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Our Mission

The Boundary Peace Initiative represents a growing number of area residents of diverse backgrounds brought together over the 2002 Iraqi crisis.
We support multilateral action for non-violent conflict resolution, human rights, ecological integrity for the planet and international law, through education and dialogue locally and globally.
We encourage everyone's participation as we strive for peace and justice to build a better world for future generations.
BPI web site: www.boundarypeace.20m.com

Boundary Peace Initiative meets on the 2nd & 4th Thursday @ 7 pm Due to health issues meetings are at Laura's. For directions call 250 442 0434.

To Do

The BPI needs volunteers to help at the concession and lunches for the No Boundaries Film Festival in Feb. For more info please call Laura at 250 442 0434 or email L4peace@telus.net

Let's continue working together to end all violence and abuse and wars; to eliminate all causes of poverty; stop abusing the environment and all causes of Climate Change. Remember together we can and we will have a world of true peacefulness.

Healthy, wealthy, unwise: Billions spent on treatment should be diverted to prevention

By: Ed Finn—Editor Emeritus of CCPA The Monitor (October 2014)

In mid-summer, the Ottawa Citizen ran a spread by staff writer Andrew Duffy under the heading "Health and Wealth". It opens by pointing out that "low-income Canadians are sicker, more likely to go to hospital, and more likely to die at a young age than wealthier individuals"

This was far from the first time the connection has been made between health and wealth—between being well and being well-off. The CCPA's Monica Townson, for example, has written a couple of books and many articles about the "social determinants" of health. So has Dennis Raphael, professor of health policy at York University in Toronto. CCPA board member Jim Silver's new book *About Canada: Poverty* draws the connection through his discussion of complex poverty in this country (see excerpt on page 26 of the Oct. CCPA Monitor). They provide well-researched facts and figures to show that our health is mainly determined by how national income and wealth are distributed. We become more prone to illness if we are deprived of good living conditions, nutritious food, comfortable housing, and adequate incomes.

In his Ottawa Citizens essay, Duffy notes that where you live in the nation's capital has a direct influence on your well-being. Those fortunate enough to live in one of the cities five or so higher-income areas, "have lower rates of diabetes, and make fewer trips to the hospital every year", than people who live in poorer neighborhoods. Statistics show that disease rates and hospital visits are much higher—in some cases as much as 60% higher—among residents of the lower-income areas of Ottawa than among those in affluent parts of the city.

The same wide health-and-wealth disparities prevail all over the country. In Hamilton, Ont, for instances, "researchers found that people living in that city's richest neighborhood enjoyed a life expectancy of 86.3 years—21 years more than those living in Hamilton's impoverished north end."

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The problem, of course, is international in scope. The World Health Organization (WHO) makes that clear in the annual reports of its commission on the social determinants to health. In a recent report, the commission disclosed that health inequities are rampant, not just between but also within countries.

For example, the commission found that a girl born in Lesotho, in southern Africa, is expected to live 42 years less than a girl born in Japan. The risk of a woman dying during pregnancy and childbirth in Sweden is 1 in 17,400 compared to odds of 1 in 8 in Afghanistan.

But the health inequities are just as stark inside most countries. Life expectancy for Aboriginal males in Australia, for example, is 17 years shorter than for other males in that country. Adult mortality is more than 2.5 times higher in the lowest-income than in the highest-income neighborhoods' in the U.K. In the United States, according to the WHO commission, "886,202 deaths could have been averted between 1991 and 2000 if mortality rates between white and African Americans were equalized."

In Canada, a long-term Statistics Canada study released in 2013 established beyond doubt the clear correlation between levels of income and life expectancy. The study monitored 2.7 million Canadians over a 16-year period, dividing them into five income quintiles, from highest to lowest. During these 16 years, 16% of those tracked (426,979 people) died, with the mortality rates increasing as income rates declined.

Each successively lower level of income had a higher mortality rate", the study concluded.

The obvious lesson to be learned from this and similar studies is that the overall wealth of a nation doesn't determine the overall health of its citizens. That vital effect is largely the outcome of how the national income is allocated.

Canada's GDP, for example, as measured on a per capita inflation-adjusted basis, was US$36,138 when last measured kin 2012. That's nearly double the US$18,500 that prevailed throughout the early 1970s when our major social programs such as Medicare were at their peak. But today, despite the enormous gross increase in constant-dollar GDP,

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its gross misdistribution hinders improvement to the social determinants of health that are so desperately needed.

Monique Began, former federal minister of national health and welfare and now a professor at the University of Ottawa, has served as Canada's representative on the WHO commission on the social determinants of health. She urged Canadian governments to act on the commission's report and recommendations.

"Canada likes to brag that for seven years in a row the United Nations voted us 'the best country in the world in which to live', she said in 2008. "Do all Canadians share equally in the great quality of life? No, they don't. The truth is that our country is so wealth that it manages to mask the reality of food banks, in our cities, of unacceptable housing, of young Inuit adults' very high suicide rates. The report is a wakeup call for action towards living up to our reputation."

The WHO commission made this point bluntly: "Increasing national wealth alone does not necessarily increase national health. Without equitable distribution of benefits, national growth can even exacerbate inequities." It singled out Sweden, Norway, Denmark and Finland for using their wealth most wisely, humanely and equitably.

"Nordic countries...have followed policies that encouraged equality of benefits and services, full employment, gender equity and low levels of social exclusion. This...is an outstanding example of what needs to be done everywhere."

But as the WHO commission also conceded, some low-income countries, such as Cuba, Costa Rica and Sri Lanka, "have achieved levels of good health despite relatively low national incomes." Again, it all depends on how the national income is apportioned.

Cuba's achievements in the health care field are truly remarkable. Despite its low national income, the country has endowed all its citizens with excellent hospital care, complete drug, dental and vision coverage, and a system built on the preservation of health rather than treating ill-health. The Latin American School of Medicine in Havana is the largest medical university in the world. No wonder it has been acclaimed by the WHO as a model for other countries to emulate.

Incredibly, Cuba has also outstripped the richest countries in extending medical support to those in need elsewhere. At last count, there were nearly 40,000 Cuban medical professionals—more than from all wealthy G8 countries combined, and over 15,000 of them doctors—working in 66 countries, including El Salvador, Guatemala and Haiti. Cuba is invariably the first country to send medical personnel to any country devastated by earthquakes or hurricanes. It even offered to send 1,500 doctors and nurses to help with disaster relief after Hurricane Katrina pounded New Orleans in 2005, only to have former US president George W. Bush churlishly reject the offer.

There's no doubt that many Canadian physicians, even the Canadian Medical Association itself, have become increasingly aware that most of their recurring patients are poor, and that poverty breeds ill-health.

In his Ottawa Citizen articles, Duffy relates that the Ottawa Hospital calls the patients who most often use its services, "familiar faces." They're the ones who most frequently come to the emergency department and are most often admitted to hospital wards. "[T]he one thing that unifies them," says Dr. Jeffery Turnbull, the hospital's chief of staff, "is that they're poor."

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Most doctors feel helpless to deal with such chronically ill people, for whom the hospital becomes their only recourse for aid. But Duffy found one doctor in Toronto, family physician Dr. Gary Bloch, who's trying to help these people financially when conventional medicine is futile.

Dr. Bloch says that it's not smoking, obesity, high cholesterol, high blood pressure, to too much salt or soda pop that's making most of these people sick. It's poverty. So his prescription is more money. He and the family health team he has assembled help low-income patients in inner-city Toronto to fill out applications for welfare and disability support and to get money from properly filling out their income tax returns.

"It's a really simple bottom line," Dr. Bloch told Duffy. "If you have someone living in poverty and you want to improve their health, you have to deal with that poverty. If you don't, you're just going to be throwing the health system's money away."

True enough. But as much as Dr. Bloch's poverty alleviation efforts may be applauded, and even in the unlikely event most other doctors followed his example, it still would be putting Band-Aids on a massive social affliction that requires major political surgery.

The "simple bottom line" is not poverty. Poverty is just the most obvious symptom of the nation-wide "disease" of inequality. And that inequality in turn produces not a genuine health care system, not a system designed to keep people healthy, but a system geared almost completely to their "treatment"—through drugs or chemicals or surgical intervention—after they become sick. It's a sickness response system, activated by sickness, motivated by the treatment of sickness, and funded for costly elusive cures rather than keeping people healthy.

Our entire Medicare apparatus—doctors, drug companies, hospital administrators, nursing home operators, medical device makers; even, regrettably, the scores of charitable cure-obsessed organizations—all operate on the assumption that "health care" begins only after people get sick. Whether they admit it or not or even realize it, they too have acquired a vested interest in sickness rather than health.

It is the prevalence of illness, even its spread and severity, that justifies all the billions of dollars spent on medical staff, technicians, high-tech gadgets, hospitals, clinics, prescription drugs—the whole panoply of a system that is only nominally devoted to the preservation of health.

The Chinese once had a genuine health care system in which people paid their doctors a modest fee for keeping them well. If they got sick, the payments stopped until they recovered. Understandably, doctors were motivated (and financially rewarded) by preventing illness, not treating it. So the emphasis was on closely monitoring patients, giving them frequent medical checkups, and stressing the need for good food and exercise.

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(From page2) **Healthy, wealthy…**
This system kept Chinese patients healthy and their doctors wealthy. Under the present Canadian system, a similar nationwide outbreak of wellness would seriously deplete the income of doctors—and the profits of drug companies.

I've stopped contributing to organizations that are fixated on finding cures for diseases that could be avoided by effective preventive measures. If only the Canadian Cancer Society, with its focus on treatment, could transform itself into the Cancer Prevention Society! If only even one-tenth of the billions of dollars now spent on treating the unnecessarily sick with drugs were instead invested in assuring them better health through a decent standard of living! If only our governments were governing in the public interest instead of big business interest!

It's only our governments that have the resources—and moral obligation—to improve the social determinants of health. Unfortunately, committed as they are to serving corporate demands, they continue to tolerate, even to condone, needlessly high levels of poverty and distress. Millions of people suffer as a result, but their misery lead to more illness, which in turn raises the profits that accrue from treating illness.

So, it's fundamentally a political problem. If we lived in a democracy, there would be some hope of finding and implementing a political solution. But that's a big, big "IF". I'll discuss it here next month.

Can Social Enterprises Really Solve Poverty?
From: Forbes 4/2014

Half the world lives on less than $2.50 a day. That's over three billion people. Over a billion have inadequate access to water, and some 2.6 billion lack basic sanitation. Every third child in the developing world does not have adequate shelter. The sheer scale of the problems of global poverty are overwhelming.

In the fight against poverty, one of the most exciting developments in recent years has come in the form of a new kind of business. It goes by many names: social enterprises, inclusive businesses, market-based solutions to poverty, among others. These enterprises create sustainable social impact by providing the poor with beneficial products and services, while creating improved livelihood opportunities. These innovative models can be found today in a wide range of areas, from healthcare to education, sanitation to housing. The excitement around them is heightened by the belief that they will achieve scale by tapping investment capital—including from impact investors, which intentionally deploy capital to achieve social impact as well as financial return—just as mainstream, commercial businesses have done.

But while the proliferation of new market-based solutions is encouraging, not many have made a

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Book & Film Recommendations

Books

A Desperate Passion an Autobiography
By: Helen Broinowski Caldicott, M.D. © 1996
Publisher: W.W. Norton & Company, Inc.

In this engaging and inspiring memoir, a renowned activist looks back at crucial events and people that have shaped her life and work. Raised in Australia, Helen trained as a physician and devoted herself to the treatment of children with cystic fibrosis. But it was in the political turmoil of the 1970s and 1980s that she found her true calling. Resigning from the faculty of Harvard Medical School, she helped to found and was the first president of the Physicians for Social Responsibility (PSR) and the Women's Action for Nuclear Disarmament (WAND), two organizations at the forefront of the nuclear-freeze movement. Over the next ten years Caldicott brought her message to world leaders, to the media, and to audiences of thousands whom she roused to action with singular eloquence. In 1985, PSR's umbrella affiliate, the International Physicians for the Prevention of Nuclear War, was the recipient of the Noble Peace Prize.

Physician, wife, and mother of three, Caldicott found that success as an activist did not come without cost. She reflects on the adverse impact her political work, with its constant traveling, had on her family, her medical career, and her personal well-being. This is a candid, revealing self-portrait of a charismatic and uncompromising woman whose remarkable efforts to save the world continue as she speaks out on environmental dangers and the threat to the body politic posed by multinational corporations.

Ed. Note: This story mirrors the experiences of many women in worldwide society and is reflected in the workplace, in politics and activism. Although this book is dated, we are still challenged by the same struggles as women, as peace activists and as people. I do recommend this book to inform on the anti-nuclear movement, the environmental and peace movements as well. And then, think about what has changed and what still needs to change.

Ed. Note: *If you have read a book or seen a film that you feel would be of interest or informative please let us know. Email the name of the book, the author and the publisher with a brief explanation of the book, and for the film the name, the producer and a brief explanation of the contents to Laura at l4peace@telus.net. Thank you.*

(From page 3) **Can Social Enterprises Really Solve Poverty?**
significant dent on the problems they are trying to address. When our colleagues studied 439 market-based solutions in Africa, they found that a mere 13% of them had achieved significant scale.

The problem is that these social enterprises are usually operating in an environment that doesn't support them, and sometimes is outright hostile. Take, for example, the value chain barriers facing organizations trying to deliver innovative, life-saving drugs to the rural poor in developing countries. While people in rural areas might desire and be able to afford these medications, logistics providers might not exist to get these products to their villages. And even if logistical hurdles were overcome, how would villagers get their hands on these drugs when they have no doctors to write prescriptions or pharmacists to fill them?

Or consider the public goods barriers facing an organization offering clean-burning cook stoves to poor customers. This firm is faced with not only the challenge of designing, developing and delivering a quality product at an affordable price, but also with convincing customers of the benefits of its innovation. The problem is that many of its target customers have low awareness of the health hazards of smoky cook stoves, and therefore little appreciation of the benefits of a clean-burning stove. On top of all of this, there may also be government barriers that potentially inhibit the growth of these new industries, such as where governments make solar lighting products bear a significant tax burden while heavily subsidizing the use of kerosene.

For the entrepreneur who is striving to make these models work, this is a steep, uphill struggle. Some choose to try to solve these problems themselves; for instance, they might extend their business models into gaps in the value chain, but at significant cost to the business in terms of complexity and risk. Others try to influence change in the environment. For example, an entrepreneur might try to make the case to government policymakers for more conducive regulation, but lacks the relationship access and clout needed to be effective.

The landscape of social enterprise is strewn with these tales of struggle and frustration. And yet, only a few solutions have achieved impressive scale and by doing so have been able to improve the lives of millions of people.

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(From last column) **Can Social Enterprises Really**

What's different about the solutions that scaled is that they resulted from the powerful interplay of social enterprises and *industry facilitators.* From smallholder tea in Kenya, to microfinance in India, to solar energy in Bangladesh, we have seen that while innovative enterprises are clearly the engine of change, external facilitators can help them succeed and scale by working alongside them to tackle the tough barriers that stand in the way. We have seen a range of different actors—foundations, aid donors, nonprofits, multilateral development agencies, impact investors, government agencies—step into industry facilitation roles, but the common theme is that they worked to resolve scaling barriers to the benefit of all social enterprises in an industry, not just one.

Can social enterprises really solve poverty? Our considered view is that they can indeed make a tremendous contribution, but only if those of us who support these enterprises widen our lens and change our approach. We need to start seeing the systemic nature of the challenges that they face and play a stronger role to helping them overcome those challenges. If we do not, we run a very real risk that social enterprises will continue to inspire and excite, but not change the world in any significant way, and will always be the idea whose time never came.

Harvey Koh is a Director at Monitor Deloitte and co-leads the Monitor Inclusive Markets unit based in Mumbai, India.

This piece was written in advance of the 2014 Skoll World Forum on Social Entrepreneurship. View the entire advance series and subscribe here to watch the live-stream April 9-11 from Oxford, England.

Every gun that is made, every warship launched, every rocket fired, signifies in a final sense, a theft from those who hunger and are not fed, from those who are cold and are not clothed.

President Dwight D. Eisenhower

War is over ... If you want it.

John Lennon

The Boundary Peace Initiative (BPI) welcomes articles. All articles are the responsibility of the author and may not be common consensus**.** To submit an article, contact **Laura** at **250-442-0434** or **L4peace@telus.net**. The BPI is a member of: BC Southern Interior Peace Coalition, Canadian Peace Alliance, Abolition 2000, Lawyers Against the War, Canadian Voice of Women for Peace, an affiliate of the Fellowship of Reconciliation and works with various local and global groups.

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