

# Student Public Policy Essays

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## GRADUATE

### Health and Health System Performance Measures and Indicators:

Are They Reliable for Evidence-Based Decision-Making?

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## UNDERGRADUATE

### The Right to Food and Food Security:

Should Food Banks be Abolished in Order to Hold  
Government Responsible?

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**The Student Public Policy Essay is published as a result of a contest targeting students at the University of Regina. The winning essay, judged by an independent group of scholars and policy practitioners, is made available to the public through this publication.**

In an effort to engage the student population and better utilize the pool of talent that exists in this province, SIPP developed the Student Public Policy Paper Essay Contest.

Most students have not had the opportunity to publish original pieces of work. The Saskatchewan Institute of Public Policy wanted to reward the top student essay, at both the graduate and undergraduate level, dealing with a significant issue of public policy through publication. Full details regarding the Student Public Policy Essay Contest are available online at [www.uregina.ca/sipp](http://www.uregina.ca/sipp).

## Director's Introduction

### GRADUATE PAPER

In his paper, Health and Health System Performance Measures and Indicators: Are They Reliable for Evidence-Based Decision-Making?, Raman Visvanathan describes the current state of the development of health and health system performance indicators in Canada and assesses the extent to which health care planners and policy makers can reliably use performance indicators and measures of population health status and health care system performance for evidence-based decision-making.

### UNDERGRADUATE PAPER

In her paper, The Right to Food and Food Security: Should Food Banks be Abolished in Order to Hold Government Responsible?, Ramona Furkert explores the reasons why so many people have increasingly become dependent on food banks to supplement their income and examines how the Government of Canada has failed to ensure the right to food and food security for Canadian citizens by turning these rights into a charitable cause and shifting responsibility to the community level.

It is our hope that the student policy essays will showcase the interests and talents of the young women and men in the area of public policy.

Ian Peach  
Director, Saskatchewan Institute of Public Policy

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# **Health and Health System Performance Measures and Indicators: Are They Reliable for Evidence-Based Decision-Making?**

**by Raman Visvanathan**

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## **Introduction**

Over the past decade there has been an evolution of thought about the use of health care performance measurement systems. Initial enthusiasm, which could be characterized as the performance measurement imperative, led to the proliferation of measures and the fragmentation of effort. This was followed by a sober reassessment and reflection on the complexity of the task. More recently there is a growing sense of optimism that the efforts being undertaken nationally and internationally will provide the necessary infrastructure to support evidence-based decision-making.

## **Why Measure Health System Performance?**

It is universally accepted that the defining goal of health systems, the reason why they exist, is to improve health. There is mounting pressure on health systems to improve their performance. The result is widespread interest in the explicit measurement of the “performance” of health systems, embracing quality, efficiency and equity goals and in influencing or managing performance.

The aim of evidence-based decision-making is to ensure that decisions about health and health care are based on the best available information. To use evidence-based decision-making one must first assess what constitutes evidence, both in relation to health-enhancing interventions and to organizational or policy-level decision making. One also needs to explore the availability and accessibility of reliable information and knowledge that identifies how interventions, practices and programs effect health outcomes. Decision-makers struggle to make appropriate

choices to improve the performance of their health systems, as evidence on how to improve the performance of health systems is lacking.

Relevant and comparable information on health outcomes would serve two primary purposes. The first is to monitor current trends and future needs in population health. The second is to measure and evaluate the performance and effectiveness of various health policies and medical-care interventions. With such information on outcomes available, policy makers would be able to take a more evidence-based approach in identifying priorities and allocating resources among competing and emerging health needs, programs, regions, and social groups.

Significant challenges exist in using performance indicators to create intentional change in health care systems. First, the state of the art is embryonic, meaning that there is an insufficient evidence base for understanding what works, under what circumstances, and with what consequences. Secondly, the costs, both direct and indirect, are daunting, particularly in developing the necessary information infrastructure, which is deficient in many countries. Thirdly, the complexity of the health care sector, and the multiplicity of audiences and actors, means there are likely to be both intended and unintended consequences to any approach.<sup>1</sup>

There is a long way to go in terms of providing valid and reliable measure of *outcomes* (the actual impacts of policies and programs within society). The development of causal models which allow us to attribute outcomes to programs and to distinguish program impacts from non-program effects within society continues to be difficult. Given the problems of attribution, all measures of program impacts must remain open to debate as to their validity, reliability, and significance. However, the real value of performance measurement comes not from providing the ‘right’ answers, but from helping to frame questions and to structure a dialogue about how to improve public services.

## **What are Performance Measures and Indicators?**

A performance measure, or indicator, can be defined as a measurement tool, screen, or flag that is used to monitor and evaluate important governance, management, clinical, and support functions that affect patient outcomes. In general terms, health indicators represent summary measures that capture relevant information on different health attributes and dimensions and the performance of the health system. Indicators are seen as a guide to monitor, evaluate, and improve services delivered. These measures attempt to reflect and monitor the health status of a population and contribute to high-level assessment of the performance of the health system.

A distinction can be made between performance measures and performance indicators. Ideally, performance measures report unambiguously on the relationships that exist between program activities and the outputs and outcomes associated with them. Performance indicators are said to be less precise than actual measures of program impacts. They usually provide only a proxy indication of performance. Given the current state of knowledge, the distinction between true measures and approximate indicators is somewhat artificial.<sup>2</sup>

In some cases indicators are aggregate metrics. At the other extreme, users may be able to mine complex, multi-level systems of data to produce a wide range of indicators and sub-indicators. These systems may allow comparison of health status and health system performance and characteristics among different jurisdictions, institutions, providers, or patient groups.<sup>3</sup>

Indicators range from a direct count to a calculation of proportions, rates, ratios, and more sophisticated indices (for example life expectancy at birth). Quality and usefulness of an indicator are defined by its *validity* (effectively measures what it attempts to measure) and

*reliability* (repeated measurements in similar conditions produce the same results). Additional attributes to ensure quality are its *specificity* (measures only the phenomena that it is meant to measure), *sensitivity* (has the capacity to measure changes in the phenomena that it is meant to measure), *measurability* (is based on available or easy to obtain data), *policy-relevance* (is capable of providing clear responses to key policy issues), and *cost-effectiveness* (results justify the investment in time and other resources).<sup>4</sup> In reality, these criteria are difficult to achieve, and indicators, at best, are indirect or partial measures of a complex situation.

The heightened interest in the measurement and monitoring of the performance of health care systems is evident at an international scale. This has led to the systematic definition and collection of health information for monitoring health system performance. More often than not, this has taken the form of a collection of specific health indicators with which to describe a variety of health and health system-related trends and factors. A usual approach is to develop a conceptual framework that defines the appropriate dimensions and sub-dimensions that are required to describe the health of the population, and the performance of the health care system. The common framework fosters a common vocabulary and conceptual definitions. As noted in a recent review by Hurst and Jee-Hughes<sup>5</sup>, it may be difficult to compare conceptual frameworks for health and health system evaluation of different countries because of differences in the way basic terms are defined and understood.

Another issue which faces all who devise sets of performance indicators is whether or not to aggregate the indicators to provide composite or summary measures. The main argument in favour of aggregation is that without it, those trying to monitor performance may drown in a sea of detail. The main argument against aggregation is that to the extent indicators reflect performance against different goals, aggregation requires adding ‘apples’ and ‘oranges’. Value

judgements are required to weigh different objectives. Moreover, if only summary indicators are published, the origin of variations in performance tends to be concealed. However, it is possible to publish both summary measures and their components.

The most important work in providing quality health care for Canadians happens “at the coal face” – in every interaction people have with health care providers and people working on the front lines of Canada’s health care system.<sup>6</sup> If we think about what health care is about, in the end, the core event is an encounter between a provider and a patient (or a population, if we are including non-personal health services). Obviously, finding the quality and outcome of that encounter is very complicated.

There is a particular interest in measuring the quality of health care. Measuring performance of health care against dimensions such as quality is an activity still in its infancy. Quality can be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.<sup>7</sup> Quality can be captured in the form of health outcomes and responsiveness. A traditional definition of a health outcome is a “change in a patient’s current and future health status that can be attributed to antecedent health care.”<sup>8</sup> For performance purposes, health outcomes can be defined narrowly as those changes in health status strictly attributable to the activities of health systems. In other words, we are interested not so much in health status itself, which depends on many determinants, but in changes in health status, both positive and negative, attributable to the health care system.

In an attempt to isolate the impact of the health care system on health attainment, a number of approaches have been developed. For example, the notion of “avoidable mortality” which is also known as “mortality amenable to medical/health care” has been developed.<sup>9</sup>

Avoidable mortality refers to deaths from certain conditions that are considered to be largely avoidable given timely and effective health care. As Nolte and McKee suggest, one possible solution uses mortality data at a population level that are available in many countries and is based on the concept that deaths from certain causes should not occur in the presence of timely and effective health care. A major limitation is that, for many conditions, death is the final event in a complex chain of processes that involve issues related to underlying social and economic factors, lifestyle, and preventative and curative health care. Partitioning deaths among the categories is an inexact science. Furthermore, what is considered amenable to health care will change over time as new pharmaceuticals and management strategies are developed. Testicular cancer, for example, has now become potentially a largely curable disease, although the extent to which this is achieved by different health care systems varies. Nolte and McKee conclude that amenable mortality does have some value in helping to understand the performance of the health system. However, disaggregated values should be used as they enable comparison of elements that make up the overall figure, permitting investigators to dig down to look at specific policies and learn from different experiences.<sup>10</sup> Korda and Butler conclude that while observed declines in avoidable mortality may also reflect changes in other factors that influence mortality, they are “suggestive” of the health care system being a determinant of health improvements.<sup>11</sup> The use of ‘avoidable’ mortality and morbidity entails adopting hypotheses about causation. There is evidence which must cause us to question how well these mortality and morbidity indicators reflect the impact of health services themselves, as opposed to other factors affecting health.

Efficiency relates the levels of goal attainment to the inputs used to achieve them. Murray and Evans describe a second method to assess the performance of the health care system by defining efficiency as the ratio of attainment (above a minimum) to the maximum possible

attainment (also above the minimum).<sup>12</sup> Efficiency is used to capture how well inputs are utilized and combined to produce the outcomes people desire.

‘Patient satisfaction’ measures attempt to capture patients’ subjective happiness or unhappiness with the responsiveness of care. ‘Patient experience’ measures attempt to capture factual aspects of responsiveness, such as how long patients waited for attention and the extent to which staff provided helpful information. The former will be affected by expectations and are often subject to a “gratitude” effect – typically 90 per cent or more of patients express satisfaction with health care, *ex post facto*.<sup>13</sup> The measurement of patient experience is more straightforward than the measurement of health outcomes. It is relatively easy to conduct patient surveys or to collect administrative data on patient experience. More importantly, putting aside difficulties of respondent bias or recall, in the case of experience there will be a one to one relationship between the information collected and the concept specified.<sup>14</sup>

Self reported health status is a prominent indicator of population health. Survey response biases may affect the comparability of such indicators. A key methodological issue describing health status is how people reply to questions requiring categorical responses such as very poor, poor, satisfactory, good and very good. Different groups classify themselves in different ways in terms of the underlying variable being measured. In some surveys, for example, people who are highly educated or who have higher incomes report worse levels of health status than those with relatively lower education or income, despite more objective evidence to the contrary. A major concern with survey instruments that enquire of people’s experience with the health system is that people from different cultures or socio-economic backgrounds may have different expectations.<sup>15</sup>

Data quality is also a critical issue. The Canadian Institute for Health Information (CIHI) has identified five dimensions of data quality, including accuracy, timeliness, comparability, usability, and relevance.<sup>16</sup> “The availability of information based on valid, reliable data is the *sine qua non* condition for the analysis and objective evaluation of the health situation, evidence-based decision-making, and programming in health.”<sup>17</sup> In the quest to ensure the availability, acceptability, and credibility of data, government must address the question of what level of investment would be necessary and affordable to provide a complete, accurate and timely common information data set.

### **The Performance Measurement and Management Cycle**

There is much interest among policy makers in improving the performance of health systems. More particularly, there is interest in pursuing what is, in effect, a performance measurement and improvement “cycle”, in which measurement of performance would be followed by appropriate actions, such as raising the performance of poorly performing providers or selecting better policies to promote efficiency and equity.<sup>18</sup> Measurement and analysis in performance improvement could be related to evidence-based medicine, evidence-based management, and evidence-based policy.

Ideally, the steps that should be taken in any health system to improve performance with the help of performance measurement can be described in terms of a performance measurement and improvement “cycle”. This cycle has four elements, 1) the health care system, 2) conceptualization/measurement, 3) analysis/evaluation, and 4) action/management. Evaluation is desirable, *ex ante*, to identify, for example, the causes of weaknesses in performance and the cost-effectiveness of steps which could be taken to tackle them. Evaluation is desirable, *ex post*,

to monitor and to evaluate the results of taking action and to add to the evidence base for future decisions. The final element of the cycle is “action.” This is the activity or management intervention which is necessary to change the behaviour of the health system. The cycle is completed if actions lead to changes in performance. There are at least four key sets of actors in health systems – consumers, providers, managers and governors – and, depending on the problem to be tackled, it will require actions or changes in behaviour among some or all of these sets of actors for improvements in performance to be realised.<sup>19</sup>

### **The Implementation of Comparable Indicators in Canada**

The September 2000 First Ministers Communique on Health gave direction to Health Ministers to collaborate in the development of a comprehensive framework using jointly agreed upon comparable indicator reporting on health status, health outcomes and quality of service. From this, a Performance Indicators Reporting Committee (PIRC) was established to identify comparable health and health system performance indicators. As noted, each jurisdiction produced a report, made public in the fall of 2002. While there was a core set of common indicators, their reports varied widely in style, scope, and areas of focus. In 2003, First Ministers’ directed continued development of indicators for public reporting on themes of timely access, quality, sustainability, and health and wellness.<sup>20</sup>

The Federal/Provincial/Territorial (FPT) Conference of Deputy Ministers (CDM) of Health directed the Advisory Committee on Governance and Accountability to prepare a plan for comparable reporting, in compliance with the terms of the February 2003 First Ministers Accord on Health Care Renewal 2003 Accord (the 2003 Accord). The policy direction for this work was developed and approved by the CDM and the Performance Reporting Technical Working Group

(PRTWG) was established to undertake the technical work required to select and oversee development of comparable indicators for FPT reporting. The PRTWG included representation for each FPT jurisdiction, as well as CIHI, Statistics Canada, and the Institut de la statistique du Québec (ISQ). A series of consultations was undertaken with stakeholders and the general public to obtain feedback on what indicators are important and meaningful to them and the preferred form(s) of presentation. The reports being produced in 2004 are the result of the work carried out to date. Further work on the development of additional indicators for reporting in the longer term is being undertaken with the intent to improve reporting in future years. The Advisory Committee on Governance and Accountability will undertake a feasibility study on the process needed to develop valid, more reliable and appropriate indicators to achieve the goals described in the 2003 Accord.<sup>21</sup>

In September 2002, all 14 jurisdictions, including the federal government, released their reports on 67 comparable indicators. This marked the first time that health ministers from all provinces, territories and the federal government reported to their constituents at the same time on a set of comparable health indicators. The 2003 Accord directed Health Ministers to further develop indicators to supplement the work on comparable indicator reporting. The Accord also focused indicator development and reporting activities on several specific program and service areas for the health system, such as primary health care and homecare services, identifying the development of these services as important strategies for health system reform and sustainability. The Accord identified four broad themes and six priority areas for reporting to Canadians.

## **The 2004 Reporting Plan**

Each jurisdiction publicly released its report on November 30, 2004.<sup>22</sup> The short list of 18 indicators are detailed under the four themes and the 70 indicators are listed under six priority areas. This current plan for reporting comparable health indicators replaced the Plan for FPT reporting on 14 indicator areas established in September 2002.

The 2004 set of indicators are organized under three themes.

1. Timely access: Indicators under this theme measure access to essential services and waiting time involved in receiving these services.
2. Quality: Indicators under this theme measure several aspects of quality of health care service, including patient safety, patient satisfaction and health outcomes.
3. Health Status and Wellness: Indicators under this theme measure the health of the entire population. They are influenced by many factors, including education, economic status and living conditions.

For each of the comparable health indicators, the published reports include a definition, the rationale, notes for interpretation, technical specifications, data availability, considerations for indicator quality and comparability, and responsibility to produce the data. Provincial and Territorial reports provide commentary on the set of 18 indicators and the full list of 70 are reported on websites hosted by CIHI and Statistics Canada.

The theme of ‘sustainability’ and the priority of ‘home care’ are under development and therefore not covered in the 2004 report. The theme of sustainability includes efficiency and effectiveness related indicators under the headings of health human resources, equipment, information systems, and value for money.

The array of indicators reflects a focus on issues related to accessibility as measured by wait times. The priority of timely access to quality care has led to a commitment by First Ministers, resulting from the First Ministers' Meeting on the Future of Health Care in 2004, to the dual objectives of better management of wait times and the measurable reduction of wait times where they are longer than medically acceptable. This reflects the political nature of highlighting of these indicators. The World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD) frameworks are more balanced and focused on equity and financial burden.

### **Analysis of the 2002 and 2004 Comparable Indicator Reports**

A detailed assessment of the jurisdictional reports produced in 2002 and 2004 reveals improved reporting on a number of fronts. As one would expect, the initial effort in 2002 fell short of the aspiration to report comparable indicators in compliance with the guidelines. While much progress has been made, not all jurisdictions are able to report on all 70 indicators in 2004, and some smaller jurisdictions are substantially underreporting. The reporting depth and breadth varies widely among provinces and territories, with the shortest at about a dozen pages and the most comprehensive reaching to 352 pages in 2002. Clearly, there has been a consistent movement to reduce the length and improve the readability of reports from 2002 to 2004.

It is obvious that the level of effort put in to the report varies by jurisdiction. Fortunately, most provinces and territories have substantively complied with the direction provided by First Minister's, though some have taken the tack to 'ritualistically' prepare a report, they are simply going through the motions of producing a report without substantive analytic assessment. The

variation in the apparent effort is likely influenced by the jurisdiction's interest in complying with the reporting requirements and their level of investment in data collection and analysis.

Saskatchewan would appear to be a leader in reporting on comparable indicators, as their reports include a number of elements not contained in other reports and are more thorough and readable than others. The discussion includes important contextual information such as contributing factors, trends, what is known and unknown, and information on what progress is being made on the issue under discussion. The report also includes references to web sites containing more detailed information on the subject. Saskatchewan is the only jurisdiction reporting consistently on provincial and territorial comparisons. A degree of caution must be exercised, as the volume of the report may diminish the readership. British Columbia and Newfoundland and Labrador deserve mention for their reports as they provide clear, concise, and informative reporting that is very readable.

The comparable indicator reports are to be reviewed by third parties to validate the reported indicators. The provincial auditors seem confused about how to handle this new assignment. In 2002 the auditors all issued *no opinion* on the reports. In 2004, the approach had shifted to acknowledge the source of the information in the report and apply a number of procedures, including checking that the presentation of results is consistent with the stated methodology. It is not clear if this work substantively improves the quality of the information presented.

The current reporting regime does not include an intergovernmental roll-up to provide comparative reporting on a comprehensive basis. It would be valuable to produce a report in which indicators are immediately comparable to help facilitate exercises such as benchmarking.

## **Health Council of Canada**

The Romanow Commission recommended the establishment of the Health Council of Canada (HCC) with a mandate to work with the provinces and territories to establish a national framework for measuring and assessing the quality and safety of Canada's health care system, comparing the outcomes with other OECD countries, and reporting regularly to Canadians.<sup>23</sup> The framework was to build on the intergovernmental work of the PIRC and the comparable indicators project. The 2003 Accord announced plans to form the Health Council of Canada, but, the actual mandate is narrower and less ambitious than that recommended by the Romanow Commission. The Health Council of Canada produced its first annual report in 2005<sup>24</sup>, which notes the background of the FPT comparable indicator's work done to date and recognizes the enormous effort behind developing a comparable health indicators framework and producing ongoing data for public release. The report suggests that the next step is to assess the extent to which data are useful to policy makers, planners, health care providers, and others working in the system. It also notes that reporting varies greatly. The HCC recommends that Health Ministers take another look at their approach to generating these indicators.

## **Health Quality Council**

The Fyke Commission on Medicare<sup>25</sup>, in its final report, issued in April 2001, recommended the establishment of a Quality Council for Saskatchewan as well as the continued development of performance indicators. The Health Quality Council (HQC) was officially launched in February 2003, making Saskatchewan the first province in Canada to create an organization that has a mandate to focus exclusively on quality improvements in health care. The HQC strategic plan for 2004/05 includes as objectives; 1) defining the first version of a list of

core, standardized quality indicators for use in Saskatchewan, and 2) publishing and disseminating multiple public reports on quality indicators in this fiscal year.<sup>26</sup> The HQC is presently developing a data warehouse. A number of other provinces, including Alberta and Ontario, are also working towards the establishment of provincial health quality councils, both of which appear to have mandates to develop and report on performance indicators.

### **Health Indicator Infrastructure Organizations**

There are a number of key players in our health information system. Statistics Canada has been central for over a century, with the population census and vital statistics. More recently, Statistics Canada's health statistics program, with strong support from Health Canada, has matured in the areas of health surveys and data integration, and has become increasingly responsible for reporting on Canadians' health status and its determinants. The Canadian Institute for Health Information (CIHI) was established in 1994 as an independent, pan-Canadian, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information.<sup>27</sup> CIHI's mandate is to coordinate the development and maintenance of a comprehensive and integrated approach to health information for Canada and to provide and coordinate the provision of accurate and timely data and information required for:

- Establishing sound health policy;
- Effectively managing the Canadian health system; and,
- Generating public awareness about factors affecting good health.

In 1998 a group of health stakeholders were brought together to identify health information needs. One of their priorities was comparable quality data on key health indicators

for health and health services. In response, CIHI and Statistics Canada launched a collaborative process to identify what measures should be used to report on health and the health system.<sup>28</sup> These consultations resulted in the Health Information Roadmap – an initiative that outlines a national vision for modernizing health information in Canada and a number of projects related to improving the Canadian health information system. One of the Roadmap projects at CIHI is the Data Quality Enhancement project. The goal of this project is to enhance the quality of existing data holdings and ensure that new data holdings and information products meet the standards of excellence. The five dimensions of data quality include accuracy, timeliness, comparability, usability, and relevance.

A National Consensus Conference was held on May 4, 1999, hosted by CIHI in cooperation with the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Services, Health Canada, and Statistics Canada. In response to the feedback from a consultation process on health information needs, CIHI launched the Health Indicators project. The purpose of the project was to identify what measures should be used to report on the health of Canadians and the health system and then compile and make this information widely available. These indicators are primarily intended to support regional health authorities in monitoring progress on improving and maintaining the health of the population and the functioning of the health system for which they are responsible.

The first indicators reports, published in 2000, provided information on the overall health of the population served, the major non-medical determinants of health, the quality of health services received by regional residents, and characteristics of the community or the health care system.<sup>29</sup> Health system performance is directly reflected in one of the four major dimensions of the model. This dimension includes eight categories designed to capture various aspects of health

system performance, including responsiveness (accessibility and acceptability), those related to processes of care (i.e., continuity of care or safety), and outcomes directly related to a medical or health intervention (i.e. effectiveness). The *health status* dimension includes a broad range of indicators spanning deaths to disability to well-being. Non-medical determinants are those that fall outside of the sphere of health care, but which have been shown to affect a variety of health outcomes or processes. Community and health system characteristics provide useful contextual information. The notion of equity spans all dimensions of the framework. It is notable that the model is skewed toward measures of population health and health outcomes. Measures of health system performance require substantial development.

The full implementation of the framework requires some continued development and implementation. Each year CIHI's annual reports have added new indicators as data system have matured. Of note in the 2004 report is the elimination of indicators related to health status and non-medical determinants of health. The trend for the reporting has been a reduction in the areas reported on, with a greater focus on the performance of the health system and less emphasis and reporting on general conditions. The reports provide inadequate introductory commentary and analysis is not evident, in contrast to the impressive progress being made by all provincial and territorial jurisdictions with respect to comparable indicators reporting.

### **Hospital Indicator Initiatives**

In certain provinces there has also been some effort to monitor hospital performance, most notably in Ontario. Hospital performance may be defined according to the achievement of specified targets, either clinical or administrative. Ultimately, the goal of health care is better health, but there are many intermediate measures of both process and outcomes. Given that the

definition and the functions of hospitals are changing as emphasis shifts from inpatient care to ambulatory care, community care and public health, these dimensions of hospital performance should also be captured.<sup>30</sup> In Canada, the Canadian Council on Health Services Accreditation (CCHSA) has developed a set of standardized performance indicators for health facilities. The CCHSA currently provides close to 100 indicators measuring eight dimensions of health care.<sup>31</sup>

The Ontario Hospital Association (OHA) and the Ministry of Health and Long Term Care are joint sponsors of the *Hospital Report Series* and have produced reports measuring the performance of Ontario acute care hospitals since 1998. The reports present data on four key areas of activity from hospitals which voluntarily chose to participate: clinical Utilization and Outcomes, Financial Performance and Condition, Patient Satisfaction, and System Integration and Change. A total of 38 indicators were selected in 1999 based on soundness, relevance, and feasibility. The reports continue to provide reporting on the balanced scorecard approach and now cover Acute Care, Complex Continuing Care, and Emergency Department Care.<sup>32</sup>

The principle methods of measuring hospital performance are regulatory inspection, public satisfaction surveys, third-party assessment, and statistical indicators. The design of performance measurement systems should aim to improve hospital performance, rather than to identify individual failures. A well-rounded performance measurement system should not rely on a single source of data but should use a range of information to help triangulate evidence. The *Hospital Report Series* may be the most practical indicator tool, with the potential to substantially affect decision-making in hospital settings; this type of work should be expanded to other health care facilities (organizational providers) and to other jurisdictions.

## **International Developments in Performance Measurement**

In 1992 the OECD put forward initial ideas about a common set of objectives for the health care system. More recently, WHO has put forward a somewhat similar proposal and has devoted its *World Health Report, 2000* to reporting estimates of the performance of the health systems of its 191 Member countries against its proposed objectives.<sup>33</sup> The report also carries out these analyses using one component only: health improvement itself. While the WHO report contains a large number of ‘performance’ scores, it is the ‘overall score’ which provided the ‘headline’ score. Canada, as noted, uses wider health information frameworks that also cover health status and non-medical determinants of health. The WHO and OECD frameworks offer high level concepts whereas the national frameworks show an understandable tendency to put forward concepts which are easier to make operational.

The fascination with broad, national-level summary indicators of population health and health system performance reached its pinnacle with the *World Health Report, 2000*. The overall performance of the health system was assessed as a composite measure, including level and distribution of health attainment, responsiveness of the health system, and degree of fairness of financing. The WHO report exemplifies a regrettable tendency for health system performance measures to be reduced to ordinal rankings. The criticism of the WHO rankings goes beyond concern about the “league table” approach and includes issues related to the uncertain relationship of conventional population measures to health service performance and the question of how best to assess health system equity. Navarro, for one, has agreed that countries should be ranked, but on disaggregated indicators such as infant mortality, deaths at work, waiting lists for serious operations, or other indicators that are more likely to be comparable across countries and linked to policies or practices.<sup>34</sup> The WHO has decided that, for the next round of performance

assessment, a composite measure of attainment would not be published but that development work on composites would continue, with the possibility that they would be included in future rounds.<sup>35</sup>

Policy can be dramatically influenced by performance indicators, as was demonstrated in the following examples from the United States and United Kingdom. The decision by Prime Minister Tony Blair to invest significant new resources in the National Health System (NHS) was influenced by data showing Britain to be spending at a lower percentage of GDP than most Northern European countries. Another example is the United States, which was influenced by international performance data to train more general practitioners when the data showed that the United States trains a higher proportion of specialists than most European countries.<sup>36</sup>

In November 2001, Canada's Minister of Health hosted a three-day OECD Conference called *Measuring Up: Improving Health Systems Performance in OECD Countries* and looked at progress in pursuing a performance measurement and improvement cycle. The conference is part of an ambitious three-year health project launched by the OECD in May 2001 to provide concrete information to national policy makers, helping them to improve their systems' performance and make difficult allocation decisions.

### **The Way Ahead**

Actualizing the contribution of performance measurement and management to systematically improving health systems is both a matter of will and skill. There must be the will to develop a coordinated and sustained strategy to achieve consensus on performance priorities and to implement improvement strategies. There must also be the skill to undertake capacity building in requisite competencies and infrastructure.<sup>37</sup> Dr. Paul Thomas concludes that the most

appropriate stance to adopt on performance measurement is realism about its potential and its problems. This will involve “steering a reflective and practical, middle course between naïve faith in rational techniques and the cynical use of performance measure for purely symbolic purposes.”<sup>38</sup>

What information is needed and at what level of detail? An essential step is to identify the intended audience for the report and provide the type of data required for the decisions they are expected to make. For the public, the reports must balance the need to be easily read and understood, with the need to be accurate and complete. Clinician and health care organizations are another important audience for report card data. Consideration must be given to whether a single report can meet the needs of all audiences, or whether more targeted reporting is required. Health systems are extraordinarily complex. In consequence, one must beware the seductive reductionism of devising a single measure to capture all dimensions of health status, let alone health system performance. A balanced approach with an array of indicators is desirable, as each set of stakeholders will need a different type of information to make better decisions. This goes well beyond putting a coloured cover over a mind-numbing statistical compendium, or reducing complex data to a league table of a star-ranking system.

Often, the most difficult part of improving health system performance is putting into action policies for improving performance. In general, successful action will involve changes in the behaviour of the actors in the health system. The aims of the actors may not be the same as the aims of those trying to influence them. It is possible to distinguish four key sets of actors in any health care system: consumers, professional providers (clinicians), managers, and governors.

Improvements in information about performance may be a necessary condition for behaviour change but they are by no means sufficient. There is potential to make demonstrable

improvements to the performance of health systems when information, incentives and action are all aligned with appropriate policy objectives. Appropriate incentives and the ability to act are required if suitable action is to take place. In general, performance improvement requires actors to be empowered, for their incentives to be aligned with policy goals and for them to be well informed about the consequences of their actions. Some of these conditions are often missing in health care systems.<sup>39</sup> “What we must begin to do is to align information systems, selection of performance measures, reporting systems, organizational or professional culture, and implementation mechanisms.”<sup>40</sup>

### **Developing an “Infrastructure”**

Performance measurement and reporting has made dramatic advances in the past decade but it is still insufficient to support widespread diffusion, predictable systematic application, and routinely fair and accurate assessments. The investment of new resources into building capacity will be required. The potential of performance indicators to guide and compel improvements will not be fully realized until the quality of indicators themselves is dramatically improved to make performance data more useful to target audiences. This will not only require better research and development but also investment in the areas of informatics and information infrastructure.

The investment in information and its infrastructure is an indispensable prerequisite to the development of performance measurement initiatives. It involves improving data collection and standardization methods; developing information systems and the ability to link them together (i.e. linkages between the accounting systems of hospitals and private doctors; the tracking of health care episodes); and increasing the quality of information supports, based on the computerization of systems and the use of Internet networks. The Canadian experience, which

made the quality of its infrastructure an overriding objective through the central role of Statistics Canada and the CIHI, shows the importance of this investment. It constitutes a benchmark that could be an inspiration to many other countries.<sup>41</sup>

As has been demonstrated, Canada, and Saskatchewan in particular, has made significant strides in putting in place the pieces required to successfully move to evidence-based decision-making. This includes the development of a framework to describe, analyse, and improve the performance of the health system. Progress is being made in the development of effective and affordable tools that can be used by decision-makers to provide timely and relevant information on the performance of the health care system. This information informs strategic decision-making and program management and allows progress towards targets to be monitored and policies to be evaluated. The periodic assessment of results and the sharing of information and reporting on indicators enables shared learning across jurisdictions.

Canadian initiatives can be seen as complementary to work currently underway in other organizations, such as the WHO and the OECD. While the adoption of a common health indicators conceptual framework does not seem to be an objective, it would further stimulate efforts to develop and collect common health indicators internationally. A harmonized effort to develop common indicators would not only foster increasingly robust cross-national comparisons and analysis, but may also facilitate the development of comparable data that can be used as a basis for setting international benchmarks.

## **Areas for Further Work**

Hurst and Jee-Hughes conducted a selective review of the performance indicators/measures being developed by the WHO, the OECD, Australia, Canada, the United Kingdom and the United States, which suggests that the development of indicators is proceeding at different speeds in different areas of performance measurement. According to their study, “relatively slow progress is being made in the area of health outcomes. Faster progress is being made with the development of indicators of the responsiveness of health services to consumers. There is slow progress with the development of equity indicators and with the compilation of overall measures of the efficiency of health systems that command any reasonable degree of confidence.”<sup>42</sup>

There are a number of indicator areas where gaps could be addressed through further research. For example, competence and continuity indicators are not well developed. Competency may be difficult to assess at an aggregate level, but must be considered as a critical determinant of health system performance, particularly outcomes. One of the most contentious issues in quality is that of current professional knowledge. In assessing the extent to which continuity between care providers in different health care sectors is ensured may be somewhat elusive from a measurement perspective. One key item with which there is absolutely no connection in our health care system at the patient level is the link between costs and outcomes. In policy terms, this is an extraordinary lacuna.

As previously noted, the theme of ‘sustainability’ and the priority of ‘home care’ are under development and therefore not covered in the 2004 provincial/territorial comparable indicators reports. Given the emerging growth in and importance of home care, it is important that the developmental work on these indicators be expedited.

The “science” of performance assessment is maturing as the methods and applications will continue to develop over time through experience in applying the methods at the national and sub-national levels. Data quality depends on the quality of primary data collection – for many jurisdictions this may be a problem.

### **The Role of Evidence in Support of Decision-Making**

Evidence can be used for at least four distinct purposes: strategic decision-making, program implementation or management, monitoring of outcomes or achievements, and evaluation of what does and does not work in health systems. The time frame for these uses differs, ranging from the immediate for strategic decision-making to the long-term for building an evidence base for evaluating alternative strategies in order to improve health systems performance. In addition, the requirement for strength of evidence varies for the four uses. The development of a consistent approach to generating and disseminating evidence for all four uses can be built on five guiding principles: validity, reliability, comparability, consultation, and explicit audit trail. A measure is valid if it measures the construct that it was intended to measure. Reliability may be defined as the extent to which a quantity is free from random error. Evidence for monitoring or evaluation requires that it is comparable over time, across communities within a population, and across populations. Comparability requires a common scale. Consultation provides an opportunity for experts to identify new data sources, discuss limitations of the existing data sources, and recognize known biases that should be taken into account in the analysis. The trail from primary data collection, adjustments for known biases, and statistical modelling should be replicable. Measurement is only useful to the extent that it provides policy-makers with the information they

need to improve the performance of their health systems and, through it, the well-being of ordinary people. The science of measuring performance and its causes will evolve steadily.<sup>43</sup>

A common recognition of the importance of evidence has emerged. ‘Best available evidence’ is a key phrase, meaning that all available sources should be used to provide relevant inputs for decision-making. Often data may give a highly uncertain assessment of key parameters. Nevertheless, decisions must be taken and systematic assessments of the evidence – even if highly uncertain – are better bases for decisions than no evidence at all.<sup>44</sup>

Health status indicators can serve as clues to the nature and magnitude of health services that will be required in the future. Measures do provide means for improvement, though, it is necessary to do more than identify that a problem exists. It is also necessary to understand what causes it and what can be done to rectify it. One of the goals of performance measurement is to help reach some informed judgement about how processes have unfolded and to identify success and failure. The ultimate endpoint is an impact on health outcomes, which depends in turn on the quality and cost-effectiveness of services provided. There has not been sufficient investment to ensure that the information systems needed to measure performance are in place.<sup>45</sup>

There is a clear need for an enhanced data infrastructure that allows for more explicit and rigorous examination of the health of populations and their health care systems. Just as astronomers could not function without significant investments in telescopes and related observational tools, population health and health services researchers cannot function without major investments in richly multivariate cohort databases, and in the skills and institutional settings for their analysis. Progress is being made, as there is the opportunity to take advantage of the refinements in analytical techniques and new information technologies that enable more

sophisticated tracking of the success of programs and offer opportunities to improve the dialogue on public policies.

Performance reports might play their most useful role in signalling to responsible decision-makers, and to others, the need to conduct more systematic and in-depth evaluations of policies and programs which do not appear to be working very well, based on the latest published performance evidence. To promote deeper understanding of what the numbers mean, public organizations need to be able to tell their stories. Stories serve to put measures in context and to provide explanations. The performance story will never achieve the status of scientific proof, but over time it can become more credible. While measures can serve as a vital management and decision-making tool, providing information that can be used to make improvements in program design and service delivery, they are not a substitute for analysis and judgement. A central challenge is how to put evidence into practice and how to change in reality the two key components that constitute care – its technical content and the organization of its delivery.

Evidence-based decision-making will take place when reliable and valid indicator information is used to determine the course of action, whether that is to allocate resources, choose between alternatives, or decide among program options. In other words, indicators will be used to complete the performance cycle by taking action.

To date, most performance indicator reporting initiatives try to provide utilitarian reports that serve a variety of readers and can be used for multiple purposes. More targeted reporting, with customized reports for specific users, will help to facilitate the use of indicators and measures in evidence-based decision making. For example, institutional reporting similar to the Ontario *Hospital Report Series* could be expanded to other institutional settings. Also, targeted reports aimed at the audiences of management and policy-makers would be practical and useful tools.

Improving our collective understanding of the determinants of health system performance is a long-term endeavour. The science of measuring performance and its causes will evolve steadily. There are many encouraging examples of performance reports that have led to improvements in the quality of service and there is much to be learned from the ongoing experiences.

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# **The Right to Food and Food Security: Should Food Banks be Abolished in Order to Hold Government Responsible?**

**by Ramona Furkert**

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## **Introduction**

Food banks in Canada have been providing assistance to needy families since 1981. First established to provide emergency assistance, they have become a staple in many communities and can now be found in every province and territory in Canada (CAFB, 2004). According to statistics by the Canadian Association of Food Banks, the number of people who rely on food banks for support is increasing and low-income families are relying on these services on a regular basis. This is an indication that Canadian governments have not met their international obligation to ensure the right to food. An exploration of the reasons why so many people have increasingly become dependent on food banks to supplement their income and an examination of how the Government of Canada has failed to ensure the right to food and food security for Canadian citizens by turning these rights into a charitable cause and shifting responsibility to the community level is the basis of this paper. Finally, a review of the argument for the abolishment of food banks will analyze whether this is the best plan of action for holding Canadian governments more responsible for ensuring the right to food.

## **Right to Food**

First we must understand what the right to food means. Governments have an obligation to ensure that all individuals have physical and economic access to enough safe and nutritious food, which helps to facilitate healthy and normal lives. Article 25 of the Universal Declaration of Human Rights states: “everyone has the right to a standard of living adequate for the health and well-being of

himself and of his family, including food”. Subsequent international declarations, including the International Covenant on Economic, Social and Cultural Rights (Article 11), the Convention on Ending all Forms of Discrimination Against Women, and the Convention on the Rights of the Child (Articles 24 and 27) provide legal obligations to the participating State Parties to ensure that these rights are being realized. The Government of Canada has ratified all of these conventions. Consequently, its commitment to ensure these rights should have been reflected in federal and provincial legislation. No such legislation exists to date. In fact, there are only four municipalities in all of Canada that have chosen to acknowledge the right to food in their charters; Toronto, Saskatoon, Kamloops and Prince Albert (Roberts, 2003). For example, the Prince Albert Food Charter<sup>1</sup> outlines ways in which the right to food and food security must be realized, including the ability to access safe and nutritious food by all individuals, especially high risk categories such as seniors, children and young mothers. It also advocates for training and income-generating programs for local farmers, as well as the need to use all available land for food production. Lastly, it recognizes the need for inter-municipal agreements to make all of this happen.

### **Imported and Exported Food in Canada**

The Canadian agricultural economy is based on export. As such, Canada sells a lot of food to other countries, and in turn import food that we would otherwise not have access to, or can import at a lower price than the cost of production here. For example, due to Canada’s geographical location, items such as bananas or oranges cannot be grown. These items can be imported cheaply and are available at the grocery store. Other items, such as apples and grain products, which can be grown in Canada, are often imported from other countries because it costs less to grow and harvest them there, making imported goods cheaper to purchase than local

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<sup>1</sup> This document can be accessed on line at <<http://www.ryerson.ca/~foodsec/Documents/princealbertcharter.pdf>>

products. A good example of this phenomenon can be seen when we look at produce prices at farmers' markets and organic food stores. These items often cost more than they would at the grocery store even though they are locally grown. Globalization has provided the opportunity for wealthy nations to import products from developing nations cheaply, because these countries are willing (or forced)<sup>2</sup> to sell their labor and products at very low rates. Low-cost food production in certain regions influences the cost of food available locally. In Canada, most people, including farmers, depend on the availability of imported food and this can be problematic. As food prices tend to fluctuate, depending on growing conditions in certain regions of the world, some people are not able to afford food for themselves, especially healthy food. As a result, they are forced to visit food co-ops, soup kitchens, or food banks to meet their own needs.

### **Food Banks**

Food banks are charitable organizations that collect food donations from individuals or corporations and redistribute that food to needy families, usually in the form of a hamper. The idea of a food bank is not new, since churches, charities, and community organizations have been involved in this type of work for decades (Riches, 1986: 68). Food banks were established as umbrella organizations for other charities, acting as a central collection and distribution center. This allows for a greater number and quantity of donations to be collected and distributed more systematically. In Canada, the Canadian Association of Food Banks currently represents 550 food banks from every province and territory, which in turn represent more than 2,600 agencies (CAFB, 2004). In 1985, the number of food banks in Canada was 95, with the majority of these

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<sup>2</sup> Some countries may be forced to export a certain amount of goods in order to stimulate the economy. This is sometimes necessary in order to receive continued funding from international development or monetary funds such as the World Bank and the IMF. Because products are now being exported to foreign markets the government often has to import food for local consumption. This forces individuals to have to work in order to earn a wage that will allow them to purchase basic necessities. The lack of available jobs often creates competition to provide the cheapest labour and often forces workers to accept any type of work under any type of working condition, in order to secure employment.

being located in Western Canada (Riches, 1986: 15). It is interesting to note that the western, agricultural provinces displayed the highest need for food assistance. Today, Ontario is host to the greatest number of food banks (216), followed by British Columbia (95) and Alberta (77) (CAFB, 2004). Food bank use in Canada has doubled in the last 15 years, from just under 400,000 people per month in 1989 to over 800,000 people per month in 2004<sup>3</sup> (CAFB, 2004).

Why do so many people rely on food banks for assistance? Those who work for a living should be able to afford food for themselves and their families, and the government has safety nets in place for those who cannot work or are unemployed. The reality is that those who work for minimum wage or receive social assistance often do not make enough money to reach the “low-income cut-off” (LICO) set by the Government of Canada. According to Statistics Canada, the annual income of a four-person family living in a large city needs to be more than \$31,000 after taxes (CAFB, 2004). At present no province or territory has adequate minimum wage legislation or social assistance rates that would allow a family of four to live above the LICO (CAFB, 2004). For example, in Saskatchewan, a full time, minimum wage worker earns \$13,832 before taxes; even if both parents work this amount still falls short of the LICO. The same holds true for social assistance rates. In Saskatchewan, a single, employable adult receives approximately \$675 per month for clothing, food, and shelter; a family of four with two parents receives \$1370 per month (DCRE, 2005).<sup>4</sup> Considering that the majority of food bank users cited social assistance as their primary source of income (54.4 per cent), followed by employment (13.3 per cent) and disability (7.9 per cent), it is obvious that the amount of income that these families are receiving is not adequate to ensure a basic standard of living (CAFB, 2004).

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<sup>3</sup> This is based on figures recorded by participating food banks in March of every year.

<sup>4</sup> There are also additional benefits that are not included in this figure, including child tax benefits and other assistance monies, which come from the federal government.

Canadian governments have policies in place to assist individuals who may not have the physical or economic resources to provide food for themselves. These consist of social assistance benefits or other government transfers that help provide the necessary funds to purchase basic necessities, such as food. Therefore governments feel that they are fulfilling their responsibility to protect the rights that are enshrined in domestic legislation and ratified in international law (Riches, 1997: 59). When one looks at the actual amount of money that is being allocated for people on social assistance, however, it becomes obvious that these safety nets are insufficient and hardly allow individuals and families to meet their basic needs. It is necessary for federal and provincial governments to take more concrete action to ensure that every man, woman and child is able to have access to the necessary resources that would allow them to meet their basic needs, whether this be in the form of adequate social assistance rates or better social programming.

Some argue that when the federal government replaced the Canada Assistance Plan<sup>5</sup> with the Canadian Health and Social Transfer in 1996, it shifted the burden of responsibility onto the provincial governments, resulting in a lack of financial resources to provide adequate social programming (Morton, 2005). The loss of an estimated \$7 billion in federal transfers between 1995 and 1998 forced the provinces to cut social programming and create more stringent eligibility requirements for social assistance benefits (CAFB, 2004). It also created a number of discrepancies between eligibility and benefit amounts between the provinces. Although these changes have had a negative effect on the ability of provinces to provide adequate social programming, it should be realized that the inability of people to meet their basic needs with the amount of social benefits that they received existed long before that. Almost 100 food banks had opened their doors between 1981 and 1984. Food bank use increased dramatically between 1989

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<sup>5</sup> The Canada Assistance Plan Act was a 50/50 cost-sharing program between the federal and provincial governments for social programming, including welfare and unemployment benefits.

and 1997, remaining fairly steady until 2003 and increasing again in 2004 (CAFB, 2004). This suggests that, while federal government funding may have been part of the problem, there would still have been a number of people who needed extra assistance in meeting their basic needs even if the federal government had continued to run a cost-sharing program with the provinces.

Interestingly enough, food banks, including the CAFB, do not receive funding from any level of government and rely solely on corporate and individual donations of food, money, and time to operate. Some, however, may receive grants from the municipal government to cover administrative and support staff, provide start up funds, or reduce rental fees. The City of Regina, for example, has provided funding in the form of reduced rent for property as well as providing a number of free bus tickets for clients (Graves, personal communication, 2004). Even if it were offered, direct government funding would be refused because it would legitimize food banks and allow the government to claim that they are ensuring the right to food, when in fact they are not. It would also fail to solve the underlying problems that cause poverty and hunger, namely a failure by the federal and provincial governments to provide adequate assistance and social benefits to Canadians. In order to make the government accountable for its responsibilities it is imperative that food banks continue to operate as charities.

Yet at the same time, food banks have been operating for so long and have become so efficient that they have inadvertently become an integral part of the Canadian economy (Yadlowski & Theriault, 1998: 1). Every major food bank in Canada relies on several large food drives per year, along with regular donations from individual and business sponsors. Three major corporate sponsors for food banks across Canada are Kraft, Kellogg's, and Campbell. All three companies provide a large number of items that are no longer sellable, usually because they are dented or near expiration. These items can be donated to food banks through the CAFB's

ShareGoods program, which collects donations and distributes them equally among member agencies. This ensures that food is adequate and meets some nutritional standards. The ShareGoods website<sup>6</sup> provides no indication of corporate tax breaks or other financial benefits for donors, although corporations are allowed to use the ShareGoods logo as part of their marketing material. Before concluding that these corporations are donating these items purely out of good will, it should also be noted that by donating unused items, rather than disposing of them in other ways, a company saves money. In other words, the system is based on the needs of the corporation instead of the needs of the people. As Graham Riches points out, this makes it difficult to distinguish between surplus and wasted food, neither of which necessarily meets the nutritional needs of those who receive it (1986: 17). Thus, it becomes open to question whether or not individuals' and corporations' reasons for donating are completely unselfish. It is already clear that corporations sometimes have other motives in mind and perhaps many individuals have other agendas as well. Regular donations to charitable organizations can appear to be selfless acts, when in fact they make privileged individuals, who are supporting the less fortunate members of society, feel superior to others. Either way, it is important to note just how dependent food banks are on public assistance to fulfill their goals. Somewhere along the way the right to food is no longer recognized as such, and those who depend on food banks for support are at the mercy of those who donate. The amount and quality of food that clients receive is no longer considered to be important, as long as the people have *something* to eat.

Saskatchewan has the annual Let's Talk Turkey campaign, 10 Most Wanted List, Grow a Row, and Hunt for Hunger, as well as other fundraising activities which allow for individuals to make contributions to food banks. There are opportunities for farmers to donate fresh milk, grain or produce; Brownies and Scouts organize food drives and pick up donations from donors'

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<sup>6</sup> The website can be viewed at <http://www.fcPMC.com/about/sc/sharegoods.html>.

homes; and the Roughriders encourage fans to bring canned goods to football games. Corporations also participate in food drives and local businesses, such as Safeway and Co-Op, regularly donate food that can no longer be sold. The entire community is involved in ensuring that the Regina Food Bank has enough food to provide hampers for those who are less fortunate. It is never enough, however, and clients at the Regina Food Bank are only able to get a hamper once every two weeks, sometimes less often if there are not enough supplies. Depending on food stocks, a hamper will contain enough food for 1-3 days (41.2 per cent), 3-5 days (17.6 per cent) or more than five days' worth (41.2 per cent) (CAFB, 2004). But when food supplies are low the food bank must reduce the number of times a family can receive assistance per month, or cut back on the quantity of food that is provided. To ensure that clients get the most amount of food, the food bank will often ask the community for help in times of need, and given the response to local food drives it appears that people are willing to help. This suggests that most people believe that it is the responsibility of charities to provide food for those who cannot provide for themselves. Individuals believe that the best thing they can do is to support those charitable organizations that provide the basic necessities to less fortunate people. The ongoing support of such charitable organizations ensures that the government will never be held responsible for providing more social benefits and ensuring that all individuals have access to adequate food. In fact, as long as people view food banks as a necessity, they will fail to effectively lobby the government to uphold its responsibilities.

### **Food Security**

The discussion about the right to food is incomplete without also examining the idea of food security. We have already seen that many people do not have access to enough food, but the right to food is not only about having enough food to eat. It also requires that food be accessible in

a dignified and affordable manner, is culturally acceptable, and is safe and nutritious (Koc & MacRae, 2001: 4). Canada is a developed, affluent nation, one that produces a lot of food for local consumption and for export. It cannot, therefore, be argued that Canadians go hungry because of a lack of food. As Riches points out, the roots of hunger are found in the structural inequalities of our society, marked by the unequal distribution of wealth and the powerlessness of those who live in poverty (1997: 53). Although we have seen that those who rely on social assistance often do not have enough money to meet their basic needs, having access to food is not necessarily only about having the money to buy it. It also means that everyone should be able to have physical access to those products in the first place. For example, when one does not have the land to grow their own food they should be able to access a grocery store or other food outlet, such as a farmer's market in order to purchase the food. When this is not possible it can be argued that the individual is not able to access food in a dignified and affordable manner.

Regina is a prime example of this problem. Over the last several years, the city has experienced an increase in the number of big box stores, most of which are now located on the outskirts of the city. The majority of low-income families live in the core area, a location that used to be served by a Superstore before it opened new stores in the north and east ends of the city. In fact, one of the stipulations in the Superstore's move to the north end was that it would keep its downtown store open in order to serve clients in the core area. This agreement lasted for about two months. Families who live in the core area must now take public transport or use cab service in order to reach one of these stores. For those who already have troubles making ends meet, it is highly unlikely that there would be any extra money in the budget for several cab fares in order to access a grocery store. This may lead some individuals to utilize the food bank, which is easily accessible by bus and is more centrally located, than most large, discount grocery stores.

Food must also be culturally acceptable. For example, First Nations peoples may prefer to receive wild game meat or fish, but it is not always possible to meet such requests. Another group of clients who may find food donations inadequate are recent immigrants. As individuals who are used to consuming food that is much different from a Canadian diet, they would find it difficult or unacceptable to prepare or consume some of the items that are included in their hampers. The availability of recipes for such items would presuppose that those individuals are able to read and understand the English instructions, something that may not be possible for someone who has just immigrated to Canada.

Food must also be safe and nutritious. When someone receives a food hamper from a food bank filled with Kraft dinner, rice, potatoes and bread, and very little fresh fruits and vegetables, it becomes apparent that this does not constitute nutritious food. The Regina Food Bank often receives a large number of cakes and baked goods, which can no longer be sold at the store level. In fact, there are so many cakes that they are distributed as part of virtually every food hamper or put on a shelf for clients to take freely.<sup>7</sup> The same holds true for snack foods, such as pudding, fruit cups, or cookies. Unfortunately, clients cannot be choosy about what they receive. There is an overwhelming lack of fresh fruits and vegetables, largely because these items cannot be processed efficiently enough to make it into a hamper. For example, produce might be picked up from a business near the end of the day, brought back to the food bank for cleaning and sorting and then stored in a fridge overnight before being handed out as part of a hamper the following day. By the time a head of (already wilted) lettuce makes it out to the client it certainly does not look very appealing. Hampers also often include items that clients may not know what to do with, such as pumpkins, eggplant, or zucchini. Efforts have been made

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<sup>7</sup> Personal observation during a practicum placement in 2004.

to provide recipes and preparation tips for such items, but this presupposes that clients have access to kitchen facilities and necessary utensils.

Since food banks depend on individuals and corporations for food donations, they cannot be choosy about the type of food they receive. They will often ask for certain items to be the focus of a food drive, but at the end of the day they will take whatever donations people are willing to offer. Therefore, the nutritional value of the food that is being handed out cannot be guaranteed. The Public Health Agency of Canada cites cancer, diabetes, obesity, and cardiovascular disease as symptoms of bad nutrition.<sup>8</sup> Individuals who do not have access to nutritious food are clearly at a higher risk of developing some preventable diseases. This should be reason enough for the government to take positive action to ensure that everyone has access to nutritious food, since the future burden on the health care system will prove to be rather costly. Instead, money could be put towards social programming and benefits now in order to enable all individuals to attain the highest level of health. Instead, governments have failed to recognize the benefits of such proactive measures, opting instead to place the onus on individuals and communities to make the best of what they have.

Across the country, many food security programs have now been implemented in large centers. These include school lunch programs, community kitchens<sup>9</sup>, food co-ops<sup>10</sup>, and Good Food Box programs<sup>11</sup>. Regina also runs the Food Security Project<sup>12</sup>, which makes small patches of land available for gardening and allows individuals or groups to access large food processing kitchens in order to cook large meals. The Regina Food Bank hosts many of these projects,

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<sup>8</sup> <http://www.phac-aspc.gc.ca/hl-vs-strat/index.html>

<sup>9</sup> A group of individuals will plan a number of meals, share the cost of ingredients, cook the meals together and divide them amongst all of the participants. The cost of meals is significantly less and participants are able to interact with other people, thus breaking some of the social exclusion that may arise as a result of living in poverty. It also allows immigrants to get to know others and practice their English skills.

<sup>10</sup> Where large quantities of food are bought (preferably) locally and sold to members at nominal cost with a very small mark-up.

<sup>11</sup> Resources are pooled to purchase produce from local farmers. Not only does this help foster the local economy, but it also allows clients to purchase these products for less money than it would cost at the grocery store.

<sup>12</sup> A partnership between the City of Regina, Regina and District Food Bank and REACH.

making its kitchen facility available for community kitchen groups, providing cooking classes for children, youth and adults, and offering Good Food Boxes<sup>13</sup>. Most of these programs have been developed and implemented at the community level in order to meet the growing food needs of the individuals that live there. In some cases, the municipal government has provided some funding, but there is no mention of provincial or federal funding for any of these programs.

### **Increasing Government Involvement**

Should food banks be abolished in order to hold the government accountable for its responsibility? Theoretically, yes, but in practical terms, no. Food banks have been operating in Canada for over 23 years now, with yearly increases in the number of people who rely on them. This suggests that the need for food banks will not cease anytime soon. Meanwhile, governments have not upheld their responsibilities under international conventions, and this has created a need for charitable organizations to pick up the slack and ensure that all individuals can meet their basic needs. Until governments enshrine these rights and responsibilities in federal and provincial legislation it is clear that food banks will continue to operate. It is impractical for food banks to cease operating because the number of people who depend on them is constantly increasing, and if the government is not providing enough assistance to these people where else will they turn? It is true that a radical move, such as doing away with food banks, may force people to organize themselves and force governments to acknowledge their responsibilities and explain the lack of action to ensure the right to food. But change does not happen over-night, and if governments have failed their people for this long, what will persuade them to make changes for the future? If food banks are forced to close, their clients will simply be referred to soup kitchens and church organizations that initiated this type of work in the first place. This will not

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<sup>13</sup> City of Regina. [http://www.regina.ca/content/info\\_services/social\\_devel/food.shtml](http://www.regina.ca/content/info_services/social_devel/food.shtml)

solve the problem; it only shifts the burden of responsibility from one charitable organization to another, instead of shifting it to government, where it belongs. In the meantime the Regina and District Food Bank is preparing to move to a bigger location in order to accommodate the increasing number of people that need assistance.

## **Conclusion**

According to Ed Bloos, the Regina food bank plans to expand its Lifeskills Education Center to provide more basic education and training to clients (personal correspondence, 2004). Ideally, it would also be home to family physicians and social workers, in order to centralize all of the services that food bank clients may need to access. Lastly, Bloos envisions a food bank that also owns areas of land in order to grow fresh produce, which can then be offered in hampers. This would also allow clients to gain skills and work experience by helping to plant and harvest the produce. The goal is to foster an environment that is empowering to the people, since all of these programs enable clients to become more involved in the process, instead of just being on the receiving end of a charitable donation. But the burden of responsibility still lies with charitable organizations and it becomes clear that they are expected to provide more and more services to individuals who have been failed by the government. Instead of limiting their involvement, they are expected to provide more, picking up the slack for the provincial and federal governments. As long as this happens, government will not feel the need to provide more programming and services, since the needs of the people are being met, even if it is done through charitable organizations.

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