative analysis was conducted to compare the five groups' social networks, social support and quality of life. Other analyses identified differences between the groups in the actualization of support. Multiple regression analysis identified the best predictors of psychological distress and quality of life within poor populations.

### Rationale

This study provides a better understanding of the specific relationships between some social support components, psychological distress and quality of life.

### Key Findings

According to Caron, the findings confirm that the poor are more vulnerable to mental health problems. Half of income security recipients in these two disadvantaged Montréal neighbourhoods show a high level of psychological distress, more than twice the level in the Quebec population as a whole and 56% higher than in the general population of these same neighbourhoods. Other residents of these areas who are somewhat more affluent also have a higher level of distress than the population of Montréal.

The results, the paper suggests, confirm the important role that social relations play in psychological distress. The availability of social support, rather than the number of persons in a network or the number of persons interacting in a network, appears to be

key to preventing distress. People not in distress, irrespective of economic level, report a higher general availability of social support than people in distress. Those not in distress also report receiving more support with respect to emotional support, concrete and material assistance, reassurance of their worth, social integration, and guidance during stressful periods. Among the 30 variables entered into a regression analysis, **emotional support** and **the presence of stressful persons** were the most powerful predictors of distress among poor people. Emotional support seems to protect people against psychological distress, while the presence of stressful persons increases psychological distress.

## Policy Response

Discussant **Tariq Bhatti,** Director General, Operations, **Cities Secretariat, Infrastructure Canada,** remarked that because it tries to define the root causes of psychological distress, this paper makes "a wonderful contribution" towards prevention, health promotion and evidence-based decision-making.

## Key Policy-Relevant Findings

Bhatti remarked that the paper raised several interesting avenues of thought for research and policy that feed nicely into the policy framework being developed by the Cities Secretariat. The framework focuses on economic, social, environmental and cultural pillars of sustainability. The paper examines:

- the notion of the *relative* contribution of social support within a multidimensional model of variables that affect mental health: given similar circumstances, some people are more vulnerable than others;
- the ideas of *core vs. marginal variables,* where the core has to do with social relations, and the two most strongly associated variables are (1) the perceived availability and satisfaction with emotional support, and (2) the number of harmful persons in one's life; and
- the role of *perception*: This is where individual differences lie. If distress is regarded as transitional, and individuals have hopeful visions of the future, they experience distress differently and handle it more effectively.

## Key Policy- and Decision-Maker Audiences

At the **national government level**:

- Cities Secretariat, Infrastructure Canada
- Human Resources and Social Development
- Citizenship and Immigration Canada
- Canadian Heritage
- Statistics Canada (study on distressed neighbourhoods)

- Canadian Institute of Planners (for neighbourhood regeneration and urban development)

These departments, suggested Bhatti, could benefit from a workshop on place-sensitive policy and program development, during which they could share experiences and learn from each other. Similar workshops or themes could be a part of, for example, the Federation of Canadian Municipalities' annual conference.

- The **municipal/community level** is key, noted Bhatti. For example, as part of the Gas Tax Fund, municipalities will be required to develop long-term sustainability plans. Place and health research provides an opportunity to influence such plans.
- At the **international level:** the World Urban Forum's *State of Cities* report
- For **neighbourhood regeneration and development**: the Canadian Institute of Planners

## Key Applications

Policy- and decision-makers, suggested Bhatti, may wish to:

- include these elements in any bi- and tri-lateral agreements between different spheres of government;
- feed into local planning at the community level;
- invest in "model" communities and showcase the lesson learned; and
- create a world-wide audience and movement on place-based policy and program development.

## Outstanding Policy Questions

- How can economic, social, cultural and environmental factors of place and health be integrated at different levels of government for greater coherence and collective action?
- How can horizontal collaboration and management be implemented in order to achieve collective accountability for results?
- Bhatti suggested that program and policy development initiatives include and pay more attention to mental health considerations.
- He also suggested that policies target both people and place. At the individual level, that would mean targeting individuals and populations where they choose to live and work. At the place level, that would mean focusing on the current and future sustainability of communities where people choose to live and work.

# Studying Living Environments and Health at A Local Scale: The Case of Three Territories In The Region of Quebec

Maria De Koninck, *Département de médecine sociale et préventive, Université Laval*
Robert Pampalon, *Institut national de santé publique du Québec (INSPQ)*
*Équipe de recherche sur les inégalités sociales de santé, Université Laval*

## Research Question and Method

This study is part of a current research trend that attempts to explain the root causes of inequities in health aiming to better our understanding of how these inequities are socially constructed. The research question was: Why do different areas with a shared socio-economic profile present contrasting health profiles?

The multidisciplinary research team selected three Quebec-region sectors (downtown, suburban and rural) which were further subdivided into "neighbourhood units." To define these, they implemented a threefold approach that combined historical, socio-economic and perceptual material.

The research team adopted a multidisciplinary approach and used quantitative and qualitative methodologies: in-depth analysis of all available data, including Census data and hospital admission and mortality records; field observation; phone surveys and face-to-face interviews with key informants; telephone surveys with a representative sample of the population and in-depth interviews with residents. Throughout, the team worked with the support of an advisory committee made up of local actors.

## Rationale

DeKoninck explained that social inequalities have been identified as determinants of health inequities. Living in precarious material or social conditions is considered to be particularly harmful to health and well-being. According to the research team, however, effective interventions in population health are still limited. Health determinants are too often considered independently of each other. Thus, the objectives of this study were, through an exploration of the role of the community, family and working environments as health determinants, to:

1. identify and quantify at the local level the primary factors that contribute to health profile inequities; and
2. understand the interaction among these factors and identify their effect on public health.

## Key Findings

The research team is currently analyzing study results, and reported on preliminary results for Limoilou, one territory in their study. According to a range of measures, the health status of Limoilou's citizens is poorer than that of Quebec's population.

Although results presented are partial and preliminary, they give some indication of how different factors combine to create local environments, and how such environments may contribute to construction of health inequities. De Koninck used Macintyre et al's[2] reflections to identify **composition, context** and **collective function** explanations:

- **Composition** refers to characteristics of a given population (e.g. schooling, employment, whether people are single or coupled, etc.). One indication of how composition comes into play is the perceived reputation of neighbourhoods. Some interviewed citizens described feeling comfortable in their neighbourhoods because they were not "out of place"; in some cases, gentrification can be seen as a reason to move away (from people not like them). Residents of some neighbourhoods consistently referred to their relative poverty as a shared experience, thus giving credibility to the composition effect. Poverty also raises problems of perceived safety and low satisfaction with quality of neighbourhood. Residents' perceived level of control over their environment was underlined as key to understanding the impact of place on health: if lived experience of place is one of powerlessness to improve one's environment, it may have consequences on health.
- **Context** is interesting in understanding the development of the neighbourhood unit. Here, infrastructure was highlighted: the best-off neighbourhoods are so because they have physical infrastructure to be so. This dimension is significant for policies that may create positive changes.
- **Collective explanation:** When considered in relation to material infrastructure and the characteristics of the population, social and cultural dimensions can help clarify how situations result from "collective functioning." For example, with poverty comes social movements (populations group and regroup) and social dynamics (community groups are more active to alleviate poverty, while they may be less productive in terms of economic development).

While these three concepts are instructive, the researchers noted, they are insufficient to explain the effect of place on health. "Human agency is extremely important," said De Koninck. "We have to go to people and determine why events such as a job loss or death can make people change places and/or use resources differently." Interventions, she stressed, must be diverse and local: "Places come alive in people's accounts of them. We need to know about the way people live." Methodological challenges are: to find the **appropriate spatial scale** and to take into account **human agency**:

- **Appropriate spatial scale:** Understanding the effect of neighbourhood on health requires a better understanding of what "neighbourhood" means to residents and their insights on their "lived experience of place."[3] Such a perspective highlights differences between neighbourhoods, beyond the apparent homogeneity of place.

2. Macintrye, S. et al, "Place Effects on Health: How Can We Conceptualize, Operationalize, and Measure Them?," *Social Science & Medicine* Volume 55, 5 (2002) pp. 125–139.
3. J. Popay et al., "A Proper Place to Live: Health Inequalities, Agency and the Normative Dimensions of Space," *Social Science & Medicine* 57, 1 (2004): pp 55–69.

- The effect of place on health, said De Koninck, is better understood when **human agency** is taken into account: researchers need to develop better ways of integrating information on the role of place.

## Policy Response

Discussant **Richard Lessard,** Public Health Director, Montréal Public Health Department, offered a "preliminary response to preliminary analysis of work in progress."

## Key Policy-Relevant Findings

Lessard noted that:

- People seem to choose where they live, based on personal and/or familial needs and according to their means.
- Once in a place, people feel they have little if any power to change that place. (After all, they "chose" it.)
- Social housing in different parts of the city is part of the solution.

## Key Policy- and Decision-Maker Audiences

- Housing, public transit, education, economic development activity.

## Key Applications

- Policy-makers, Lessard suggested, could intervene at the physical level, to remove factors contributing to poor health and add what is necessary to improve health outcomes/what citizens value through vehicles such as integrated urban renewal programs. If residents "choose" a place, but that place is not ideal (as measured in health outcomes), suggested Lessard, policies should try to modify the place—for example, by decreasing pollution, increasing security, making parks and recreational areas more available and making public health programs more available—in order to make it healthier place. Policy- and decision-makers can consult with citizens to find out what people need to be healthy.

## Outstanding Policy Questions

Outstanding policy questions suggested by Lessard included:

- Market vs. state approach to housing: how can we resolve this?
- There is always some state intervention into neighbourhoods, but do we go further to modify neighbourhoods?
- Are there changes in the physical environment of neighbourhoods that have a desired impact?

## Canada's Rural Communities: Understanding Rural Health and Its Determinants

Marie Desmeules, *Public Health Agency of Canada*
Claudia Lagacé, *Public Health Agency of Canada*
Ray Pong, *Centre for Rural and Northern Health Research, Laurentian University*
Denis Heng, *Centre for Rural and Northern Health Research, Laurentian University*
Judith Guernsey, *Dalhousie University*

### Research Question and Method

How healthy are rural Canadians compared to their urban counterparts? How can we account for rurality in population health and health policy? Marie Desmeules described a national collaborative research program to examine the health status, health determinants and health services utilization of rural communities, with the following objectives:

- to explore and address important conceptual, methodological, data-availability and quality issues in rural population health research;
- to provide a comprehensive profile of the health status and health care utilization of rural Canadians based on secondary national and provincial data;
- to use a population health model to identify the determinants of rural health; and
- to suggest appropriate strategies to address identified rural population health problems.

Administrative health (e.g. mortality, hospitalizations and physician visits) and survey data at the regional, provincial and national levels were used to identify potential disparities between rural and urban areas (as defined by "metropolitan influence zone"). Researchers developed a framework that incorporates the rural dimension of the concept of place by portraying the hypothesized relationships between major categories of determinants and the health status of rural populations. This framework recognizes the compositional, contextual and collective features of place and shows that the relationships can be direct, indirect or reciprocal.

### Rationale

Desmeules noted that information on the health status of Canada's rural populations is currently limited. Most of the theoretical work on place and health has been based on studies of urban environments. This urban focus contributes to the difficulties of characterizing Canada's rural populations and the health status of these populations.

There is increasing recognition that communities have widely different opportunities that shape their development and health, and increasing acknowledgement (e.g. the Romanow Report; the Ministerial Advisory Council on Rural Health; and the Strategic Initiative in Rural and Northern Health Research of the Canadian Institutes of Health Research [CIHR]) that the policy process should not overlook this diversity of conditions.

## Key Findings

Desmeules discussed that while rural-urban differences do not exist for some health measures, and some adverse health measures are higher in urban areas, rural areas generally showed a disadvantage for the health measures examined in this study. Higher overall mortality risks among rural communities seem to be driven by higher death rates from causes such as circulatory diseases, injuries and suicide. The most rural areas are often at highest risk.

In particular, higher mortality rates were found in rural Canada for preventable causes such as suicide, injuries and various chronic diseases (including cardiovascular disease and diabetes). These higher mortality rates remained even after adjustment for various socioeconomic and demographic factors. Health-related behaviours such as the prevalence of smoking and obesity were also elevated in rural Canada, while analyses of physician-visit rates by rural vs. urban areas—for mental health services, for example—indicated lower use. These findings can provide useful evidence in the development of enhanced programs and policies aimed at improving the health of Canadians living in rural communities.

## Suggested Policy Implications and Questions

Desmeules suggested that:

- When taking "place" into account, should policy target *communities* or *individuals*? While in some cases policies and interventions targeting individuals (e.g. enhanced cancer screening) could be the most cost-effective approach, for others (e.g. healthy weights), community contexts (values, beliefs, culture, physical environment, etc.) should not be overlooked. A combination of both individual and community approaches to a particular health issue could be considered for rural communities.
- Although some of the existing studies on the issue indicated poorer health in rural areas, rurality does not systematically equal poor health when compared with urban places of residence.
- Policies that are effective in urban communities may not necessarily be applicable to rural communities.
- Selective use of individual health status indicators may lead to views that overemphasize the notion of a rural health deficit in Canada. By increasing the number of indicators that are employed, a more balanced view of the health status of rural Canadians is more likely to emerge.

- Analysis of all-cause mortality demonstrated that the effect of rural place of residence on mortality is not homogeneous. Using a dichotomous definition of rurality (i.e. urban/rural) may mask important differences between rural communities. Assessing rurality in a more dynamic context, based on commuter thresholds, for example, may shed light on how degrees of rurality shape health status.

### Policy Response

- Rurality is not simply a variable, remarked discussant **Robert Pampalon,** of the Institut national de santé publique du Québec: 20% of Canada's population is rural, and we must tailor research and policy specifically to these populations.

### Key Policy-Relevant Findings

- Rural areas are afflicted by premature mortality, increased rates of motor vehicle accidents, suicide (for men), circulatory diseases and prostate and cervical cancers.
- Rural residents smoke more, are more overweight and consult general practitioners less often for preventive screening practices (e.g. Pap tests, breast and prostate cancer screening).
- There is an upward trend in mortality when examining major cities to increasingly rural areas.
- The contextual influence of rural areas, above and beyond socioeconomic factors, contributes to premature mortality in these areas.

### Key Policy- and Decision-Maker Audiences, and Key Applications

- **National and regional health authorities:** Pampalon suggested the possibility of introducing health policies and programs with some reference to rural realities, and with specific targets to reduce differences between rural and urban areas, and improve health in rural areas. He also suggested introducing health-status and health-resources monitoring systems with explicit reference to rural realities.
- **Policy-makers responsible for specific health programs,** such as programs to prevent suicide, decrease tobacco use or promote healthy eating or healthy weights: How can these programs concretely reach rural residents (or, in the case of suicide, young men)? How are these programs adapted to rural realities?
- Pampalon noted that **medical school** could increase rural general practitioners' awareness of about the importance of preventive screening practices, and other rural realities.

Pampalon also identified the National and regional authorities in charge of health-related public sectors:

- Transportation could address quality of roads and the absence of public transportation in rural areas.
- Education could address high-school drop-out levels.
- Employment could address high levels of unemployment.

## Outstanding Research and Policy Questions

Pampalon suggested further research into the following areas of rural health:

- social problems among young men and women in rural areas (e.g. child abuse and neglect, juvenile delinquency, crime)
- occupational accidents and illnesses
- mental health
- social and cultural factors related to health:
  - how rural residents define health
  - social dynamics in rural families and work environments
  - resiliency of rural communities
- explanatory factors of rural-urban migration among elderly: what is the role of health status in migration?

## Unpacking Geographies of Income Inequality and Health in North American Metropolitan Areas

James R. Dunn, *Centre for Research on Inner City Health, St. Michael's Hospital*
Nancy A. Ross, *Department of Geography, McGill University*

### Research Question and Method

This project's starting point is the "paradoxical relationship" between income inequality and working-age mortality in metropolitan areas in Canada and the U.S. The researchers examined urban income inequalities ("median share") and health (age-adjusted mortality rates for the "working-age" (25–64) population) in Canada and the U.S. in an attempt to identify social and economic factors that differ substantially between the two countries and that could be the basis for a differing relationship between income inequality and health.

### Rationale

The authors noted that there is a distinctively different pattern in the relationship between income inequality and working-age mortality in Canada and the U.S. These differences provide a compelling paradox for comparative study of the potential pathways linking income inequality and health at the metropolitan level.

While a large body of literature investigates the relationship between income inequality and population health, studies of this relationship have paid a peculiar inattention to geography and place. The authors propose that any inquiry into the relationship between income distribution and population health is inherently geographical; income inequality is a "true" place-based, contextual variable.

From a metropolitan policy perspective, note the authors, this analysis is timely. Canadian cities, after many years of downloading of problems and costs from senior governments, are now back on the political agenda. More than 80% of Canadians are urbanized; more than 50% live in either metropolitan Toronto, Vancouver, Montréal or the Calgary-Edmonton corridor.

### Key Findings

The effects of income inequality on population health, note the authors, need to be understood in a multi-scalar, place-based and geographical fashion.

Canada has a range of mechanisms—distinct from the U.S.—that buffer the impact of inequality and relative poverty. These key differences could possibly account for the difference in the relationship between income inequality and health in Canada and the U.S. According to the authors, they include:

- Canada's much more aggressive and effective systems of income redistribution through tax and transfer programs;
- the redistributive impact of social goods—especially universal health insurance and universal public elementary and secondary education—that are the underpinnings of good health;
- smaller intra-metropolitan disparities in the quality of public goods and services in Canada, which render residential segregation by income less severe and the effects of segregation less damaging. Metropolarities[4]—or, inequalities expressed spatially in the landscape—are offset in Canada through:
  - high government transfers to individuals and households that reduce the overall burden of social need;
  - targeted but relatively generous transfers from senior levels of government to low-income individuals and households; and
  - Canadian provincial governmental control that exerts a high degree of control and authority over municipal governments.

The attributes of place discussed in this project represent a plausible potential explanation for the paradoxical pattern of income inequality and population health. While not easily quantified and tested in the traditional positivistic manner, attributes of place may buffer or exacerbate the population health effects of underlying inequality in those places.

According to the researchers, policy implications that arise from this research include:

- preserving a progressive income tax system and reducing the importance of regressive sources of revenue (redistributive social services could be funded from progressive taxes);
- reducing financial barriers to "goods" (health, education, housing) that shape life changes;
- evaluating social service financing and delivery options for social and spatial equity (e.g. widening debates over municipal amalgamation or devolution to include equity as a factor); and
- strengthening links between social and city planning.

4. The term "metropolarities" is coined by E.W. Soja *Postmetropolis: Critical Studies of Cities and Regions*. (Oxford, UK: Blackwell Publishing , 2000).

## Policy Response

Discussant **Dianne Patychuk** responded to the paper from her perspective as a social epidemiologist at the City of Toronto Public Health Department. Her job, she explained, involves using information to support decisions that reduce health inequalities (e.g. allocating resources, identifying priority issues and communities, locating services to reach the people who need them the most, etc.). She asked "how can we use this project's findings in our understanding of strategies to reduce population health inequalities?"

## Key Policy-Relevant Findings

The explanations of the differences between Canada and the U.S. ring true, said Patychuk, and insert place into population health as a key player as they move the discussion from people and populations of concern to places of concern to policies of concern.

- The findings suggest that governments can provide policies that reduce disparities by addressing non-cash solutions/measures of wealth. Capacity for alternatives to regressive tax policies exist.
- The measure of the "health of places" is relevant in addition to population health status measures.
- Income is more of a determinant of life chances and chances for health when access to determinants depends on level of income. What are the levers that are available to buffer the relationship between income and health?

## Key Policy- and Decision-Maker Audiences

The "city-state movement" is going to happen, and indeed is happening in Toronto, stressed Patychuk. Municipal as well as provincial and federal governments are key audiences, as well as business organizations that give attention to social infrastructure and national organizations that offer urban strategies, such as the Federation of Canadian Municipalities (FCM).

## Key Applications

"Place is porous," noted Patychuk. The equitable distribution of universally good-quality public goods requires multi-sectoral plans and a policy environment that respects the shared values and interests of the collective social milieu (beyond the interests of individual communities or neighbourhoods).

On a scale that stretches from "micro" (individual/family) to "macro" (labour market) strategies, this paper focuses on the "meso" strategies that address the whole issue of public goods and how they could be used to address inequalities. Meso strategies include maximizing the use of income-tax funded (progressive) strategies to make social goods (e.g. health, dental, education, transportation, housing and recreation services) available, while moving away from regressive strategies, such as user fees.

## Outstanding Policy Questions

Patychuk noted the following questions:

- Although Canada's urban centres boast a more equitable distribution of wealth and lower health inequities than their U.S. counterparts, that does not mean that there are not health inequalities within Canadian cities—infant mortality is one example. She noted that we need to look at health inequalities within and between Canadian cities.
- What is the impact on access to "public goods" in Canadian communities of post-recession social and economic polices since 1994 (tax, transfer and social welfare, labour market restructuring) that attenuated labour market (LM) inequalities? A number of nationally funded projects are underway in neighbourhoods in cities across Canada involving governments and non-governmental organizations (e.g. United Way). These offer "natural experiments" in how local communities prioritize actions between micro, meso and macro policies.

## The Conundrum of Conceptualizing and Measuring Place: Towards a Multi-Concept/Multi-Method Approach

Lise Gauvin, *Université de Montréal*
Eric Robitaille, *Léa Roback Reseach Centre*
Mylène Riva, *Université de Montréal*
Louise Potvin, *Université de Montréal*
Clément Dassa, *Université de Montréal*
Lindsay McLaren, *University of Calgary*

### Research Question and Method

Lise Gauvin presented "a story of the successes, setbacks and challenges" of this research project, describing the conundrum of conceptualizing and measuring place as "a riddle that [currently] eludes a satisfactory solution." She used the example of the comic book character "The Riddler" to illustrate this point.

This project had three aims:

- to enumerate and critique the definition and operationalization of place in health research;
- to illustrate the difficulties in defining and operationalizing place through the examples of Montréal and Calgary; and
- to propose an approach for overcoming conceptual and methodological challenges.

The research had five building blocks:

- First, researchers illustrated the challenges of defining and operationalizing neighbourhoods through examples of various attempts to map out neighbourhoods in Montréal and Calgary. For example, *administrative boundary files* describe territories that are created by community-based organizations to achieve specific organizational objectives, while *statistical spatial boundary files* describe territories that are created by community-based organizations to achieve specific organizational objectives; the city of Montréal has been divided according to the Centre local de services communautaires (CLSC), school and police districts; boroughs; Census tracts; dissemination areas; street blocks; and by the urban plans of older neighbourhoods, to name a few.
- Second, researchers described the "well-known but too infrequently addressed methodological problem" known as the modifiable areal unit problem (MAUP).
- Third, researchers enumerated and critiqued the conceptual definitions of "neighbourhood" used in health research.

- Fourth, they provided a brief overview of how neighbourhoods have been operationalized in health research conducted over the past decade, and commented on the size of associations between neighbourhood characteristics and health outcomes.
- Finally, the team proposed a multi-concept/multi-method approach that consists of identifying the specific health outcome of interest, defining the specific exposures to be linked to health outcomes and identifying area units that are homogenous in terms of exposures.

## Rationale

Over the past decade, interest in the study of place as a determinant of population health has accelerated. A growing literature has accumulated that associates the spatial dimensions of locations with a variety of health outcomes. With the renewed interest in place and health comes a vexing problem for researchers: how to identify the most appropriate unit of analysis for studying place effects on health?

The researchers found that a multi-concept/multi-method approach to conceptualizing and operationalizing neighbourhood in relation to health represents the most viable solution for building evidence about the association between characteristics of residential locations and health outcomes.

## Key Findings

One of the most promising approaches to defining and operationalizing neighbourhoods for research on health outcomes lies in a three-pronged approach that:

- identifies the appropriate areal unit for the specific exposures and specific health outcomes of interest;
- examines associations between specific health outcomes and specific exposures; and
- explicitly indicates whether the focus is individual health, population health or both.

"We still have many lessons to learn," noted Gauvin. Place and health researchers, she said, need to:

- develop an interface between conceptualizations of neighbourhoods and their operationalization;
- entertain the idea that neighbourhoods may be best viewed as "*fuzzy sets*" rather than "contoured entities";
- examine how to craft longitudinal designs;
- explore the utility of more novel measurement approaches; and
- consider degree of exposure to residential neighbourhoods.

## Policy Response

Discussant **Mike Benigeri,** Coordinator of the Carrefour montréalais des informations sociosanitaires/Agence de développement des réseaux locaux de santé et de services sociaux de Montréal, approached this paper from both the points of view of an ex-researcher and an administrator.

As an **ex-researcher,** he empathized with the difficulties in conceptualizing and measuring neighbourhoods. Opportunities for aggregation, he suggested, may exist based on data from the Canadian Census. He suggested that the researchers pay special attention to the concept of social isolation, and underscored the significance of the MAUP.

As an **administrator**, Benigeri posed four questions that underscored some of the differing needs between researchers and policy-makers:

- Benigeri suggested that as a policy-maker he is more interested in and helped by research that emphasizes results and recommendations over methodology.
- How should territories be chosen? "We have all kinds of existing territories already, and we have to work with them as they are. We don't have the option of building [still] more new ones."
- Is it about neighbourhoods or people? "We have to intervene in the territories, *with* the people. If we have to put money somewhere, we know where; it's not a question of people and territories, it's what do we have to do, and how?"
- Should the focus be on health status or health services needs? "We need a study on health services. It's not enough that we know that people are poor or single parents; we need to know how much to allocate to be effective—twice the money to mental health services, or five or ten times?"

In closing, Benigeri offered some thoughts on **reconciling the two perspectives:**

- We need, he suggested, increased partnerships between researchers and administrators.
- It may be useful to gradually integrate new territorial units (e.g. within the centres de santé et de services sociaux (CSSS)) in the health care system.
- Finally, said Benigeri, we need to orient research on *what needs to be done* and on *how to do it.*

# Estimating Small Area Health Status in the Vancouver Census Metropolitan Area

Michael Hayes, *Faculty of Health Science/Department of Geography, Simon Fraser University*
Lisa Oliver, *Department of Geography, Simon Fraser University*
Nadine Schuurman, *Department of Geography, Simon Fraser University*
Darrin Grund, *Faculty of Health Science, Simon Fraser University*

## Research Question and Method

What is the spatial distribution of health inequalities throughout the Vancouver Census Metropolitan Area (CMA)? How, for example, does the health status of downtown Vancouver compare to that of other communities?

Within the Vancouver CMA, the research team is developing a technique to estimate health status for flexible spatial units by aggregating Census Dissemination Areas (DA), based on an integrated land-use database the team has assembled through its CPHI *Urban Structure, Population Health and Public Policy* research program. Key socio-economic variables (e.g. average income, unemployment) and several indices of deprivation (e.g. Pampalon; Manitoba Centre for Health Policy) will be used to create DA deciles of social characteristics upon which to base estimates of disparity in health status within the Vancouver CMA. The DA deciles are linked to respondents in the Canadian Community Health Survey (CCHS) Cycle 1.1 using postal codes contained in the confidential microdata file. Major health outcomes contained in the CCHS have been selected, including self-rated health, injury, chronic conditions, depression and health utilization. Proportions and/or averages of each health status measure for deciles of the selected socio-economic variables and deprivation indices have been calculated. Using these averages, health status for any spatial unit can be estimated by assessing the selected socio-economic data for DAs of interest. Implications for choosing particular measures of area deprivation will be discussed.

## Rationale

One of the limitations of small-area analysis of health status is that data are often fixed to pre-defined units such as health regions. Researchers and policy-makers have often desired the ability to estimate health status at more flexible spatial units than typically available. After several reorganizations of British Columbia's regionalized health system, which do not treat the Vancouver CMA as one integrated urban system, and therefore do not allow comparison of the distribution of health status within the CMA, this project aims to bring some coherence to the spatial definitions of Vancouver's underlying urban system, in order to be able to compare data, and, as Michael Hayes put it "to try to imagine the world differently and to try to convince administrators to imagine their world differently."

## Key Findings

This project is currently analyzing data. The research team has recently entered into a partnership with the B.C. Ministry of Health that will allow the team access to the vital statistics database, providing further opportunities to assess the extent of health inequalities within the Vancouver CMA.

*There was no discussant for this research presentation.*

## Place and Health in First Nations Communities

Christopher E. Lalonde, *University of Victoria*
Kathi Avery Kinew, *Assembly of Manitoba Chiefs*
Robin A. Yates, *University of Victoria*

### Research Question and Method

This research project examined the relationship between "cultural continuity"—the persistence of culture and tradition over time and through change—and suicide rates among First Nations youth in British Columbia.

Lalonde noted that for the First Peoples of Canada, the effect of place on health is rooted in a relationship to the land that extends over thousands of years of cultural adaptation. To discuss "place" is to discuss "culture." These research projects focus on this intersection of culture and health. What happens when place is dictated and health is cultural? The team will be working with the Assembly of Manitoba Chiefs to examine the relationship between cultural continuity and health outcomes in Manitoba First Nations.

To understand the relationship between self-continuity and suicide, researchers studied several variables that painted a picture of First Nations communities' levels of cultural community in British Columbia. Variables included attempts to secure title to traditional lands; levels of self-government; control over education, health delivery and police and fire protection services; and the establishment of cultural facilities to preserve and enrich cultural lives. The research team hypothesized that each of these factors was protective against suicide, and "to the extent that each of these 'protective factors' was present in a given community, some quanta of cultural continuity would be added in place, and some reduction in that community's overall suicide rate would occur." This model is now being adapted for use in Manitoba.

### Rationale

Lalonde discussed that it is widely reported that First Nations Canadians fall behind the general population on almost every indicator of health and well-being. Higher rates of injury, accidental death, suicide and discrepancies on other measures of health are often used to support the mistaken view that "being Aboriginal" is somehow equivalent to "being at risk".

According to the investigators, this research is needed for a number of reasons. First, connections between population health research and indigenous methods will lead to new understanding, shared knowledge and effective strategies to protect against suicide. If factors that are protective against suicide and factors that are linked to higher rates of suicide are known, it might then be possible to reduce suicide in First Nations communities by facilitating the sharing of knowledge and successes across First Nations communities. Further, given that suicide is only one—albeit extreme—indicator of

health, understanding protective and risk factors for suicide may lead better overall health outcomes in these communities. As well, this research helps to lay to rest misconceptions that "being Aboriginal" means to be automatically at risk for higher suicide rates.

## Findings

The team found that in British Columbia, suicide rates were directly related to control over several variables related to cultural community: with no control, suicide rates soar. With control over all variables, suicide rates were virtually nil. Self-government had the highest preventive effect.

Next steps for the team are to understand how and why these factors are preventive. In one attempt to discover why, University of Victoria researcher Robin Yates will conduct a qualitative exploration of councils with more than 50 per cent of women on council, for whom the suicide rate is much lower. Kathy Avery Kinew, of the Assembly of Manitoba Chiefs, discussed some of the cultural considerations of conducting research in general, and particularly on "place and health" and suicide, for First Nations communities (see page 34 for a fuller discussion).

## Policy Response

Discussant **Irene Linklater,** Research and Policy Development Director, Assembly of Manitoba Chiefs, acknowledged the workshop's "language of choice" ground rule by beginning her remarks in Ojibway. "If I were to speak in my language," she noted, "that is the language I would speak in".

## Key Policy-Relevant Findings

- Communities that have taken active steps to preserve and rehabilitate their own cultures have dramatically lower suicide rates. A better understanding of the problem of suicide in First Nations communities, Linklater suggested, can be acheived by focusing on the interface between personal and cultural change.
- Linkater noted that this research can influence the development of First Nations policy, which incorporates inherent and treaty rights and looks at issues of self-determination and law-making. It examines how First Nations are affected by policy, and how First Nations can rebuild.
- Further, she discussed that culture is the basis of understanding relationships between people and between nations. The Manitoba First Nations will adapt and improve the B.C. study's methodology to map relations between youth suicide rates and risk behaviours and measures of cultural continuity within First Nations in the province, and to promote cultural continuity.

- Research, analysis and policy development for First Nations, stressed Linklater, must be culturally informed and directly involve First Nations youth, elders and researchers. It must incorporate First Nations languages and values in the transmission and transfer of knowledge. Knowledge translation is a reality for peoples whose first language is Cree, Dakota, Dene, Ojibway and Oji-Cree—not English or French. Measurables and tools are not predetermined, but developed through the community.

## Messages for Key Policy and Decision Maker Audiences

Linklater raised the following points and questions:

- Collecting accurate data on variability in suicide rates and risks in Manitoba will provide a solid foundation for suicide intervention and prevention.
- The association between health status (suicide risk) and unique circumstances within individual communities in Manitoba requires clarification.
- If cultural continuity is found to be associated with lower or absent suicide rates, can we find ways to expand this concept to other First Nations regions?
- It is important that indicators appropriate to First Nations are developed, applied and interpreted in ways that respect the perspectives and understandings of distinctive cultural peoples.

Policy and program activities in suicide prevention, intervention and treatment, noted Linklater and Kathy Avery Kinew, should be designed and developed with the experience, vision, goals and strategic objectives of Manitoba First Nations. With sufficient resources and leadership, we can successfully empower ownership and control over First Nation community life and collective rights.

## Family and Place: Effects on Health and Educational Achievement

Leslie L. Roos, Randy Walld and Leonard MacWilliam, *Manitoba Centre for Health Policy, Department of Community Health Sciences, University of Manitoba*

### Research Question and Method

Leslie Roos introduced this study as the inadvertent "anti-place paper." When it comes to outcomes related to well-being, he asked, does place matter?

This paper compares siblings and children living in the same neighbourhood (but not in the same family) regarding several adolescent outcomes related to well-being. A large sample of same-sex siblings and neighbours (~18,000) is taken from a cohort born between 1978 and 1985. Specific outcomes include health care costs and utilization between ages 12 and 16 and an educational achievement index derived from Grade 12 exams and school attendance (at age-appropriate grade level, grade level below that expected from age and non-attendance).

### Rationale

Roos noted that effects of family and place may be seriously misestimated without careful attention to research design. Standard analytical techniques do not deal with important biases resulting from omitted variables and measurement error. Appropriate designs can avoid such problems.

### Findings

This paper, said Roos, reminds us about the importance of the family as a place where people live their lives. The closer one looks to the individual-level variable for explaining health outcomes, the more likely one is to find higher correlations.

While the research team did find differences in health care utilization and educational achievement based on place, family influences are totally dominant, with very high correlations between siblings. Large effects are shown to be associated with being in the same family, while the correlations representing upper bounds on neighbourhood effects are quite small (generally between .06 and .00). Neighbourhood correlations were strongest within the same postal code.

Such results emphasize the importance of health and social interventions directed toward the family, and de-emphasize the importance of broad community programs with goals for improving health and education. Improving well-being through cost-effective policy remains a challenge.

## Policy Response

"I am your audience," discussant **Mark Wheeler,** Assistant Director at the Policy Division, Health Canada, told the group. Wheeler commented on the "work we do in the Policy Division at Health Canada, and how we came to be interested in place and health."

## Key Policy-Relevant Findings

According to Wheeler, this paper adds to the weight of evidence that "place matters"; place to this point in time, he noted, has not been a major consideration in health programming. The paper gives some indication of the relative importance of place, in that family characteristics still provide a better explanation of differences in health services utilization and educational attainment.

From these contributions, it is possible to think about place and health in two different ways, by focusing on **places of concern** and **people of concern**.

- **Places of concern:** For example, what do we know about the people who live in a certain place? What is the local economy? What is known about the physical environment?
- Studying **people of concern** may help to increase understanding of health outcomes that are not neatly explained in terms of data on health indicators. For example, according to CCHS data, why does St. John's have significantly higher levels of physical inactivity and mid-field standing on self-rated health (17th of 25), while Thunder Bay has significantly lower levels of physical inactivity and very low standing on self-rated health?

If, as the Roos paper suggests, there is merit in longitudinal studies, said Wheeler, policy- and decision-makers need to be very clear on what data they will need. That in turn requires an explanatory model, or framework, for place and health. Such a model would include physical environment and social capital measures. The merits of longitudinal work not withstanding, decision-makers risk being overtaken by events as underlying factors change.

## Outstanding Policy Questions

Wheeler raised the point that place and health stakeholders do not know enough to make sophisticated distinctions between places and people of concern, citing a "chicken and egg" problem of distinguishing between individual/family and neighbourhood factors. For example, an element of self-selection in choice of neighbourhood may mean that people of modest means and/or with lower educational attainment are drawn to some places more so than others for reasons of financial capacity, and it may be that these people are more inclined than others to use tobacco. Should tobacco use be broadly accepted in such places, it may be difficult for children of non-smokers in such places to resist peer pressure to take up smoking. A neighbourhood influence could effectively trump a parental influence.

Wheeler asked if there is a residual "something" about poorer neighbourhoods that makes them unhealthy. For example, how can some neighbourhoods "buffer" associations between income and smoking, or lessen the probability of smokers being unhealthy compared to non-smokers?

## Summing Up: Day 1

At the end of the discussion, Louise Potvin and Michael Hayes, members of the workshop coordinating committee, posed the following four research questions to guide future thinking on the study of place and health:

- What can be learned from in-depth interviews and ethnographies of neighbourhoods and how important is it to learn those things given the cost, both from a research point of view and from a policy-making perspective?
- "Residents of rural areas have specific needs." We need to use a dynamic and more informative measure of rurality that reveals a robust and pervasive gradient that follows the increase of rurality of where people live. Are the results reported for the whole of rural areas in Canada a true place-based effect when we cannot characterize those places in terms of experiences of everyday life across the continuum of rural to urban?
- How should place effects be conceptualized? As a residual effect after everything else has been taken into account? How could we take into account cross-level interactions and the cumulative effects of those interactions?
- Are there different meanings for place effects associated with different outcomes?

# Clarifying Concepts: The Problem of Defining "Place"

What is place? How is it defined and measured? How can research and policy communities communicate their understandings of it? As one research paper put it, the term "place embodies a lot of things. It is a shorthand way of describing a host of factors that may have health consequences for communities, populations, families and individuals."

Over the course of the "Place and Health: Research to Policy" workshop, the various terms used to describe "place," and the great flexibility of the use of those terms, made it clear that there are many different working definitions of this concept—often used interchangeably—that both enrich and complicate the study of place and health and knowledge transfer in the field. The question of the definition of "place" has ontological, methodological/empirical and practical implications.[5]

## Place is …

*Throughout the "Place and Health" workshop, a host of terms to describe "place" were introduced by researchers from various fields and by policy- and decision-makers. The sheer number of terms for "place" points to the complexity of this field of study.*

neighbourhood • location • environment • Census tract • city • state • province • country • border • site • culture • community • family • history • nationality • ethnicity • city block • postal code region • rural • urban • Metropolitan Influenced Zone (MIZ) • a set of [stressful or supportive] social relationships • housing • Census metropolitan area • porous • socioeconomic status • individual • population • mobility • mutable • hierarchy • something external to ourselves • something we carry inside

- **Ontological:** How do we know about and imagine place? Is it something intrinsic, something carried around inside people, developed over time? Is it something that exists outside people that has an effect on health and well-being, on identity?
- **Methodological/empirical:** How can knowledge of place and health be articulated and made accessible and usable? How can its parameters be defined for research? What are the units of analysis?
- **Practical:** How can place as it relates to health be made more understandable and digestible to policy-makers? To interdisciplinary research?

Workshop participants agreed on the need for greater conceptual clarity about the notion and definition of terms like "place" and "neighbourhood," especially in terms of defining the unit of analysis. An inventory of the typologies of "place" could help foster an interdisciplinary approach to place and health research and help provide a way forward.

5. The opinions and recommendations expressed are those of researchers and discussants and do not necessarily reflect those of the Canadian Population Health Initiative.

One participant made a comparison to the field of obesity research: once a universal measure of obesity/healthy weights (body mass index, or BMI) was agreed upon—and despite the fact that BMI is not a faultless measure—the field could move forward. Is there a definition of "neighbourhood" or "place" that researchers could agree upon as a means of moving forward? This question raised more questions than answers, and provided a jumping-off point for further discussion:

- In terms of a definition, are place and health researchers seeking consensus, or diversity and breadth? As much as common terms would further the study of place and health by allowing researchers to come up with common outcomes, it was felt that the concept of "place" is more **abstract and multifaceted**, and harder to define, than the concept of "obesity." It would be impossible, participants mused, to come up with only one generic working measure for "place" (e.g. the terms "neighbourhood" and/or "community" have different meanings in fields of sociology, psychology, epidemiology and geography).
- Place and health researchers, participants suggested, would benefit from continuing to **foster an interdisciplinary approach** to place by sharing data and definitions, and by looking to each other's fields (geography, environment, sociology, epidemiology, etc.) and to government portfolios/departments (Transport, Environment, Infrastructure, Housing, etc.) to see how different fields envision, conceptualize and operationalize "place."
- Analyses (e.g. by Nancy Ross and colleagues) of administrative, **"off the shelf" definitions of place**, such as Census geographical areas and other current and historical measures, can offer value to researchers and the policy community. Some administrators in the group pointed out that policy- and decision-makers are less interested in the "ideal" definition of place and boundaries than they are in solutions or recommendations related to the health of citizens and populations—solutions or recommendations that are applicable within current boundaries: "We already have boundaries in place—why not use them?"
- To what extent to do **local actors**—residents and other stakeholders—define the places where they live? How can research take into account the history, perspective and experience of the people who live in the places studied?

  This topic—the combination and relative weight of quantitative and qualitative approaches—generated much discussion. To truly understand place and health, many argued, we must take the time to understand the personal/psychological trajectories embedded in place. This may be accomplished via methodologies that may include (but are not limited to):
  - ethnography;
  - personal and/or in-depth interviews;
  - focus groups;
  - concept mapping; and
  - community-based and controlled data gathering and analysis.

In short, workshop participants felt that researchers need to talk to people, to find ways to integrate local actors into research projects, and to disseminate results to local actors.

Such approaches, however, are time- and resource-intensive. How important is it to integrate local actors, given the cost of such methodologies, both from the point of view of research and from a policy-making perspective? When can quantitative research stand alone?

- Many participants agreed that **place and health researchers "should not let perfect become the enemy of the good**." The workshop participants noted that a focus on definitions should not immobilize research, nor should fairly robust definitions be dismissed because they are not perfect. Common definitions do not have to be perfect to be useful.

In the end, do place and health researchers simply pick a fairly robust set of definitions and move forward? Who does this? How does the research community agree upon definitions? Has it already been done (e.g. Census tracts)? Which definitions have the most relevance to policy? Again, the notion of "*kachimaa mawiin*/maybe for sure"—raised earlier by Kathi Avery Kinew of the Assembly of Manitoba Chiefs as a way of framing the uncertainties surrounding place and health in a productive light— informed the discussion: the definition of place will change with the context, and vice versa.

A way forward was proposed in the form of a **research network on place and health.** Such a network could help advance research, collaboration, interdisciplinarity and policy uptake in the field and perhaps foster policy-intervention research. (See page 47 for a detailed discussion of this idea.)

## Place as Culture: A First Nations Example

As Kathi Avery Kinew of the Assembly of Manitoba Chiefs (AMC) pointed out, for Canada's First Peoples, culture is place. "Culture is the premise upon which we see all things beginning and ending," she noted. For example, First Nations peoples in the Prairies still see themselves as Buffalo and Caribou people; the provincial and national borders more recently superimposed upon the original lands of the Ojibway, Cree, Ojicree, Dene and Dakota peoples do not necessarily reflect—and can complicate—First Nations' approaches to place and health.

Place as culture also informs First Nations' approaches to health. As Kinew put it, "if the land is not healthy, then we are not healthy." As Michael J. Chandler and Christopher Lalonde's investigation into cultural continuity as a hedge against suicide in B.C.'s First Nations discovered, the more control First Nations bands have over a range of factors that are markers of cultural continuity (e.g. self-government, land claims, education), the lower that band's suicide rate.

As the AMC investigates protective factors against suicide in Manitoba First Nations, Kinew noted that the research team must take into account this cultural view of place and conduct its investigation accordingly. For example, First Nations communities find talking about suicide difficult: a taboo on "seeking death" by speaking about suicide and the cultural practice of not uttering the name of a person who has passed to the spirit world pose a challenge to implementing mainstream prevention strategies, and means that research into suicide in First Nations requires much discussion, engagement and ceremony, and the active involvement of and respect for community Elders.

Kinew noted that Manitoba First Nations intuitively understand the continuation of self through time and that culture is the foundation of self and a people. Thus, a program in suicide prevention that looks at aspects of cultural continuity may make more sense in a First Nations context.

## From "Place" to "Neighbourhood": Approaching Neighbourhoods Pragmatically

Over the course of the "Place and Health: Research to Policy" workshop, the term "neighbourhood" came up repeatedly as an integral unit of study for many researchers, and as a basic area of intervention (and evaluation of interventions) for researchers and policy-makers alike.

A strong bid arose to **consider housing as a key factor** in defining "place" and "neighbourhood" and as an area for further research. Housing is important because it is linked to the constitution of place and the use of land. Some discussion ensued as to the degree to which housing has an effect on health: at what level does it make a difference?

The idea that **"neighbourhoods are porous"** was embraced by workshop participants, who discussed at length the complexities of studying neighbourhoods as units with **constantly shifting boundaries and mobile inhabitants.** Workshop participants asked: How many neighbourhoods would we need to test to get to common measures? How do researchers account for the heterogeneity and homogeneity of neighbourhoods? What is the right balance, and at which scale? Can there be spatial analyses without imposing fixed boundaries?

The **"mixity" of neighbourhoods** also emerged as an important characteristic of a place. The people with whom residents interact daily seem to matter to their health all well-being (as, for example, Jean Caron's research illustrated). Are social relationships the ones that really matter? Is place merely a characteristic of those relationships, or is it a fundamental determinant?

**Rurality** came up repeatedly as an important concern when defining place and neighbourhood. Participants noted that residents of rural areas have specific needs. To assess and address those needs, it was suggested, researchers can benefit from using a dynamic measure of *degrees* of rurality, across a spectrum from quasi-urban to very remote. As Marie Desmeules et al's work suggested, results reported for the whole of "rural Canada" may not be "true" place-based effects when they cannot be characterized in terms of everyday life across the continuum of rural to urban.

The varying degree of residents' **mobility** was itself discussed as an important measure or indicator of health status. Definitions and measures, many suggested, should take into account the dynamic nature of place, both the ways in which neighbourhoods and residents change over time and geographical and personal histories.

### Conceptualizing neighbourhoods via . . .

- . . . a focus on deeper understandings of what constitutes neighbourhood(s)
- . . . in-depth examinations of neighbourhood particulars, integrating information from smaller samples
- . . . "bottom-up" definitions, where people decide what constitutes their neighbourhood/community, perhaps measured through social aspects such as community belonging (e.g. Maria De Koninck's research) versus "top-down" definitions, such as boundaries/municipal jurisdictions/economic considerations, etc.

It was also evident that definitions of "neighbourhood" shift according to research objectives: researchers do not know what a "true" neighbourhood or family is, but rather base definitions according to research questions.

Again, are "true" definitions possible—or desirable? Researchers, it was suggested, may need to move away from absolute definitions toward a methodology through which neighbourhood can be defined. Different research questions might allow the same data to "speak" differently—multifaceted interpretations could facilitate more "complete" pictures of neighbourhoods and their residents, and perhaps more effective interventions.

## People, Places, Policies, and Times of Concern

The phrase "people of concern, places of concern, policy of concern, and time of concerns" emerged as a heuristic to organize the discussion.

Mark Wheeler, of the Policy Division, Health Policy Branch at Health Canada, came up with the term **"people of concern, places of concern"** to guide thinking about place and health.

- **People of concern:** What makes some people "healthier" than others, despite seemingly similar levels of service and socioeconomic status? (Maria De Koninck and Robert Pampalon's research on living environments and health at a local scale asked precisely this question, as does Chris Lalonde et al's work.)

  Further, as many research papers pointed out, some people are more place-bound than others, including children, older adults, immigrants, low-income individuals, some Aboriginal communities, people with mental health disorders and people who live in rural or remote communities. What does place mean for these various populations? Marie Desmeules's team, for example, examined how place of residence affects mortality rates for rural Canadians.

- **Places of concern:** How is place a health determinant in and of itself? What is known about the people who live in places of concern? What is the local economy? What is known about the physical environment? How does the increasingly community-based delivery of health care play a role? What are the various ways in which resources are allocated to communities? And so on.

- **Policies of concern:** Tariq Bhatti of the Cities Secretariat at Infrastructure Canada added this term to "people and places of concern" to refer to the overarching ways in which services are produced. Jim Dunn and Nancy Ross's research, for example, compared the health status implications of federal, provincial, state and municipal policy in the United States and Canada. Desmeules et al's work, on the other hand, asks how policy may have to be designed differently for rural versus urban areas/people.

- **Times of concern:** Finally, Blair Wheaton, of the University of Toronto's sociology department, urged workshop participants to take into account **times of concern:** adding time to place adds power to place; adding place to time adds power to time. This concept was embraced by participants. Taking into account times of concern might mean:
  - focusing on specific times in people's lives rather than on their life course. For example, is place's influence on children uniform throughout the life course?
  - examining places throughout history (social, political, administrative, economic, civic, etc.); and
  - examining the mobility of people and communities—and how they move—over time.

People, places, policies and times of concern are always present in the nexus that place forms. Taken together, they are parameters that interact in and can enrich place and health research. While some research of necessity focuses only on one or two of these parameters, an important part of the analysis and interpretation of data lies in considering the implications for all four parameters. Focusing only on place as a geographical entity—as it is often the case in place and health research—may be misleading.

# "I Am Your Audience": Bridging the Gap Between Researchers and Policy-Makers

In keeping with CPHI's mission to contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians, one of the workshop's objectives was to discuss implications and possible directions based on best evidence for policy development related to place and health.[6]

Throughout the "Place and Health: Research to Policy" workshop, policy-makers sent a clear message to members of the research community that there is great receptivity at all levels of government for their work, and a clear momentum for research to provide a strong place-based anchorage to policies and programs. Mark Wheeler, of the Policy Division, Health Policy branch at Health Canada, put it directly in his comments to the research community: "I am your audience." This point was echoed by other decision-makers and government representatives within the group.

Despite this receptivity to their work, it also became clear that the research community held some reservations about engaging with or influencing policy. Though by no means uniform, this hesitation tended to centre around two concerns:

- First, **researchers did not want to risk releasing preliminary or inconclusive results**. They did not want to offer advice that could not be backed by conclusive "proof" or risk basing policy decisions on potentially "incomplete," "flawed," or "incorrect" conclusions or interpretations of data. As one researcher put it "the studies aren't finished yet."
- Related to the above concern, **researchers did not want to appear prescriptive** or heavy-handed with their recommendations.

As well, some members of the research community cited time constraints ("We're so busy doing our work that we don't have time to lobby politicians") as a barrier to engaging with policy-makers. Others simply were not sure how to engage: where were the points of entry into policy? Who were the key actors? How could they best position their messages in order to make sure those messages got "heard"?

Given researcher and policy-maker communities' differing concerns, time frames and needs, this section explores some of the challenges of translating research to policy and offers some strategies to improve the transfer of knowledge.[7]

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6. The opinions and recommendations expressed are those of researchers and discussants and do not necessarily reflect those of the Canadian Population Health Initiative.
7. For a fuller discussion of research into policy, please see Canadian Institute for Health Information, "*You say 'to-may-to(e)' and I say 'to-mah-to(e)'": Bridging the Communication Gap Between Researchers and Policy-Makers* (Ottawa: CIHI, 2004).

Workshop participants discussed at length the communications gap between research and policy worlds. Both policy-makers and researchers addressed researchers' concerns about influencing policy, given that data may be preliminary and that the concept of "place and health" is, in many ways, still in its infancy:

- Many policy- and decision-makers stressed that they were not necessarily looking for prescriptions, but rather the advice and expertise that come from the research world. The fact that research results might be preliminary, or that the field of place and health is still young, should not discount the rich body of knowledge and expertise that researchers can bring to the table, and the value of their input.
- Policy- and decision-makers also pointed out the simple truth that policy would still continue to be made in the absence of researcher input—to do otherwise would be *laissez-faire*. They encouraged researchers to contribute to the "advice pool" of policy synthesis. If they do not, someone else will.
- To the extent that they are publicly funded, one junior researcher pointed out, researchers—like policy-makers—are public servants. Thinking of themselves in this light may encourage researchers to connect with policy-makers and share research findings that could influence policy design.
- Is researcher reluctance to influence policy a particularly North American phenomenon? One participant drew on her international experience in developing countries to point out that in other contexts, researchers are incredibly eager to share results and be part of the policy-making process.
- "Do not let the perfect become the enemy of the good": Participants discussed the consequences of waiting for the "right" answer (missed opportunities for influence; by the time you have that answer, things will have changed). Given the dynamism of place, they asked could one "right" answer exist?
- At the same time, both researchers and policy-makers agreed on the need to be aware of the risks of what one participant termed "policy-based evidence-making"—the ethical concerns and potential biases of allowing a policy agenda to shape independent academic research.
- A discussion of ethics also raised concerns around ethical issues of characterizing neighbourhoods, sharing data and designing interventions. Institutionally based ethical review boards have little experience in dealing with the ethical issues of working with neighbourhoods and communities: Who controls the data? Who has access to results? How should interventions be designed? Community-based participatory research projects (e.g. work with Aboriginal communities; Maria De Koninck or Jean Caron's work) have developed several tools to help conceptualize the ethical aspects of place-based health research with a community focus.

## Sharing "Big Ideas," Not Data: How To Spend Gas Tax Dollars?

**"Kachimaa mawiin • Maybe for sure":** Participants from both research and policy communities encouraged a wider embrace of chaos and more willingness from researchers to take educated risks and make so-called "mistakes." Given the absence—or impossibility—of certainty, place and health stakeholders cannot know the "for sure" of interpretations of data, but can make more or less educated guesses that embrace the "maybe."

Sometimes policy crafted based on "preliminary results" or "incomplete" data has positive effects. The example used was the "brain drain" theory: one participant noted that although the threat of Canadian talent exiting the country to go to the United States ultimately proved to be unfounded, policies to encourage Canadian talent to stay may still have positive effects. Sometimes policy created for the "wrong" reasons has the "right" result.

The gas tax came up as a contemporary example. Municipal and provincial governments will be looking for ways to allocate funds from the gas tax, a time-sensitive project that would benefit from expert input. Policy-makers are looking for this input.

If asked for his recommendations on how to allocate gas-tax funds, one senior researcher and decision-maker said he would allocate them toward public transit and affordable housing. While he had no definitive data to suggest that these two areas would garner the most benefit from the gas tax, or that they were most in need, his professional, academic and lived experience suggested that these areas were a priority. Further, he argued, even if empirical evidence later proved his hunch incorrect, improving public transit and access to affordable housing would hardly be a waste or have perceptible negative effects.

## Bridging the Gap: Connecting Researchers and Policy-Makers

Discussion turned also to how to bridge the gap between research and policy worlds. As Michael Hayes put it "How can I get the mayor to be interested in this work? What if he or she doesn't think there's a problem?" Several points of note emerged on "best practices" for engaging the policy audience:

- **Have a compelling story.** This point came up again and again. As Hayes put it "It's one thing to have the data, but the pay dirt is how to engage. If you can't tell the story, if you don't have a good narrative, you'll get nowhere. Get a good visualization, first and foremost, and then use local issues as the driver." For example, at the municipal level for a large Canadian city, waterfront development, clean air or user fees all have "place and health" implications for policy.

- **Understand the value of qualitative research.** Related to the above, participants argued that place and health could benefit from qualitative research, such as in-depth interviews with stakeholders, ethnographies, etc. Qualitative research may help provide the narrative context or "story" to which decision-makers can relate. In a different vein, qualitative research emerged as an important topic of discussion for place and health research: many stressed the importance of taking into account the psychological and social histories embedded in place.
- **Build relationships at all levels and branches of government:** Networking (e.g. through workshops and conferences) is an important part of building relationships. Further, as one decision-maker noted, both researchers and policy- and decision-makers can benefit from building intersectoral bridges, nationally and internationally, between the various government sectors that are examining the spatial aspects of their policies (health, transport, environment, housing, etc.).
- **Tailor messages to each level of government.** Policy decisions are made and influenced at several levels. With so many actors, how or where can researchers make their voices heard? Workshop participants discussed that at the **federal government level,** researchers have many points of entry, including:
  - the Minister;
  - policy analysts who write the Minister's briefing notes and do the legwork;
  - Party Caucuses, who provide a chance for party members to quiz their colleagues; and share ideas that they have received from their communities;
  - Members of Parliament;
  - Parliamentary committees;
  - central government agencies, including the Public Health Agency of Canada, the Treasury Board Secretariat, Privy Council Office and Finance Canada; and
  - public servants—from junior policy analysts to analysts to assistant deputy ministers.

  Some participants noted that there may be more opportunities for small-scale change (e.g. pilot projects) at regional levels than at the centre. Beyond the federal level, participants suggested that place and health researchers might do well to engage **municipal and provincial government** officials and employees.
- **Understand what policy-makers want.** As some policy- and decision-makers pointed out, they often want advice rather than prescriptions. They need information that is relevant, accessible, immediate, useful, robust and targeted. The need to understand policy-makers' time frames for action and preferred media was also discussed.

## Building a House

As discussion on "research into policy" drew to a close, the metaphor of building a house arose as a way of envisioning an interdependent relationship between research and policy worlds—connected, perhaps by research into policy interventions. Research,

ideally, provides a strong foundation for the house. Policy builds it. Then, people need to live in that house (perhaps first as a "show model" or pilot project, later as pilot communities). Only once it is lived in will researchers and policy- and decision-makers be able to see if the foundation is solid, if the structure is liveable and where it needs repairs and renovations. Taking into account the time-based nature of place and health and the dynamic nature of people's lives and places, the house will most assuredly need regular maintenance and repair. Policy can be tweaked or rewritten based on the lived experience of the people in the house and how well the structure itself stands the test of time.

# From "Research *to* Policy" to "Research *on* Policy": Taking the Next Steps

## A Multidisciplinary Approach to Place and Health

At the end of two and a half days of intense discussion, at least one conclusion was obvious: as Louise Potvin, of the Department of Social and Preventive Medicine at the Université de Montréal would sum up "**place and health research begs for interdisciplinary work**." [8]

The many definitions of the terms "place" and "health" are themselves an indicator that multiple perspectives are necessary in order to make sense of how one affects the other, and vice versa. Developing a typology of "place"—and further "operationalizing" or putting into play current understandings of "place"—will feed into interdisciplinary and intersectoral work and help place and health researchers document and share the state of knowledge in the field: What is and is not known? What do place and health stakeholders need to know? What knowledge is emerging?

At a practical level, interdisciplinary research raises questions of methodology. Combining the multiple attributes of place necessitates combining multiple databases—a project that poses challenges related to the transparency and comparability of data. As discussed below, participants suggested that a research network on place and health might be the place to begin to address such challenges. An interactive place and health Web site (perhaps supported by a research institution or an organization like CPHI) could act as a clearinghouse for multiple databases.

Taking into account the idea of multidisciplinary research, a senior researcher raised the idea of a household panel study in Canada that follows people and their descendants through the life course. Such as study would generate longitudinal, cross-sectional data that could be mined and compared in a variety of ways. "Most people think in terms of 'education and work,' or 'work and health,' with covariates of 'family,'" noted this workshop participant. "We have to move beyond that to start thinking about everything at the same time, in real time. … All the building blocks define your life."

Another researcher also cautioned participants to remember to "walk before running." She sensed a "fundamental time-space trade-off" and made a plug "for the space stuff," suggesting that while fine-grain analysis of space-based data may miss temporal aspects in the short run, it has an important place in place and health research.

8. The opinions and recommendations expressed are those of researchers and discussants and do not necessarily reflect those of the Canadian Population Health Initiative.

## Life Course Trajectories and Transitions

Looking at **life course trajectories and transitions** was identified as one opportunity for building bridges across research domains. Such a research trajectory might take into account that people build their futures on the basis of their pasts, that people's lives and health are inextricably integrated and that people's health and well-being are often affected by the lives of others with whom they come into contact. Which characteristics of place interact with which aspects of life course? Is place's influence on children the same throughout the life course? How is such research feasible? What methodology could best address the time-space tradeoffs inherent in examining life course trajectories?

## Policy-Intervention Research

As the discussion on operationalizing place and health drew to a close, it became clear that participants felt a strong need for more research on policy interventions in the form of:

- place-based policy interventions;
- health-services at the place level; and
- "place-based" health-promotion and prevention programs.

Such research could evaluate the effects of place and health policy in neighbourhoods and beyond, and would address questions of policy effectiveness and appropriateness.

The "building a house" analogy seemed applicable here: members of research and policy worlds would build policy based on a solid foundation of research and then analyze and evaluate the outcomes. Outcomes would influence policy design and uptake, engage communities and citizens, and shape and hone research questions. Questions that arose for further consideration included:

- How can interventions be adapted given the dynamic nature of place and its inhabitants? What happens as people move and places change?
- How do the interactions between individual and neighbourhood levels affect intervention and policy?

Participants discussed obstacles to pursuing and operationalizing intervention research, specifically:

- a lack of funding or support from traditional sources for this type of research;
- a lack of understanding or experience on how to handle the ethics of research on populations. As such research projects are designed, institutional ethics committees will have to address issues arising from place and health research (i.e. characterizing neighbourhoods, sharing data, designing interventions, etc.). Work with Aboriginal communities may provide some examples and ways forward;
- problems of heterogeneity of neighbourhoods: Who is to say that if it works in one place, it will work in other places?

## Moving Forward: A Place and Health Research Network and Continuous Quality Improvement

Workshop participants raised the idea of creating a place and health research network as a way of advancing research, collaboration, interdisciplinarity and policy uptake in the field. With members from both research and policy worlds, a research network could:

- act as a bridge between research and policy worlds and between various disciplines interested in the health effects of place;
- potentially shorten the time between research and the uptake of information;
- host a content-heavy Web site on place and health (following the success of the Manitoba Centre for Health Policy's online concept dictionary, introduced to participants at the Banff workshop in 2002); and
- act as a clearinghouse for multiple databases and other information sources on place and health.

A place and health research network might also facilitate policy-intervention research. Workshop facilitator Lillian Bayne brought up the Institute for Healthcare Improvement (IHI)/Berwick model of "plan, do, study, act" to describe, in a nutshell, the process of policy-intervention research. Mark Daniel, Chair on Biopsychology and Population Health at the Université de Montréal, seized on this idea and fleshed out a four-step model of **continuous quality improvement** (CQI) that would allow for implementation and rapid evaluation of place and health policy. A research network on place and health, suggested Daniel, could:

- sketch out approximate levels of influence of place on health;
- allow that such an influence varies according to definition;
- recommend the general adoption of level-specific definitions; and
- justify (1) and (3) by grading the provisionality of what is known in terms of influence at any given level (allowing for review of knowledge based on "non-standard" definitions centred on newly recommended definitions).

# Conclusion: Beyond Val David—Next Steps for Place and Health

## CPHI's Role in Place and Health Research

In her closing remarks to workshop participants, Elizabeth Gyorfi-Dyke, Director of CPHI at CIHI, suggested that CPHI plays a role in supporting place and health.

Gyorfi-Dyke outlined CPHI's future directions on place and health. Building on previous accomplishments that include its *Housing and Health* report, a report on developing Healthy Communities Index and the Banff and Val David workshops, CPHI's activities and plans for moving forward include:

- co-hosting the 2005 Canadian Public Health Association (CPHA) conference with the CPHA, the Institute of Population and Public Health (IPPH) at CIHR, the Public Health Agency of Canada (PHAC) and Statistics Canada. One of the conference themes is place and health;
- commissioning a research synthesis on urban health and healthy weights;
- commissioning a scoping paper on urban health and healthy transitions to adulthood;
- releasing a rural health report(s) with PHAC;
- continuing to conduct knowledge translation of funded research;
- partnering with the Canadian Mortgage and Housing Corporation (CMHC) on housing research;
- commissioning research on other gaps (e.g. Christopher Lalonde's research on Aboriginal Peoples); and
- upgrading the CPHI Web site.

As well, CPHI will publish a place and health report in April 2006 as part of its *Improving the Health of Canadians* report series. As part of this work, an Expert Advisory Group on place and health has been formed (please see box). Gyorfi-Dyke briefly described the outline for this report, including the focus on urban health.

### CPHI's Expert Advisory Group on Place and Health

- Marie Desmeules, Chief, Population Health Assessment Section, Public Healthy Agency of Canada
- Karen Dufton, Director of Communications, Cities Secretariat, Infrastructure Canada
- James Dunn, Researcher, St. Michael's Hospital
- Trevor Hancock, Medical Consultant, British Columbia Ministry of Health Services, Population Health and Wellness
- Michael Hayes, Associate Dean, Faculty of Health Science, Simon Fraser University
- Russell Mawby, Director of Housing, City of Ottawa
- Cordell Neudorf (Chair), Vice President and Medical Officer of Health, Saskatoon Health Region
- Michael Wolfson, Assistant Chief Statistician, Statistics Canada

## A Place and Health Research Community: Next Steps

Michael Hayes and Louise Potvin closed the "Place and Health: Research to Policy" workshop by commenting on the fruitful discussion and possible next steps for place and health research in Canada.

The field, they noted, has progressed considerably since the Banff workshop of 2002. At that time, suggested Potvin, "we were more in the clouds," with a focus on framing the questions and issues up for discussion. Since then, "we have started to land," as research projects outlined at Banff progress and understanding and framing of the field becomes increasingly sophisticated.

Hayes and Potvin also expressed their excitement at the breadth of young talent in the room. They looked forward to seeing how graduate students and young researchers would continue to shape the field of place and health research.

Place and health as a research discipline still faces many obstacles, Hayes and Potvin noted, many of which were discussed over the course of the previous two days. To that discussion, Potvin added the question of funding: where will researchers get the money to do their work and carry on the research process? One encouraging development is CIHR's program for research development in social and environmental health.

The organizers expressed the need to formalize the place and health research network.

Stakeholders need to have more, similar conversations on place and health, to reconvene and assess "where we are and where we're going, and with whom we should be engaging to have a research conversation in Canada."

Finally Hayes and Potvin thanked the many people whose collected efforts made the workshop a great success: facilitator Lillian Bayne; CPHI and the Centre Léa Roback for funding and support; CPHI staff; Isabelle Therien and Andrée Thibeault, whose administrative skills made the workshop function smoothly; and finally, all the community of participants, for taking the time to attend and enrich the ongoing conversation on place and health. "We look forward to an opportunity to be together again soon."

# Appendix 1: List of Conference Participants

Manuel Arango, Heart and Stroke Foundation of Canada

Tracie Barnett, Université de Montréal

Mike Benigeri, Carrefour montréalais des informations sociosanitaires/Agence de développement des réseaux locaux de santé et de services sociaux de Montréal

Paul Bernard, Université de Montréal

Tariq Bhatti, Cities Secretariat, Infrastructure Canada

Jean Caron (Principal Investigator [PI]), McGill University

Rana Charafeddine, Léa Roback Research Centre

Patricia Collins, Simon Fraser University

Clément Dassa, Université de Montréal

Mark Daniel, Université de Montréal

Maria De Koninck (Principal Investigator [PI]), Université Laval

Marie Desmeules (Principal Investigator [PI]), Public Health Agency of Canada, Ottawa

Erica Di Ruggiero, Institute of Population and Public Health, Canadian Institutes of Health Information

Marie-Jeanne Disant, Université Laval

James Dunn (Principal Investigator [PI]), Centre for Research on Inner City Health, St. Michael's Hospital,

Heather Fraser, Health Canada—Population and Public Health Branch, Public Health Agency of Canada

Katherine Frohlich, Université de Montréal

Lise Gauvin (Principal Investigator [PI]), Université de Montréal

Rick Glazier, Centre for Research on Inner City Health, St. Michael's Hospital,

Judith Guernsey, Dalhousie University

Michael Hayes, Simon Fraser University

Denis Heng, Laurentian University

Yan Kestens, Université de Montréal

Kathi Kinew, Assembly of Manitoba Chiefs

Irene Koren, Laurentian University

Chris Lalonde, University of Victoria

Alexandre Lebel, Université Laval

Richard Lessard, Montréal Public Health Department

Ellen Lesiuk, Housing Branch, City of Ottawa

Irene Linklater, Research and Policy Development, Assembly of Manitoba Chiefs

Pat O'Campo, Centre for Research on Inner City Health, St. Michael's Hospital,

Lisa Oliver, Simon Fraser University

Robert Pampalon, Institut national de santé publique du Québec

Dianne Patychuk, Planning and Policy, Toronto Public Health

Louise Potvin, Université de Montréal

Mylène Riva, Université de Montréal

Éric Robitaille, Léa Roback Research Centre

Leslie Roos, University of Manitoba

Nancy Ross, McGill University

Christine Schippers, University of Manitoba

Nadine Schuurman, Simon Fraser University

Blair Wheaton, University of Toronto

Mark Wheeler, Policy Division, Health Canada

Janine Wiles, McGill University

Robin A. Yates, University of Victoria

## CPHI staff

Carole Brûlé

Keith Denny

Elizabeth Gyorfi-Dyke

Lisa Sullivan

## Léa-Roback Centre de Recherche staff

Isabelle Thérien

Andrée Thibeault

Lillian Bayne (Facilitator)

Susan Goldberg (Writer)

# Appendix 2: Workshop Agenda

## Workshop Objectives

At the workshop:

- To bring together research projects that have received funding from CPHI to report on their findings related to how place affects the health of Canadians.
- To discuss implications and propose directions for policy development related to place and health issues.
- To examine future directions for place and health research in Canada.

Following the workshop:

- To prepare a report on the workshop proceedings and disseminate.
- To submit research papers to a theme issue of a relevant journal.

## Wednesday, April 27, 2005

17:00–18:30 Arrival at La Sapinière in Val David

18:30–20:00 Welcome reception

- Welcome by Elizabeth Gyorfi-Dyke, Director of CPHI and Workshop Co-Chairs, Michael Hayes and Louise Potvin.
- Introduction and overview of workshop agenda and objectives by Lillian Bayne, Facilitator.

## Thursday, April 28, 2005

Day 1 of the workshop focused on **mobilizing knowledge**.

Research paper presentations were framed by the following headings:

- Research question and method.
- Rationale: Why was this research needed? What problem(s) was it seeking to address?
- Findings: Key findings, highlighting policy-relevant findings; what does the knowledge generated contribute to our understanding or management of the "problem(s)" identified?

Discussants' commentaries were framed by the following headings:

- Key policy-relevant findings: What do you see as the key policy-relevant findings from the paper?

- Key policy and decision-maker audiences: Who will be interested in these findings and why?
- Key applications: How might the key audiences apply these findings?
- Outstanding policy questions: What related policy questions or major issues have not been addressed? What related research and/or knowledge gaps still exist?

The discussion was framed by the following questions:

- What is the policy relevance of the research presented?
- How might the research papers presented be improved in terms of the clarity and persuasiveness of the research and policy-relevant findings?
- How might the research results be applied?
- What strategies might be employed to "translate" or mobilize the research generated?
- What makes this issue relevant both from a research and policy-making perspective?
- How can engaging in a dialogue between policy-makers and researchers provide an innovative approach to this issue?

| | |
|---|---|
| 8:30–8:45 | Roundtable introductions |
| 8:45–9:15 | **Studying living environments and health at a local scale: The case of three territories in the region of Quebec (methodological approaches and preliminary results)** |
| 8:45–9:00 | Maria De Koninck, Université Laval, Québec |
| 9:00–9:10 | Richard Lessard, Public Health Director, Montréal Public Health Department |
| 9:10–9:15 | Questions |
| 9:15–9:45 | **Place of residence and non-communicable diseases mortality risks: Are rural Canadians more at risk?** |
| 9:15–9:30 | Marie Desmeules, Public Health Agency of Canada, Ottawa |
| 9:30–9:40 | Richard Lessard, Public Health Director, Montréal Public Health Department |
| 9:40–9:45 | Questions |
| 9:45–10:15 | **Family and place: Effects on health care utilization and educational achievement** |
| 9:45–10:00 | Leslie Roos, Manitoba Center for Health Policy, Winnipeg |

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|---|---|
| 10:00–10:10 | Mark Wheeler, Assistant Director, Health Policy Division, Health Canada |
| 10:10–10:15 | Questions |
| 10:15–10:45 | Break |
| 10:45–11:15 | **Place and Health in First Nations communities** |
| 10:45–11:00 | Christopher Lalonde, University of Victoria, Victoria |
| 11:00–11:10 | Irene Linklater, Research and Policy Development Director, Assembly of Manitoba Chiefs |
| 11:10–11:15 | Questions |
| 11:15–12:30 | Discussion |
| 13:30–14:00 | **Predictors of psychological distress in low-income populations of Montréal** |
| 13:30–13:45 | Jean Caron, Douglas Hospital Research Center, Montréal |
| 13:45–13:55 | Tariq Bhatti, Deputy Head–Operations, Cities Secretariat, Infrastructure Canada |
| 13:55–14:00 | Questions |
| 14:00–14:30 | **Explaining income inequality and mortality in North American cities: Public goods, fiscal disparities, municipal fragmentation and population health** |
| 14:00–14:15 | James Dunn, St. Michael's Hospital, Toronto |
| 14:15–14:25 | Dianne Patychuk, Planning and Policy, Toronto Public Health |
| 14:25–14:30 | Questions |
| 14:30–15:00 | **The conundrum of conceptualizing and measuring neighbourhoods: Towards a multi-concept/multi-method approach** |
| 14:30–14:45 | Lise Gauvin, Léa Roback Research Centre, Montréal |
| 14:45–14:55 | Mike Benigeri, Coordonnateur du Carrefour montréalais d'informations sociosanitaires (CMIS), Agence de développement des réseaux locaux de santé et de services sociaux de Montréal |
| 14:55–15:00 | Questions |

15:00–15:30 Break

15:30–16:00 **Estimating small area health status in the Vancouver Census Metropolitan Area**

15:30–15:45 Michael Hayes, Simon Fraser University, Vancouver

15:45–16:00 Questions

16:00–17:30 Discussion

## Friday, April 29, 2005

Day 2 of the workshop focused on future directions for health and place research with the following framing questions:

- What are the pressing research questions or knowledge gaps that still need addressing?
- What are the four or five key themes for a forward research agenda?

8:30–9:00 **Future research**

- Researchers' Perspectives: Louise Potvin and Michael Hayes
- Decision-Makers' Perspectives

9:00–10:30 **Building a forward agenda for research on/in health and place: Plenary discussion**

10:30–10:45 Break

10:45–11:45 **CPHI Update on Place and Health**

Elizabeth Gyorfi-Dyke

11:45–12:00 **Closing remarks and next steps**

Louise Potvin and Michael Hayes

# Appendix 3: Workshop Ground Rules[9]

**Language of Choice**—We understand from personal contact with participants that everyone is able to understand and communicate in English and that there is a desire to avoid using simultaneous interpretation services as they detract from the informal atmosphere participants are seeking. Nonetheless, we encourage those who wish to communicate in French to do so. Every effort will be made to ensure that the essence of what is said is translated by selected bilingual participants for those who do not understand French.

**Shared responsibility:** We share responsibility for the success of the meeting.

**Mutual respect and understanding:** We welcome ideas and questions.

**Commitment:** We need everyone to commit to being here and fully engaged for the whole meeting.

**Full participation:** We need everyone's views and input for this to be successful.

**Full attention**: We ask you to turn off your pagers, personal digital devices and cell phones.

**Time management:** We will stick to (or do better than!) the times on the agenda so contributions/comments will need to be relevant and concise.

**Acronym-free**: We all commit to making this an acronym-free zone.

**Informality:** We aim for a climate of "structured informality"—we will stick to our program and time frame but try to reduce formal obstacles to communication and participation.

9. Ground Rules for the "Place and Health: Research to Policy" Workshop were developed by workshop facilitator Lillian Bayne, Lillian Bayne and Associates.

This publication is part of CPHI's ongoing inquiry into the patterns of health across this country. Consistent with our broader findings, it reflects the extent to which the health of Canadians is socially determined, interconnected, complex and changing. CPHI is committed to deepening our understanding of these patterns.