

Towards a Social Assistance System That Enables Health and Health Equity

Submission to the Commission for the Review of Social Assistance in Ontario

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Key Messages

- There are pervasive and damaging health inequities within Ontario in which people with lower income, education or employment, or facing other lines of social inequality and exclusion, have poorer health.
- The roots of these health inequities lie in poverty and income inequality, precarious work and unemployment, inadequate housing and homelessness, racism and other lines of social exclusion, inequitable access to social, health and other services and support, and other social determinants of health.
- Given their very low income, poor living conditions and limited opportunities, people on social assistance are at the most disadvantaged end of this social gradient of health and face the greatest risk and burden of ill health.
- Levels of disadvantage differ amongst people on social assistance. While all people on social assistance face significant barriers, some sub-populations, such as women and racialized Canadians, experience multiple barriers to good health.
- While social assistance cannot itself shift fundamental structures of social inequality and determinants of health, a more effective and responsive system could mitigate their damaging impacts. Unfortunately, the current system in Ontario reinforces health inequities and limits opportunities for good health. That is the problem we want to solve.
- We are a collaborative of Toronto-based health institutions, front-line service providers, policy experts, researchers and practitioners who came together to provide health and health equity related input to the Commission.
- We argue that creating the conditions and opportunities for good health should be one of the Commission's fundamental goals and one of the defining components of an effective and high-performing social assistance system.
- A more health-enabling social assistance system can be created by:
 - Ensuring people on social assistance have access to the full basket of supports essential to maintaining health such as adequate income, housing, nutritious food, and health services;
 - Ensuring access to the wider health and social services so critical to ameliorating the harsh health impact of poverty and poor living conditions;
 - Creating opportunities for people to build their skills and capacities, transition off social assistance, improve their circumstances and reach their full health potential;
 - Building on existing community resources and infrastructure, effectively linking to health and other service providers supporting disadvantaged populations on the ground, and aligning social assistance reform with poverty reduction, health reform and other key policy priorities for the provincial government; and
 - Building health and health equity into system design and planning, assessing the health impact of all social assistance policies and programs, and embedding health into the objectives and success indicators that will drive the reformed system.

Introduction

People with low income and on social assistance face a daunting range of challenges to their well-being — one of which is systemic and damaging health inequities. There is an enormous body of research demonstrating that those lower down on the hierarchies of income, education and other lines of social inequality and exclusion have poorer health. Given their very low income, poor living conditions and limited opportunities, people on social assistance are at the most disadvantaged end of this social gradient of health, and some sub-populations, such as women and racialized Canadians, experience multiple disadvantages. Unfortunately, the current social assistance system exacerbates many institutional barriers for people's health, and reinforces the social and economic foundations of health inequities.

That is the problem to which we want to contribute solutions.

We are a collaborative of health institutions, front-line service providers, policy experts, researchers and practitioners who came together to support the Commission by providing specific health and health equity related analysis and advice. Whether in front-line service provision or research and policy development, we are all working to reduce systemic health inequities. We came together because we want to ensure that the health impact of income inequality, poverty and dependence on social assistance is taken into account in the current review. This brief provides effective, evidence-based and actionable recommendations for reform that will enhance opportunities for good health for people on social assistance; and ensure that the reformed system will help to reduce the structural barriers that underlie health inequities. But we also have a more pragmatic immediate goal: to ensure that social assistance does not make health inequities worse, because it very much does now.

This brief:

- Demonstrates how people on social assistance in Ontario face the greatest challenges around low income, poor living conditions and limited opportunities — and how this far worse position has an adverse impact on their health;
- Identifies barriers with the current system that contribute to poor health — and how they can be fixed;
- Shows how reform of the social assistance system needs to take account of social determinants of health and address the impact and day-to-day realities of systemic health inequities;
- Identifies reforms that will enhance opportunities for good health of people on assistance — and the key policy and program levers to implement them;
- Draws on lessons learned from the health system that may be relevant to social assistance policy and program reform;
- Develops actionable recommendations for social assistance reform that will improve population health and health equity.

To ground and guide our analysis, we:

- Conducted a review of local, Canadian and international research literature on the social determinants of health and health inequities, how social policy and other mediating factors interact with population health and health inequities, the health situation of low-income people and those on social assistance, the health implications of current social assistance policy and programs, and emerging trends and innovative thinking on social policy in comparable jurisdictions;
- Convened a roundtable of 49 hospital, Community Health Centre, public health and other health sector experts, service providers and professionals from 33 organizations to consider how to build health and health equity into social assistance reform and to identify actionable policy solutions that protect and promote health;
- Organized a series of focus groups with front-line practitioners and community members from

Community Health Centres and public health.

We are not experts on social policy or the detailed operation of the social assistance system and our experience lies primarily in the Greater Toronto Area; therefore we leave it to other organizations to advise on many areas where reform is needed. But we do know about the adverse health impact of poverty and living on social assistance. Key policy directions for how reform can improve health outcomes and opportunities of people on social assistance are highlighted below.

Context: Pervasive Health Inequities

POOR PEOPLE HAVE A GREATER BURDEN OF ILL HEALTH

There is a consistent gradient of health in which people with lower income and education, who are unemployed or in precarious or low-paid work and/or face other dimensions of social inequality and exclusion, have poorer health. This gradient applies whether measured by self-reported overall health, mental health, prevalence of chronic conditions, or many other indicators. In Ontario:

- Over three times as many people in the lowest income quintile report their health to be only poor or fair than in the highest;¹
- Similarly, five times as many men and three times as many women in the lowest income quintile report their mental health to be only poor or fair than the highest;²
- The percentage of people who reported their mental health to be fair or poor was three to five times greater in the lowest income quartile than the highest;³
- People in the lowest income neighbourhoods had significantly higher rates of probable depression and hospitalization for depression than those from the highest income neighbourhoods;⁴
- The percentage of people with diabetes or heart disease was three to five times higher in the lowest income quintile than the highest.⁵

These differences have a significant impact over people's lives:

- In Toronto, life expectancy was 4.5 years less for men in the lowest income quintile versus the highest and 2.0 years for women;⁶
- Drilling down, national level data with more detailed differentiation by income found the difference in life expectancy between the top and bottom income decile to be 7.4 years for men and 4.5 years for women.⁷

It is never just a question of how long people live, but how well:

- The national study noted above also took account of the pronounced gradient in morbidity and found even greater disparities for health-adjusted life expectancy between the top and bottom income deciles of 11.4 years for men and 9.7 years for women;
- The routine activities of a quarter of low income people are limited by pain, twice that of high income people.⁸

1 Arlene Bierman, ed., *Project for an Ontario Women's Evidence-Based Report: Volume 1* (Toronto: 2009-10), Ch. 3. Self-reported health is regarded as a reliable indicator of clinical health status.

2 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3.

3 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3.

4 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3.

5 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3.

6 Toronto Public Health, *Unequal City: Income and Health Inequalities in Toronto* (Toronto: 2008).

7 Cameron N. McIntosh, Philippe Finès, Russell Wilkins & Michael C. Wolfson, "Income Disparities in Health-Adjusted Life Expectancy for Canadian Adults, 1991 to 2001," *Health Reports* (Statistics Canada: December 2009).

8 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3.

TOWARDS HEALTH EQUITY

Health inequities are differences in health outcomes that are avoidable, unfair, and systematically related to social inequality and disadvantage. The goal of a health equity strategy is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes.

A positive and forward-looking definition of equity is equal opportunities for good health. Given the roots of inequities in wider social and economic determinants of health, enhancing health equity is not just a concern of the health system, but will require action across many spheres of public policy.

ROOTED IN SOCIAL DETERMINANTS OF HEALTH

These inequities are not because of lifestyle, genetics or bad luck, but are rooted in structural features of contemporary Canadian society far beyond individuals' control. The foundations of these health inequities lie in the effects of poverty and income inequality, precarious work and unemployment, inadequate housing and homelessness, racism and other lines of social exclusion, inequitable access to social, health and other services and support, and other social determinants of health.⁹

Not only do the inequitable distribution and impact of these social determinants and resources lead to health inequities, but the determinants interact and reinforce each other. For example, people with lower income face higher rates of chronic conditions such as diabetes. In addition, 56 percent of people with diabetes in the lowest income quintile (and at the same time 51 percent of the second quintile) report food insecurity.¹⁰ In other words, those facing higher risk and prevalence of diabetes also have less access to nutritious foods and other resources to deal with their condition and maintain good health.

COST OF POVERTY

Not only do health inequities have a particularly adverse impact on the health of people on social assistance, but there are substantial and avoidable social and system-level costs. For example, the Association of Ontario Food Banks estimates that poverty-induced costs related to health care in Ontario have an annual public cost of \$2.9 billion, and the poorest 20 percent of Canadians account for 30.9 percent of all public health care expenditures.¹¹

In light of this data, the Association of Ontario Food Banks examined what would happen if the poorest 20 percent of Ontarians had their income increased to the same level as the 20 percent of people in the income bracket above them. It was estimated that this would save the Ontario health system \$2.9 billion annually — equal to 7.2 percent of the provincial health budget. The Public Health Agency of Canada estimates that 20 percent of all health care spending may be attributable to income disparities.¹²

9 These determinants of health have been the focus of sustained high-level policy attention in recent years: from the *World Health Organization's Special Commission on Determinants of Health* (at http://www.who.int/social_determinants/thecommission/en/), through the European Union (for a portal to a range of initiatives and reports see <http://www.health-inequalities.eu/health-inequalities/Welcome.html>) and other broad efforts, to comprehensive policies to address the determinants and their impact on health inequalities in many countries. For an excellent survey of the research and policy literature, see Hilary Graham, *Unequal Lives: Health and Socioeconomic Inequalities* (Berkshire, England: Open University Press, 2007); and for comparable Canadian material see Juha Mikkonen and Dennis Raphael, *Social Determinants of Health: The Canadian Facts* (Toronto: York University, 2010) and Dennis Raphael, ed., *Social Determinants of Health: Canadian Perspectives* 2nd Edition (Toronto: Canadian Scholars Press, 2009).

10 Bierman, *Project for an Ontario Women's Evidence-Based Report*, Ch 3, 3A.16.

11 Association of Ontario Food Banks, *The Cost of Poverty: An Analysis of the Economic Cost of Poverty in Ontario*, November 2008.

12 Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, *Reducing Health Disparities — Roles of the Health Sector: Discussion Paper*, Public Health Agency of Canada, December 2004. Accessed at http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf.

Investing in policies that help to raise the incomes of the poorest people in our society will reduce demands on health budgets, increase economic participation, and lead to greater revenue generation for governments. Most important, however, is that pursuing these policies help to keep the most vulnerable members of our society from getting — and staying — sick.

INEQUITIES ARE WORSE FOR PEOPLE ON SOCIAL ASSISTANCE

People on social assistance are at the lower end of structured deprivation and inequalities of income, living standards and opportunities, and this has a damaging health impact. There are over 850,000 people on Ontario Works and the Ontario Disability Support Program, just under 7 percent of the provincial population. People on social assistance are always in the lowest income quintile — in fact, because people on social assistance are in the lower parts of these ranges, the degree of inequities are even greater than much of this data indicates.

Data that more specifically analyzes people on assistance demonstrates this damaging impact:¹³

- People on social assistance were five times more likely than the non-poor to report their health as poor or fair;
- People on social assistance were significantly worse on 38 of 39 indicators of poor health and chronic conditions than the non-poor;
- People on social assistance had 2.4 to 4.6 times the rates of diabetes, heart disease, mood and anxiety disorders and other chronic conditions than the non-poor;
- Over four times as many people on social assistance considered suicide sometime in their lives than non-poor, and almost twenty times as many attempted suicide;
- 40 percent of people on social assistance often experienced limits on their activities and participation in social and economic life.

Particularly vulnerable populations have the poorest health. For example, homeless people are four times as likely to report poor or fair general and oral health as the general population, and 74 percent had at least one serious health condition.¹⁴

People on social assistance are not a homogenous group — some sub-populations within this already vulnerable group are especially vulnerable. For example, the racialization of poverty means that some people experience multiple disadvantages. Racialized Canadians earn only 81.4 cents for every dollar earned by non-racialized Canadians, and racialized women earn only 55.6 percent of the income earned by non-racialized men.¹⁵ This makes racialized Canadians both more likely to experience poverty and enter the social assistance system and more vulnerable even when they re-enter employment or training.

SOCIAL DETERMINANTS OF HEALTH, SOCIAL POLICY, AND ADDRESSING HEALTH INEQUITIES

The links between poor housing, nutrition and other living conditions, overall social and economic inequality and exclusion, and poor physical and mental health are well established. People on social assistance are among the most disadvantaged in terms of the social determinants of health, and as

¹³ Beth Wilson, Ernie Lightman & Andrew Mitchell, *Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario* (Toronto: Community Social Planning Council of Toronto, University of Toronto's Social Assistance in the New Economy Project & Wellesley Institute, 2009).

¹⁴ Erika Khandor & Kate Mason, *The Street Health Report* (Toronto: Street Health, 2007). http://www.wellesleyinstitute.com/research/affordable_housing_research/the-street-health-report/.

¹⁵ Sheila Block & Grace-Edward Galabuzi, *Canada's Colour Coded Labour Market: The Gap for Racialized Workers* (Toronto: The Wellesley Institute and Canadian Centre for Policy Alternatives, 2011). <http://www.wellesleyinstitute.com/publication-papers/canadas-colour-coded-labour-market-the-gap-for-racialized-workers/>.

a result, face the greatest burden and risk of ill health.

In addition, people living in poverty generally also have fewer financial and other resources, and poor communities do not generally have the networks of social connection and support available to the more affluent to help cope with the impact of poorer health, leading to fewer resources and capacity for resilience. Finally, people facing these greater health burdens and risks, and living in conditions and communities with more restricted resources and capacities to cope, also tend to have more inequitable access to health and social services. These patterns are also heavily shaped by gender: women tend to have lower income and poorer jobs, have less equitable access to key social and health services, and often must put the needs of children and other family members ahead of their own at the expense of their own health.

These three inter-dependent and reinforcing levels in which poverty and insecurity affect poor health highlight the complexity of the social determinants of health. But they also show that there are different levers for policy intervention:

- As poor housing and inadequate nutrition are key factors in ill health for vulnerable people and communities, then providing adequate housing and food security will directly contribute to improved health and reducing overall health inequities;
- As limited community resilience is a factor in reinforcing health inequities, then investing in building communities' resources and capacities can support the conditions for better health;
- As inequitable access to health, social and other services can reinforce health inequities, then targeted investment to increase access to services for the most vulnerable communities and individuals can help to mitigate the impact of systemic health inequalities.

The impact of the social determinants of health is never simple or direct, but is mediated by a range of community and policy factors. Two key dimensions discussed in the research literature on social determinants are the effect of the health system (how more equitable access to health care can help to ameliorate the impact of health inequities) and the importance of community structure and resources (how better connected and resilient communities, often expressed in terms of social capital, can also have mitigating effects). These mediating factors cannot themselves solve the social and economic inequalities that underpin health inequities, but they can mitigate their impacts to some degree — or more unfortunately — these mediating policy spheres can reinforce and exacerbate the impact of health inequities.

Given the complexity of the social determinants of health, the health of populations cannot be viewed as an issue for the Ministry of Health and Long-Term Care alone; rather, health is a key element of all social policy. Social policy and, more specifically, social assistance are among the key factors that mediate how the wider structural social determinants of health affect people on social assistance. Social policy is not confined to a single government ministry — therefore responses to social problems must also come from, and be shared amongst, multiple ministries.

Data from Quebec is suggestive. Recently published research found that although high-risk social and behavioural factors that contribute to chronic disease risk were more prevalent amongst low income residents of Quebec, health inequities are less and health outcomes are better for low income residents of Quebec than elsewhere in Canada. Low income residents of Quebec are less likely to suffer from arthritis/rheumatism than low income residents of any other province and Quebec also ranks well in the prevalence of hypertension, heart disease, cancer, and mood disorders amongst low income residents.¹⁶ The authors argue that elements of Quebec's social policy landscape that address the social determinants of health — its anti-poverty strategy, strong social support system, universal child care program, tax incentives and family benefits for parents with low incomes, and real estate tax refunds for low income families — lead to tangible health benefits for its low income population.

¹⁶Raymond Fang, Andrew Kmetic, John Millar & Lydia Drasic, 'Disparities in Chronic Disease among Canada's Low-Income Populations.' *Preventing Chronic Disease* 6(4) (2009). http://www.cdc.gov/pcd/issues/2009/oct/08_0254.htm.

By drilling down to analyze the dynamic and specific impact of the social determinants of health in these ways, we can begin to identify promising directions for policy interventions. For example, given the enormous evidence of the adverse impact of poor nutrition and housing on health, a goal of social assistance policy must be to provide the minimum standards needed to support good health. Arguably, this has long been the formal goal of social assistance, but the inadequate levels of assistance and limited supplementary programs means that people on assistance cannot afford the housing, nutrition and other foundations of a minimum standard of living needed for good health. There is also a great deal of evidence that the adverse health impact of poverty and inequality is never just because of absolute material circumstances.

Social psychological dimensions — limited opportunities for social mobility and autonomy, lack of self esteem, limited independence and security, stark and visible inequality in living conditions and possibilities — are also critical in our society.¹⁷ This impact is reinforced by social assistance administration that is inflexible. A more flexible and client-centred service approach alongside programs designed to enhance autonomy and promote opportunity could make a huge difference.

There are aspects of social policy that have had a positive impact on poverty that can be built upon. For example, enhanced income protection and security in old age can make a huge difference to the incidence of poverty among seniors, and child tax credits and benefits have made a significant difference to many families with low incomes. Participants in our Roundtable identified areas where the social assistance system affects health and well-being more positively:

- Some aspects of ODSP such as rapid reinstatement and various exemptions;
- Supports such as dental care and the Ontario Drug Benefit program do provide improved access to key health care for people on assistance — and these do ameliorate to some degree the adverse impact of poverty and other determinants.

These examples highlight that social assistance programs, if well-designed and comprehensive, can make a difference in mitigating health inequities. But we will also see below how the need to retain these benefits can be an important disincentive to securing employment or further training or education. We will return to discuss how greater flexibility and portability of these benefits could enhance opportunities and remove contradictory disincentives.¹⁸

The Problem to Solve: The Current Social Assistance System Damages Health

Social policy and social assistance systems mediate the impact of social determinants of health and health inequities — for better or worse. While social assistance cannot itself shift fundamental structures of social inequality and determinants of health, a more effective and responsive system could mitigate their damaging impact and reduce the greater health risks and burdens facing poor people. Unfortunately, the current system in Ontario tends to reinforce health inequities and limit opportunities for good health:

- It does not provide enough income or other supports to obtain adequate housing, nutritious food, and health supports essential for good health — thus directly contributing to health inequities;
- Nor does it accommodate the complex and changing needs of people with episodic, chronic and other health conditions — reinforcing their unhealthy situation;
- Even when some provisions have a positive health impact — such as dental care and access to medications — the inability to keep these benefits if moving to precarious and lower paid jobs serves to trap people on social assistance.

¹⁷Richard Wilkinson & Kate Pickett, *The Spirit Level: Why More Equal Societies Almost Always Do Better* (London: Allen Lane, 2009).

¹⁸These beneficial aspects also throw into relief the adverse situation of the working poor, who may have slightly higher income but do not have access to such vital supports for health.

People who receive social assistance usually do so because of a range of complex factors. People also have different trajectories into — and out of — poverty, and their health situations are often changeable and uncertain. However, the current social assistance system is rooted in inflexible regulations and rigid rules. This means that while the system is able to support some elements of need, it is not able to provide the flexible and adaptive support that would address complex and dynamic health needs.

A number of programs — such as special diet allowances, housing allowances and other supplements — and access to low-cost services — such as some dental care, the Ontario Drug Benefit Program and child care — are to varying degrees of explicitness designed to mitigate poor standards of living — conditions that are key determinants of good health. While many experts, practitioners and clients argue that these programs do not provide enough for adequate living conditions, they do serve to ameliorate the harsh impact of inadequate living conditions to some degree.

However, they have an unintended consequence. The provision of these vital health supports can lock people into social assistance. In effect, the possibility of losing these benefits when people take entry level jobs — which are very unlikely to have benefits or pay enough so people can afford medications and access other supports — can act as a disincentive to seeking employment.

The cost of prescription drugs is a major concern for many Ontarians. People on social assistance are able to access the Ontario Drug Benefit Program, which helps them to cover essential drug costs. This is particularly important as people on social assistance tend to be sicker than the general population and therefore require greater access to prescription drugs. However, once an individual permanently leaves the social assistance system, they are no longer eligible for provincial drug coverage. This is a major disincentive to work as very few low-skill jobs offer drug benefits — these are the jobs that people on social assistance tend to move to. This creates a perverse incentive for people with chronic or episodic illnesses who would face expensive drug costs to remain on social assistance.

“That’s one advantage of being on OW, getting your prescriptions covered. But if you’re working in a low income job like I am, then you have to pay. I paid out over \$3,000 last year in prescriptions. And I just can’t afford that.”

Best Start Resource Centre. (2010). “I’m Still Hungry”: Child and Family Poverty in Ontario. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/child_poverty_guide_rev.pdf

The Solution: A Social Assistance System That Enables Good Health For All

Our goal is to enhance the opportunities for good health and well-being for all, including the most vulnerable. We will not be commenting on the whole scope of social assistance reform, but will set out how to create and sustain a system that enables better health for people on social assistance. We identify policy options and directions that address the damaging nature of the current social assistance system and we show how a health-enabling system could mitigate the adverse impact of social determinants and contribute to better health opportunities for people on social assistance.

IDENTIFY HEALTH COMPONENTS OF A HIGH-PERFORMING SOCIAL ASSISTANCE SYSTEM

In Ontario, the *Excellent Care for All Act* sets out the pre-conditions for a high-performing health system: equity and a focus on overall population health are among the key attributes identified. This idea of identifying the key features and drivers of a high performing system could apply to most spheres of government, including social assistance policy. *Excellent Care for All*-type principles of person-centred, effective and integrated services; paying attention to program impact on the population as a whole and on particularly vulnerable communities; setting out clear deliverables and objectives, and measuring performance and delivery against them; and building quality, sustainability and effectiveness are just as relevant for social assistance reforms.

A high performing system that enables good health for clients would be:

- Adequate: so that people on social assistance can maintain a healthy standard of living;
- Flexible: with a range of responsive supports to help people get out of poverty — recognizing that there are very different pathways into/out of poverty;
- Person-centred: so services and requirements are responsive to individual and family needs and situations, are delivered in a respectful manner that does not undermine dignity, and so people can be empowered to achieve more control over their lives;
- Health-enabling: so that people’s opportunities for better health are enhanced, not constantly eroded.

Contributing to improved population health and reducing inequities in health and well-being should be explicitly included among the fundamental principles of the new policy framework for social assistance (and any legislation or regulations required). Our working group would be happy to assist the Commission in convening further health sector roundtables and organizing research and consultations to help define this health-enabling vision.

A VISION FOR SOCIAL ASSISTANCE IN ONTARIO THAT SUPPORTS HEALTH

One of the primary goals of social assistance is to provide basic protection against loss of income or employment. Just as social assistance is geared to basic income security, so too must policy makers be continually aware of the health impact of poverty and insecurity. A complementary goal should be that social assistance will also **provide basic health security**. This means:

- Ensuring living conditions, support and other factors that enable good health with a focus on women, children, and the elderly;
- Enhancing access to critical health and social services that will ameliorate the impact of health inequities;
- Contributing to reducing the impact of wider poverty, income inequality, social exclusion and other social determinants of health.

Innovative thinking and policy development from other jurisdictions emphasize that social assistance must be more than providing income security and protection, but must also enhance opportunities for social mobility. Many argue further that the broader goal of social policy is to create the conditions where people can build the capacity to reach their potential. Leading jurisdictions provide training and support to increase employment and educational opportunities, flexibly adapted and centred upon the needs and situations of participants.

Carrying this idea forward in the same way, a health-enabling social assistance system would not just ensure basic health security, but would also **enhance the opportunities for well-being and good health for all people on social assistance**. People understand how providing support and training to improve employment prospects will help people get off assistance. So too will enhancing the opportunities for good health reduce people’s dependence on and use of health care services — thus helping to reduce health system costs.

The Commission should begin from the goal of creating a social assistance system that enables all participants to have equitable opportunities for good health.

RECOMMENDATION 1

The Commission should develop a clear and powerful vision of how a high performing social assistance system for Ontario will enable good health. This vision should articulate equity in health and wellbeing as a basic value of Ontario society and recognize the provision of adequate supports for people who lose their income or employment, or who are injured, sick, or disabled.

Principles

This vision will be put into practice through a series of defining principles and concrete policy and program recommendations.

BASKET OF ESSENTIAL SUPPORTS TO ENABLE GOOD HEALTH

The fundamental problem is that poor people — and especially those on social assistance — do not have sufficient income to afford the housing, food, and other elements of an adequate standard of living. It is this inequitable access to decent living conditions that underlies their inequitable and poor health status. From a health and health equity point of view, it is critical to improve the living conditions of people on social assistance.

The longer term policy goal must be to ensure that the rates and total income available to people on social assistance will provide adequate standards of housing, nutritious food and overall living conditions, access to transportation, child care and other crucial enablers of well-being and opportunity, and the ability to live a healthy and active life. We emphasize that unless this is done — unless people on assistance can obtain the standard of living needed to maintain good health — then unfair and damaging health inequities will persist and worsen. To achieve this, systematic action is crucial.

Identifying the changes and resources needed to ensure an adequate standard of living would certainly need to be balanced against resource constraints, trade-offs with other directions and priorities. We are not naïve about the ‘fiscal realities’ of the current policy environment. But fiscal restraint needs to be balanced against the costs of not acting — in terms of preventable health damage and reinforcing generations of poverty — and the benefits of a fairer system — contributing to reducing avoidable health care and other costs, and creating wider opportunities for those currently left behind.

INCOME SUPPORTS

The income available to people on social assistance¹⁹ is simply not adequate to afford a standard of living that can maintain good health. Poverty is the fundamental problem that underlies all the specific problems to follow: inadequate income leads to inequitable and inadequate access to housing, food and other determinants of health.

RECOMMENDATION 2

The Commission should recommend the creation of a basket of essential supports to enable good health for all, including income and associated supports adjusted annually for inflation and reflective of regional costs of living.

Income supports

The basket of essential supports should include:

- 2a) An adequate income support level above Statistics Canada’s Low-Income Cut-Off, which is not reduced by tax benefits like the child tax benefit; and
- 2b) An increased child tax benefit that accounts for the real cost of raising healthy children in Ontario.

¹⁹Given the different mandates, eligibility criteria and components of Ontario Works and the Ontario Disability Support Program, different barriers are faced by recipients of OW and ODSP, but poverty and poor health are the shared outcome. We specify programs where it is important.

HOUSING SUPPORTS

Inadequate housing is directly linked to higher morbidity and mortality. The lack of social housing in Ontario means that many people on social assistance have no choice but to pay market rent, and the limited supply of affordable housing means that people can be forced to accept unsafe accommodation, forego paying for other essential items like healthy food and transportation, or become homeless.

“Many of the families are under-housed or do not have safe housing. So they are exposed to violence. Or because of their housing conditions, they are exposed to mould or second-hand smoke from drugs and cigarettes due to the apartment building. There are long waiting lists for families to secure public housing; many of the families are paying market rent but only receiving wages that accommodate public housing.” (Service Provider)

Best Start Resource Centre. (2010). “I’m Still Hungry”: Child and Family Poverty in Ontario. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/child_poverty_guide_rev.pdf

Housing supports

The basket of essential supports should include:

2c) A housing benefit reflective of the real cost of appropriate housing at different life stages, e.g. families with children, people with disabilities, and senior citizens.

NUTRITION SUPPORTS

For many people receiving social assistance, regularly getting affordable, fresh and nutritious food is impossible, which leads to ongoing negative health effects. First, fresh nutritious food is too expensive for people on a social assistance budget. Secondly, the cost and limited availability of public transportation in many areas means that significant numbers are not able to travel to grocery stores where healthy food can be purchased. This means that all food has to be purchased within walking distance, which is a particular challenge in food deserts — areas that lack access to sources of healthy, nutritious foods — where no grocery options exist beyond corner stores.

Evidence also shows that low levels of benefits mean that purchasing food is less of a priority for people on social assistance than paying rent and other essential expenses. When there are children in the household, parents often make an extraordinary effort to feed them, compromising their own nutrition. This leads to an erosion of health and ongoing medical expenses.

“If it’s a choice between food for kids and food for mom, kids come first — mom doesn’t. I just don’t eat or I don’t eat as much as I need and I’m still hungry.” (Parent Living in Poverty)

Best Start Resource Centre. (2010). “I’m Still Hungry”: Child and Family Poverty in Ontario. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/child_poverty_guide_rev.pdf

The Special Diet Allowance is designed to address this problem for those on assistance with specific medical needs. Service providers and practitioners in our Roundtable indicated that the narrow eligibility criteria for nutrition supports mean that not everyone with compromised health has access. More generally, some practitioners argue that because all people on social assistance have such limited access to good nutritious food, all need supplementary programs to support healthier diets.

“Everyone on social assistance needs a special diet — it’s called healthy food.”

(Youth counsellor, Toronto Public Health-led front-line staff focus group, August 15, 2011)

The Collaborative endorses the Dietitians of Canada (Ontario) Submission to the Social Assistance Review Commission.²⁰

Nutrition supports

The basket of essential supports should include:

2d) A nutritious food allowance that at minimum covers the regional cost of the Nutritious Food Basket; and

2e) Adequate funding of student nutrition programs that provide healthy food to ensure that school-aged children/youth are well-nourished and ready to learn.

HEALTH AND DENTAL SUPPORTS

One quarter of people on social assistance reported unmet health needs: twice that of the working poor and non-poor.²¹ Improving access to primary care is widely seen to be one of the most effective mechanisms to address the health needs of disadvantaged populations.

Access to primary care is generally high in Ontario, but varies by income. One indicator of inadequate access to primary care is the rate of avoidable hospitalizations for chronic conditions: lower income neighbourhoods in Ontario fare significantly worse than higher income neighbourhoods in this measure.²² Another indicator is preventative care: people on social assistance had significantly lower rates of screening and other preventative care, and the proportion of women who have never had a breast exam, mammogram or pap smear was significantly higher than the non-poor.²³ There is also evidence that the attitudes and knowledge of providers and structural features of primary care impact on the quality of care for poor people.²⁴

However, reflecting their generally poorer health, people on social assistance had significantly higher rates of visits with medical practitioners and nights in medical facilities. This means that in addition to the individual impact of poor health resulting from poverty, there are system costs and implications to health inequities.

Over half of low-income people had not seen a dentist in the last year (twice the rate of the highest income quartile for men and three times for women).²⁵ Inadequate dental care is frequently cited by people on social assistance as a major barrier to good health. Poor oral health has major impacts on overall health, contributing to diabetes and lung disease, in addition to causing extreme pain.²⁶ Poor oral health also affects self-esteem and the ability to enter the workforce or training.

“When your teeth look bad, you don’t feel good about yourself because having wonderful teeth is a part of the person that people want to see. It affects your ability to get a job. You just don’t feel good about yourself so you lose self-esteem about being able to go and get a job.” Social Assistance Recipient
Toronto Dental Coalition. (2001). A Report of the Toronto Dental Coalition. Retrieved from <http://www.ocfp.on.ca/local/files/CME/Healthy%20Child%20Development/Coalition%20Report.pdf>

²⁰Dietitians of Canada (Ontario), *Dietitians of Canada (Ontario) Submission to the Social Assistance Review Commission*, (August 2011). <http://www.dietitians.ca/Downloadable-Content/Public/DC-submission-to-Ontario-Social-Assistance-Review-.aspx>

²¹Wilson et al., *Sick and Tired*, p 15.

²²Bierman, *Project for an Ontario Women’s Evidence-Based Report*, Ch 7.

²³Wilson et al., *Sick and Tired*, p 15.

²⁴Gary Bloch, Linda Rozmovits & Broden Giambone, “Barriers to Primary Care Responsiveness to Poverty as a Risk Factor for Health,” *BMC Family Practice* 12(62) (2011).

²⁵Bierman, *Project for an Ontario Women’s Evidence-Based Report*, Ch. 7, 7A.38.

²⁶Health Canada, *The Effects of Oral Health on Overall Health*, (November 2009). http://www.hc-sc.gc.ca/hl-vs/alt_formats/pacrb-dgapcr/pdf/iyh-vsv/life-vie/dent-eng.pdf.

Some dental care is provided to people on social assistance, but this does not cover many basic needs. Children are eligible for dental coverage, but coverage for adults on social assistance is less comprehensive. People on OW are eligible for emergency dental treatment and dentures, while people on ODSP must speak to their case worker to determine what dental services they are eligible for. In each case people on social assistance must disclose to their dentist or denturist that they receive OW or ODSP in order for the health professional to receive pre-approval for providing services. This may stigmatize people on social assistance.

Health supports

The basket of essential supports should include:

2f) Preventive and emergency dental care for children and adults;

2g) A comprehensive drug, assistive medical devices, and eye care benefit that includes over-the-counter medications such as prenatal vitamins and infant vitamin D supplements, prescription drugs and dispensing fees; and

2h) Appropriate subsidies to enable people to participate in physical activity and recreation programs, including before and after school programs.

Enhanced Opportunities

HUMAN CAPITAL

Human capital — skills and competencies developed from education and experience that, when properly harnessed, increase productivity — is an important element of individual opportunity and social prosperity. The principle of human capital is that investing in individuals — from early childhood through high school, to college or university, and work training and experience — creates resources and capacities that can be drawn upon. By providing the right environment, the previously-invested resources are unlocked and the return on investment begins and individual productivity increases.

In the context of social assistance, human capital is important because people on social assistance may have skills and capacities that are not being maximized. This is especially the case for newcomers who may have credentials that are not recognized or may face racism, discrimination and other barriers to good jobs. By providing the right supports and resources to help people on social assistance enter employment or training, their return on investment to society over their economic lifetime exceeds the additional resources required to help them become workforce-ready.

For example, employment supports for people on social assistance should reflect both individual need and labour market requirements. The Health Sector Roundtable noted that current employment training programs do not adequately prepare people who have been out of the labour market for a long time for re-entry to the workforce. Moreover, the work that people on social assistance are supported into is not secure and the jobs are not well-paid. The ODSP Action Coalition highlights that the types of jobs the current employment supports steer clients toward are often poorly-suited to people with disabilities.²⁷ A human capital approach would identify segments of the labour market that offer 'good' jobs and would match the right people with employment training for these jobs.

²⁷ODSP Action Coalition, *Dignity, Adequacy, Inclusion: Rethinking the Ontario Disability Support Program*. Submission to the Commission for the Review of Social Assistance in Ontario, (June 2011). <http://www.odspaction.ca/sites/odspaction.ca/files/Dignity%20Adequacy%20Inclusion%20Submission%20-%20FINAL%20-%20June%2029.doc>

This would facilitate long-lasting labour market attachment and a ladder out of poverty.

The Health Sector Roundtable also highlighted that the current social assistance system does not appropriately consider people's characteristics and wishes in its employment training options. Women are pushed towards gender stereotyped jobs, such as personal support workers, that are not necessarily suitable for them (for example, this kind of work is inappropriate for single mothers without access to affordable child care outside of standard business hours). There is also evidence that people with mental illnesses or a history of addiction are discouraged from looking for work. This has a profound impact on mental health. A human capital approach would assess the needs and resources of individual people on social assistance and would actively seek appropriate employment training and supports.

RECOMMENDATION 3

The Commission should recommend a continuum of support services designed to enhance opportunities for education, training and support:

Support services to enhance opportunities should include:

3a) Career counselling that includes in-depth assessment of career goals, ambitions and labour market analysis to facilitate meaningful employment;

EXPECTATIONS OF LABOUR FORCE PARTICIPATION AND SUITABILITY

Many people on social assistance want to enter the labour force as quickly as possible to improve their economic and social position. They and focus group participants also highlighted that disability cannot be seen as a homogeneous category — there are a range of abilities within disabilities. For these reasons, those who have not worked for longer or who face more challenging disabilities need different types of training and often more intensive support. Some people, particularly those on ODSP, may never be securely attached to the work force, or workforce participation may fluctuate. However, the current social assistance system does not reflect the fact that some people require long-term or permanent support.

The current social assistance system makes entry to the labour force a priority, but in doing so does not recognize the nature of the jobs people may be able to or are forced to take. Roundtable participants emphasized that the goal must be meaningful work — only jobs that have some degree of security and autonomy have positive health benefits. Roundtable participants also highlighted that the focus on getting people on social assistance into any kind of work does not facilitate a smooth and long-lasting transition into the labour market. The types of part-time, low-paid and insecure jobs that many people on social assistance can get not only lack health benefits but also tend to be riskier, with hard physical work often required and exposure to significant workplace dangers is common.

“I really think that the kids should be placed in daycare and ... sit down with [the parent], brainstorm. What is it you want to do? What is it you'd like to do? This is what we can offer. These are the programs that are out there that you could do and if the kids were in daycare, which one would you choose? Which one would you like? Instead of saying, I think you better go do this program or you need to do this or you're not getting your cheque, right?” [Toronto Public Health Staff]

Toronto Public Health. Perspectives on Parenting on a Low Income in Toronto. October 2011. For a copy of this report, please contact (416) 338-7030.

Support services to enhance opportunities should include:

3b) Skills training and retraining aligned with career goals;

3c) Appropriate training for people on social assistance to develop basic workplace skills, particularly those on ODSP who would like to enter the workforce for the first time or after a significant period of unemployment;

3d) Support for newcomers to Canada to assist them in getting their foreign credentials recognized or pursue retraining, as well as English-language training; and

3e) Access to grants, bursaries, loans, and loan flexibility and forgiveness for those who would like to attend college or university, in addition to continued access to the full basket of essential supports.

CONDITIONS THAT SUPPORT EARLY CHILD DEVELOPMENT

There is considerable evidence that early childhood development is a crucial determinant of health throughout life. Poverty, inadequate living conditions, restricted opportunities and other lines of inequality and exclusion for children lay the foundations for a lifetime of health and other problems. This suggests the need for greater emphasis on children in social and health policy; that supporting the best conditions and opportunities early in life is a sound investment in the future. It is important to align social assistance reforms that focus on children with other broad government initiatives addressing child poverty and children's mental health, and with relevant policies and programs within the Ministries of Children and Youth Services and Education.²⁸

For low income parents, predominantly women, access to quality child care is a major factor in their ability to enter into the workforce or training. Without affordable child care that is available when and where it is needed, it is extremely difficult for parents on social assistance to accept paid employment, especially for work outside of standard business hours that is common in the low-skill jobs mostly available to people on social assistance. While some subsidized child care spaces exist, need significantly exceeds availability and few child care providers offer services outside of standard business hours. Thus a lack of affordable child care can serve to force parents to remain on social assistance.

Support services to enhance opportunities should include:

3f) Subsidized, flexible child care that accommodates education and employment training; shift, part-time, and full-time work; and volunteerism; and

3g) Subsidized early learning programs for pre-school children from birth to four years of age.

TRANSPORTATION

Public transportation provides a vital link to food, work, social engagement, and integration. Without reasonable access to public transportation, people on social assistance can become socially and physically isolated. This has long-term implications on physical and mental health. People on social assistance may be eligible for transportation assistance of up to \$100 per month to help them to participate in approved activities, such as job search programs, skills training, pre-employ-

²⁸Graham, *Unequal Lives*, Ch 10.

ment development, educational opportunities and volunteering. This is positive as it provides an opportunity for people on social assistance to participate in activities that help them to move into employment or training.

However, the prescribed nature of transportation assistance means that some essential travel is not supported. Entering the workforce or training is not simply a matter of being able to get to work or school — people on social assistance first need to be in a position where work or training is an option. This means being able to build professional and personal networks, which requires the ability to travel. Family considerations must also be made — many people on social assistance have child or parent care responsibilities that require travel. Currently, many people on social assistance are unable to afford transportation which forces them to remain at home, thereby stifling efforts to transition off social assistance.

Moreover, the ability of people on social assistance to purchase healthy, nutritious food is limited by not being able to afford to take transit to and from the grocery store. Evidence also exists that some people on social assistance are unable to attend medical appointments because they are unable to afford the transit fare. The transportation assistance level of \$100 per month may also be insufficient in some parts of the province — a monthly Metropass costs \$121 in Toronto.

Support services to enhance opportunities should include:

3h) A transportation allowance for all members of a family so that they may access employment training programs, search for jobs, attend employment and volunteer opportunities, access health and dental care, attend community and recreation programs, and get to grocery stores and other shops and remain engaged with society.

Many people on social assistance also care for vulnerable family members, which can impede their ability to complete essential day-to-day tasks, in addition to training and employment. This disproportionately impacts females on social assistance as they are primarily responsible for caregiving activities.

Support services to enhance opportunities should include:

3i) Respite care so that parents and caregivers may attend medical and dental appointments; community and recreation programs; and attend to household needs.

FLEXIBLE AND PORTABLE BENEFITS

One of the major barriers to people on social assistance moving into employment is the possible loss of health benefits. As noted earlier, many of the jobs that those on social assistance transition into are insecure and do not offer benefits. A more flexible approach would allow people on social assistance to retain access to the basket of essential supports for an extended period of time after they have exited the social assistance system. This would give clients the opportunity to accumulate assets and experience while also retaining the security of these essential supports.

The Health Sector Roundtable suggested that long-term health security could be increased by delinking eligibility for provincial drug coverage from social assistance status and instead extending eligibility to all people living on low incomes. Similarly, access to the same level of dental care that people on social assistance are entitled to, and linking eligibility the Special Diet Allowance to income rather than social assistance status, would make the transition to paid employment smoother.

“I either have to stay at my current hours or jump to full-time to get ahead. Working any bit more than I do would mean more deductions, higher rent, and fewer earnings. I fear being knocked off

ODSP and benefits, entirely. So I don't end up working to my fullest potential; I've even turned down new opportunities at work that would be good learning experiences out of fear of earning a bit more."

ODSP Recipient

Stapleton, J, S. Procyk, and L. Kochen for The Dream Team. (2011). What Stops Us From Working. Retrieved from <http://www.thedreamteam.ca/uploads/File/WhatStopsUsFromWorking.pdf>

For people on social assistance, being able to earn money is often the first step off social assistance and out of poverty. However, as it stands, the system does not empower people on social assistance to gradually transition into the workforce or training — income cut-offs mean that only small amounts of private income are allowed and the earning claw back mechanism is steep and punitive. These disincentives can lead to ongoing reliance on social assistance and consequential negative health outcomes.

"You're damned if you do, and you're damned if you don't. They want you to work, to get out and make money for your kids and stuff, but when you do that, then you're penalized. It's a ridiculous system."

(Parent living in poverty)

Best Start Resource Centre. (2010). "I'm Still Hungry": Child and Family Poverty in Ontario. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/child_poverty_guide_rev.pdf

RECOMMENDATION 4

The Commission should recommend that the social assistance system enhance the flexibility and portability of the basket of essential supports so that needing these supports does not prevent people on social assistance and their dependants from seeking and retaining employment, training or other opportunities, specifically:

- a) Continued provision of benefits until people on social assistance are firmly established in the labour market and training, then gradual reduction; and
- b) Greater allowable income before instituting income support claw-backs.

Person-Centred Support

Research on the social determinants of health demonstrates different needs and risks, different pathways and drivers of health and health inequities, and therefore different policy levers and solutions are required over the course of peoples' lives. The parallel for social assistance is that the pathways into poverty, living condition needs, and the kinds of support that enable people to get off social assistance vary for youth, parents, single adults, older people, racialized populations, newcomers, and so on — and that suitably adapted programming is necessary.

The Commission should build upon the most innovative thinking, best evidence and promising practices from leading jurisdictions to develop a new person-centred model of social assistance service delivery. It should build the perspectives, needs and preferences of clients into this development.

Our Roundtable suggested that social assistance's driving goals should include enabling clients to move from assistance to work or training. This would mean that the measure of program success would not be how many cases were moved off social assistance — for good or bad reasons — but rather how many people on social assistance got better employment, education or other opportunities — and sustained this success. It would also need to recognize that there are many trajectories for people to move off social assistance and not all people on

social assistance are ready to enter employment or training.

“[At] welfare offices, you don’t have a face; you are a number. There are a few good ones, but they don’t generally treat you like a person. It is like they’re better than you or something. They have an attitude, a nasty attitude and...they talk to you like you’re nothing.”

Ontario Prevention Clearinghouse, Ontario Women’s Health Network, Toronto Christian Clearinghouse, and Toronto Public Health. (2006). *Count Us In: Inclusion and Homeless Women in Downtown East Toronto*. Retrieved from http://www.owhn.on.ca/Count_Us_In_Final.pdf

The current goals and incentives for program managers are to process people efficiently within rigid rules and ensure they meet eligibility requirements, but this cannot address complex social and economic needs. Roundtable participants argued that from the point of view of people on social assistance, this is often experienced as a drive to cut as many people off as possible.

One crucial way to drive a more person-centred system and style of delivery is to involve clients themselves. Returning to lessons from health reform, building community engagement into strategic and service planning has become increasingly institutionalized: required by legislation for Local Health Integration Networks, and reflected in many health care institutions creating advisory panels and other ways to engage with their communities and users. Social assistance programs could set up client advisory panels on a local or regional office basis.

More generally, forms of deliberative dialogue have proven useful as ways of addressing trade-offs between competing priorities and interests, and complex health planning issues. At a service level, patient-based design is being incorporated into innovative quality improvement initiatives. If one goal is to re-design services so that people’s opportunities for mobility and development are enhanced, then people on social assistance are well placed to determine what supports are needed and how they should be provided.

RECOMMENDATION 5

The Commission should recommend the creation of a person-centred social assistance system that will:

- a) Treat people on social assistance with dignity and respect;
- b) Facilitate the pursuit of goals and ambitions for people on social assistance;
- c) Acknowledge differential needs based on gender and life course stage; and
- d) Provide culturally- and linguistically-appropriate support for people on social assistance.

A person-centred model of delivery should include regular measurement of client satisfaction with how they are treated by program staff and services and support received. These metrics would be key indicators that program managers have to deliver on and would contribute to re-orienting the system away from client surveillance to enhancing opportunities. Other accountability options explored by the Health Sector Roundtable included a complaints line, a social assistance ombudsperson, and auditing records to determine whether clients receive the supports for which they are entitled.

“The workers at the agencies should be evaluated by the users of the services.”

Ontario Prevention Clearinghouse, Ontario Women’s Health Network, Toronto Christian Clearinghouse, and Toronto Public Health. (2006). *Count Us In: Inclusion and Homeless Women in Downtown East Toronto*. Retrieved from http://www.owhn.on.ca/Count_Us_In_Final.pdf

RECOMMENDATION 6

The Commission should recommend that the social assistance system develop a transparent accountability processes including:

- a) Feedback from people on social assistance on service provision and benefits;
- b) A clear and accessible complaint and appeal service; and
- c) Provision of advocates, representatives, and an ombudsperson for people on social assistance.

RECOGNIZE THE COMPLEX, EPISODIC NATURE OF ILLNESS AND DISABILITY

The on/off system of social assistance benefits is not consistent with health processes and many people's real-life health situations. Many types of health issues and disabilities are episodic in nature, meaning that periods of acuity are followed by periods of remission. This may become an ongoing cycle, especially when appropriate health care is not easily available. This is especially true of mental illness.

People with episodic health conditions or disabilities face particular barriers in getting off social assistance. Participants in the Roundtable noted that the current system provides some supports to help individuals on ODSP to transition into employment, but these supports do not adequately reflect the episodic nature of their illness. For instance, the \$500 Employment and Training Start-Up Benefit that people on ODSP are entitled to is only payable once per year, meaning that if employment does not work out owing to a period of acuity, the individual lacks financial support to re-enter the workforce when they are again in remission. Moreover, there is a risk for people on ODSP with episodic illnesses to enter the workforce: should they lose or leave that job and if they are not eligible for rapid reinstatement, they may be required to return to the social assistance system on OW in the short-term and reapply for ODSP.

These barriers reflect the 'one-way' nature of employment supports for people with disabilities. The current system does not acknowledge that for many people with disabilities the best way to ensure long-term participation in employment or training is to facilitate smooth access into and out of employment as required. There is a continuum of participation that the current rigid system does not acknowledge or support.

RECOMMENDATION 7

The Commission should recommend that the social assistance system address the complex and episodic nature of illness and disability by:

- a) Ensuring flexible and portable benefits so people can move in and out of employment/training as they are able; and
- b) Streamlining transitions between periods when people on social assistance can work and those when they are unable to work.

Access and Navigation

People on social assistance face a range of inter-dependent challenges and require different types of social and health support services. The problem is that an enormous amount of ineffective time and energy is spent by both clients and administrators running around trying to connect disparate services, eligibilities and requirements in the current siloed structure.

For example, the Assistive Devices Program run by the Ministry of Health and Long-Term Care is mandated to provide access to personalized assistive devices appropriate for individuals' basic health needs, such as pumps and hearing aids. Up until recently, people on social assistance were entitled to have 100 percent of their assistive device covered, compared to 75 percent for the general population. The Ministry of Health and Long-Term Care recently removed this additional coverage and encouraged people on social assistance to apply for the remaining 25 percent to be paid for by social assistance providers. However, this policy change was not communicated to social assistance offices so support could not immediately be provided. Uncoordinated policy and service changes like this can have negative health impacts for people on social assistance who may have to live without necessary medical supplies or who may be forced to employ unsafe practices such as rinsing and reusing tubes when they cannot afford new ones. Participants in the Health Sector Roundtable highlighted the potential of hub-type models of integrated services being developed in some CHCs. Delivering health and social services side by side better reflects the realities of poor people's lives and the interconnected nature of social determinants. Clustering primary care and social service support would facilitate a more person-centred approach to supporting vulnerable populations.

“Another reason service coordination is so important, figuring out who's role is what and then going back and seeing who has done what, because sometimes people forget and if there are difficulties then it's set and someone else can pick up the piece.” (Public Health Nurse)

Toronto Public Health. (2010). Homeless At-Risk Prenatal Program (HARP): A Formative Program Evaluation

A more integrated approach would require greater emphasis on community-based care and support. Community Health Centres, which are expanded upon below, provide one element of the necessary infrastructure, but social assistance could also be delivered out of multi-service neighbourhood centres and other community locations. These integrated service hubs could be the base for OW and ODSP administrators and complementary social services. Roundtable participants proposed that a model of more integrated services be piloted in high-needs areas.

RECOMMENDATION 8

The Commission should recommend the creation of a streamlined social assistance system that is designed to ensure people on social assistance can access and navigate the supports they need, and is integrated with other social, health, and community services. It will:

- a) Be transparent to enable awareness of and access to available benefits and services;
- b) Provide case management to help people on social assistance navigate the system, receive the benefits they are entitled to, and access programs and services; and
- c) Provide services in community-based locations that coordinate intake and promote a more seamless provision of social, primary health, and community programs, services, supports, and resources to improve cohesion of the health and social services systems.

Enhance Coordination and Alignment

We have emphasized that the adverse impact of health inequities can be mitigated by policy and program interventions. We will highlight several key directions: some within social assistance and some that will entail improved coordination with other spheres.

In addition to highlighting some useful lessons learned in health reform, we hope to identify areas where health care infrastructure and programming can be more effectively coordinated and integrated with the social assistance system — to both benefit the health of people on social assistance and to ensure the most effective use of public resources.

PRIMARY CARE

A consistent finding of health research — and a key component of all comprehensive health equity strategies — is that one of the most effective levers to reduce health inequities is to enhance access to primary care for disadvantaged populations.

A key model and network of services that can be built on are Community Health Centres (CHCs). They prioritize providing comprehensive and person-centred care to disadvantaged populations, connect clients into further services and emphasize health promotion activities to keep people well. Roundtable participants noted that this comprehensive model of care means that CHCs deal with issues that reach far beyond health care into individual and family social supports, and community capacity building and development. CHCs could provide a greater role through their unique grass-roots level infrastructure and specialized knowledge of the community that social services could link into.

Providing primary care and other key social and health services is beyond the social assistance system's immediate mandate. But this highlights that part of reforming the system should be establishing partnerships with other providers and spheres to ensure people on assistance have the services they need to maintain good health. Building this outcome into system objectives and deliverables will drive the necessary partnerships.

Effective evidence-based success indicators for enhanced primary care for people on social assistance could be to:

- Increase the proportion of people on social assistance who have a regular primary care provider;
- Increase the proportion of people on social assistance who can get timely access to primary care when they have an urgent need;
- Decrease the difference in these indicators between people on social assistance and the general population.²⁹

We emphasize the importance of aligning social assistance reform with other policy initiatives. This is particularly clear here: expanding access to primary care is a major priority for health reform in Ontario and there are many promising initiatives underway. The Commission should ensure that its deliberations are linked to these primary care and other key service delivery reforms.

At the same time, there is increasing emphasis on quality improvement: what would high quality primary and other health care look like for low income people and those on social assistance? There is growing recognition that poverty and material circumstances need to be better taken into account within primary care and other health service delivery. For example, a treatment plan that includes taking medications with meals will not work for people who cannot afford adequate food or who are homeless.³⁰

²⁹Assessing and monitoring these indicators could be based upon quarterly surveys of access to primary care conducted in Ontario for many years. As with so much health research, the sample and data would need to be stratified by income and other socio-economic variables and be able to differentiate those on social assistance.

³⁰Bloch et al., "Barriers to Primary Care Responsiveness to Poverty as a Risk Factor for Health".

HEALTH PROMOTION

Leading health policy experts and researchers consistently emphasize the importance of health promotion strategies to promote health and delay or prevent illness. This is especially important for lower income and more vulnerable populations. Conditions such as asthma, hypertension, diabetes, depression and other chronic conditions are particularly sensitive to social circumstances (e.g. one key to preventing and managing diabetes is good diet). Poorer people are at greater risk, yet also tend to have less access to health promotion services.

Health promotion ranges from ensuring all populations have understandable information on risks and enablers of health, through access to exercise and recreational activities, to, most fundamentally, adequate living conditions. Social assistance should facilitate access to health promoting activities and support. This may include subsidizing user fees and removing other barriers that may prevent people on social assistance from being able to participate in health-promoting activities. This highlights the need to link social assistance reform and policy to other spheres; for example, ensuring there are adequate parks and activity opportunities in poor neighbourhoods, and working with healthy community partnerships to ensure the needs of the poorest and most marginalized are met.

Because chronic conditions are complex issues, they are best addressed through multi-disciplinary services and cross-sectoral collaborations. Social assistance cannot provide many of these services directly and should partner with CHCs and other community-based health promotion programs to enhance services and support to clients, and should participate in local healthy community partnerships to address the roots of higher burdens of chronic diseases in vulnerable populations and neighbourhoods. Those most at risk and with the greatest needs should be targeted.

In terms of promoting health and managing chronic conditions, health-enabling objectives for the reformed social assistance system could be to:

- Increase the proportion of people on social assistance who participate in health promotion programs;
- Increase the proportion of people on social assistance who receive appropriate screening;
- Decrease the differential for participation in health promotion programs and appropriate screening between people on assistance and the general population.

This is another example of aligning improved health promotion for people on social assistance with wider system priorities and drivers. The growth of chronic conditions is a key trend and is one critical factor in rising health care costs and concerns over long-term sustainability. Preventing and managing chronic conditions is a major provincial priority. Paying specific attention to those most at risk and most in need of services supports this goal.

RECOMMENDATION 9

9a) The Commission should advocate for improved access to primary care and health promotion services for people on social assistance and for the expansion of the Community Health Centre network as one proven way to ensure this.

The same health promotion and “up-stream” principles apply in other broad areas of social policy: investing in children’s physical, mental and emotional development will pay off in better health and opportunities for them in the long run; building ladders of opportunity out of disadvantaged circumstances is critical to addressing deep-seated poverty; and investing in education, training, skills building and other human capital is an investment in social cohesion and overall prosperity.³¹

³¹Patrick Diamond, “Social Justice Reinterpreted: New Frontiers for the European Welfare State,” in Anthony Giddens, Patrick Diamond & Roger Liddle, eds., *Global Europe, Social Europe* (Cambridge: Polity Press, 2006).

There is another — more unfortunate — lesson from health in this area. While the research evidence is overwhelming and there have been countless government commitments, up-stream health promotion has nowhere been sufficiently prioritized in practice, and has tended to be overwhelmed by hospital waiting lists, high-tech medicine and other pressing demands from the acute sector.³² The lesson is that policy makers need to be serious about investing in prevention and promotion — or pay the price later.

BUILD COMMUNITY CAPACITIES

We emphasized above that one crucial means of enhancing people's opportunities for good living conditions and health is through investing in human capital, but people do not live in isolation and it is also essential to build community opportunities and capacities — in other words, to build healthy communities. This is particularly important for people living in poverty and on social assistance whose neighbourhoods tend to have poorer services and environments. Extensive research shows that individuals who live in strong, vibrant, and well-resourced communities fare better on many social indicators of health.³³

There are many collaborative initiatives that local and regional social assistance offices should link with. Many Local Health Integration Networks and public health units have developed or supported local cross-sectoral collaborations working with disadvantaged populations. There are also local immigration partnerships and various healthy community partnerships and initiatives being created by the Ministry of Health Promotion and Sport.

One promising direction to address complex social problems is comprehensive community initiatives.³⁴ They bring together broad-based partnerships of local residents, service providers, community organizations, businesses and governments to coordinate services, share and leverage resources to build community capacity and infrastructure, and mobilize towards policy change to address the roots of poverty or other social problems. Vibrant Communities is a cross-country example of community-driven collaborations geared to building education, training, and personal and other productive individual assets to help people get out of poverty. They are solidly rooted in local communities and entail considerable local community involvement and engagement. The assets that Vibrant Communities seek to build and the community capacities that these comprehensive initiatives seek to leverage are health promoting in the sense that they improve individuals' position within the overall determinants of health.

A high-performing social assistance system should identify local assets and collaborations in order to leverage what works well within communities and to enhance opportunities for people on social assistance and all low-income people. Consumer and community advisory bodies would help understand the dynamics and assets of local communities. Adapting the principles of comprehensive community initiatives and community capacity building into social assistance reform and linking to local collaborations will allow social assistance to most effectively enhance opportunities.

9b) The Commission should recommend that the mandate of social assistance providers include partnering with appropriate local community initiatives from across sectors.

POLICY ALIGNMENT ACROSS GOVERNMENT

Participants in the Health Sector Roundtable noted that attempts to address social determinants

³²David Hunter, *The Health Debate* (Bristol: Policy Press, 2008).

³³Audrey Danaher, *Reducing Disparities and Improving Population Health: The Role of a Vibrant Community Sector* (Toronto: The Wellesley Institute, 2011). <http://www.wellesleyinstitute.com/blog/affordable-housing-blog/vibrant-effective-innovative-community-sector-and-population-health-exploring-the-links/>

³⁴For a review of evidence see <http://www.wellesleyinstitute.com/research/comprehensive-community-initiatives-lessons-learned-potential-and-opportunities-moving-forward/>

of health are hampered by inter-governmental fragmentation and isolation. For example, child poverty is being addressed within the social assistance and health systems, but their approaches are not coordinated.

There is growing understanding that complex social and economic problems require integrated and comprehensive policy solutions. This means getting beyond the current disjointed structure of Ministries, agencies and programs, and the rigid jurisdictional boundaries between different levels of government. For example, poverty reduction strategies from several provinces emphasize coordinated planning across departments and levels of government, concentrated investments in disadvantaged neighbourhoods or regions, and cross-sectoral collaborations of government, business and community organizations. Comprehensive strategies to reduce health inequities from other leading countries are also based on cross-sectoral collaboration across government and with community organizations.

The Health Sector Roundtable identified that there was a need for policy decisions and directives to be reviewed to understand how they interact with one another: under the current uncoordinated system policy can have negative impacts on vulnerable populations. There are a number of proven policy tools that can be drawn upon within social policy spheres. One that is recommended by international agencies and is being developed in a number of jurisdictions to drive more integrated and aligned policy is Health in All Policies: the idea that all policy development should consider possible health impact and implications.

A version of this approach has had promising effects in Quebec: any legislation or regulation with possible health implications must be reviewed with the Ministry of Health and signed off by the Minister. There have been exploratory efforts within Ontario in recent years: a major cross-Ministry research and policy project was completed on how to address health equity and the social determinants of health in an integrated way across the provincial government, and a Health in All Policies model has been developed within Ministry of Health and Long-Term Care. A recent Senate Subcommittee report on population health emphasized the need for integrated policy approaches to address the determinants of health.³⁵

Within social assistance policy, policies on early child development, education, youth employment, life-long learning, innovation infrastructure, transportation, land-use planning and other areas across governments affect structures of social inequality and mobility. All of these forces shape the prospects for good health and improved opportunity for those currently on social assistance. This means two things: first of all, reform of social assistance cannot effectively be pursued in isolation, but needs to be considered within the context of all those other changes in public policy needed to reduce poverty and inequality. Secondly, integrated policy development is crucial to addressing complex social problems such as improving social assistance and reducing systemic health inequities — and seeing how they are inter-connected.

A further lesson from health reform is that while all stakeholders may formally commit to equity, this commitment only gets real traction when aligned with key system drivers and policy initiatives. The goal of developing a health-enabling social assistance system will be stronger if aligned with key directions across government such as:

- Policies to improve educational and employment opportunities for youth will also help young people get off social assistance;
- Investing in child care and early child development not only enhances health, but can build opportunities for social mobility;
- Sustainability and cost-effectiveness are drivers of all government programs — investing in reducing poverty can help cut avoidable health care and other costs deriving from poverty and inequality.

³⁵The Standing Senate Committee on Social Affairs, Science and Technology, *A Healthy, Productive Canada: A Determinant of Health Approach: Final Report of The Subcommittee on Population Health*, June 2009. <http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/rephealth1jun09-e.pdf>

RECOMMENDATION 10

The Commission should advocate that the province implement a Health in All Policies Framework across Ministries and work with other levels of government to develop systematic approaches to improve health, reduce poverty, and decrease joblessness by working across sectors to address affordable housing, access to child care, labour market security, and employment conditions.

We are happy to assist by convening a roundtable of government officials, policy and health experts, and community and provider stakeholders to advise on how a Health in All Policies approach can be made to work.

Comprehensive Health-Enabling Strategy

One of our goals throughout this brief has been to identify lessons learned from the health system that may be useful to the Commission: both from extensive research and experience in providing services to disadvantaged communities and on the policy level from the process of health reform. One of the most consistent of these lessons learned from jurisdictions around the world is that addressing complex issues such as systemic health inequities requires comprehensive strategies, and all jurisdictions that have prioritized reducing health inequities have developed such strategies.

While these comprehensive strategies range far beyond health care to the macro social and economic policy changes needed to reduce overall inequality, they also include more specific strategies to ensure equitable access to high quality health care regardless of social position. There may be parallels from health equity strategies relevant to reform of the social assistance system, such as these components:³⁶

- Aligning equity with system drivers and priorities, such as quality improvement, preventing and managing chronic diseases, effectiveness, cost control, etc. Within social assistance reform, parallels could include:
 - Aligning with provincial poverty reduction strategies and with education, training, employment and immigrant settlement strategies designed to enhance opportunity.
- Targeting some resources or programs specifically to addressing disadvantaged populations or key access barriers — looking for investments and interventions that will have the highest impact on reducing health disparities or enhancing the opportunities for good health of the most vulnerable. Within social assistance reform, parallels could include:
 - Within social assistance reform, targeting enhanced services and outreach to particular populations or neighbourhoods with higher risks or specific needs, e.g. culturally appropriate and multi-lingual services to newcomers facing specific language or employment barriers; and
 - Skill-building and other programs paying careful attention to reaching and retaining those with greatest need.

DRIVE STRATEGY INTO ACTION

Another lesson from health care reform is that even the most comprehensive health equity strategy and planning can only have impact when driven into action through concrete objectives and targets, indicators to measure progress towards these targets, incentives to achieve them, and data to measure impact. All of this requires systematic performance measurement and management strategies.

³⁶For frameworks developed by the Wellesley Institute, see <http://www.wellesleyinstitute.com/resource/health-equity-into-actionplanning-and-other-resources-for-lhins>.

RECOMMENDATION 11

The Commission should recommend a comprehensive monitoring system to track and report on outcomes and progress towards an equitable and health-enabling social assistance system, including:

- a) Consent-based collection of ethno-racial, linguistic, newcomer status, years of residency, and other demographic information to enable analyses of differential access, outcome, and service patterns;
- b) Collection and linkage of social assistance data with health status data to understand and address differential health outcomes; and
- c) Collection and analysis of long-term employment outcomes to ensure that where employment is the goal, people on social assistance achieve and sustain full-time, well-paid employment.

In its call for submissions, the Commission asked for possible research opportunities to inform the review of social assistance. Opportunities could include undertaking a longitudinal analysis to examine access to health and social services and health outcomes including the knowledge, attitudes and behaviours of individuals and families on social assistance. A complementary area of research could entail synthesizing the evidence with respect to factors that contribute to successful partnerships between health and social services sectors that contribute to improved health outcomes and reduced health inequities. However, while research is important, there is already ample evidence on poverty, social assistance, and health inequities in Ontario and there is no need to delay action. We encourage the Commission to use the existing research to inform its review and to set clear, measurable goals and timelines for creating a health-enabling social assistance system.

EQUITY-FOCUSED PLANNING

The Commission needs to ensure that health and health equity are solidly taken into account at all stages of its deliberations. There are a range of evidence-based tools that can be used to ensure that health is deeply embedded in social assistance reform. Health impact assessments have been used across the world, and specific variants focus on the implications for health equity. There is also mental health and well-being impact assessment tool.³⁷ Ontario has developed a Health Equity Impact Assessment tool.

As the Commission unfolds, Health Equity Impact Assessments should be applied to:

- Its work plan to ensure that the social determinants of health and health equity are being taken into account from the outset;
- Specific policy directions and proposals as they are being developed;
- The last stages of the Commission's analysis and recommendations — as a final check to ensure that the reform proposals will enable better health for all.³⁸

³⁷Given the serious inequities in mental health faced by people on social assistance, the Commission should monitor the current Public Health Agency of Canada project to develop and test Mental Health Impact Assessment in Canada.

³⁸Within our working group, the Wellesley Institute in particular has had a great deal of experience providing workshops and other resources for HEIA. We are happy to assist the Commission in this. For primers, backgrounders and resource material on using HEIA, see <http://www.wellesleyinstitute.com/policy-fields/health-care-reform/roadmap-for-health-equity/health-equity-impact-assessment/>.

RECOMMENDATION 12

The Commission should undertake a Health Equity Impact Assessment of all of its recommendations to evaluate their impact on health equity.

The Commission should recommend that the social assistance system complete Health Equity Impact Assessments whenever policies are created or revised. In all cases, final policies should be selected and formulated to reduce health and other inequities.

Conclusions

Reforming the social assistance system must be grounded in solid values. In a rich and prosperous society no one should be left behind. The Commission should build health and health equity into its values and strategic foundations so that no one's health and well-being is stunted by social or economic inequality. Reform goals should include ensuring the conditions of life needed to maintain health and expanding the opportunities of all to reach their potential and achieve a good life. This means a fundamental shift in approach from rigid enforcement and surveillance to building individual and community capacity and enabling opportunity.

The Commission has an opportunity to be innovative. For all the attention paid to health care access and spending, the health impact of policy in other key spheres is so often neglected. The Commission can reverse this by considering the implications for health and health inequities at all stages of its deliberations and for all of its proposed reforms.

We highlighted the need for a clear and coherent overall strategy on how to build health into social assistance reform. This strategy needs to be driven into action by clearly articulating how the various directions and initiatives will be coordinated and connected, specifying concrete and measurable objectives and targets, collecting solid data and indicators to measure progress towards these objectives, and aligning these objectives to the incentives and drivers that actually make government work and institutional change happen.

A fundamental objective for the Commission must be to reduce the inequitable health outcomes faced by people on social assistance — that will be one ultimate test of the impact of these reforms.

APPENDIX I

To ground and guide our analysis, we:

- Conducted a review of local, Canadian, and international research literature on the social determinants of health and health inequities, how social policy and other mediating factors interact with population health and health inequities, the health situation of low-income people and those on social assistance, the health implications of current social assistance policy and programs, and emerging trends and innovative thinking on social policy in comparable jurisdictions;
- Organized a series of focus groups with front-line practitioners and community members from Community Health Centres and public health; and
- Convened a roundtable of 49 hospital, Community Health Centres, public health and other health sector experts, service providers and professionals from 33 organizations to consider how to build health and health equity into social assistance reform and identify actionable policy solutions that protect and promote health. The following people participated in the roundtable:

Ahmed Bayoumi, Centre for Research on Inner City Health, St. Michael's Hospital

Alexandra Lamoureux, Canadian Mental Health Association, Toronto Branch

Barbara Emanuel, Toronto Public Health

Barney Savage, Centre for Addiction and Mental Health

Bob Gardner, Wellesley Institute

Cherie Miller, Regent Park Community Health Centre

Colette Murphy, Metcalf Foundation

David Hulchanski, University of Toronto

David McKeown, Toronto Public Health

Diana Noel, Community Health Centres of Greater Toronto

Eric Miller, University of Toronto

Gordon Fleming, Association of Local Public Health Agencies

Jan Fordham, Toronto Public Health

Jenie Joaquin, Scarborough Centre for Healthy Communities

Jennifer Levy, Toronto Public Health

John Stapleton, Open Policy Ontario

Kathleen Perchaluk, United Way Toronto

Kelly Murphy, Centre for Research on Inner City Health, St. Michael's Hospital

Kwame McKenzie, Centre for Addiction and Mental Health

Lara de Sousa, University Health Network

Laurel Rothman, Family Service Toronto

Lea Caragata, Wilfred Laurier University

Lee Ann Chapman, The Hospital for Sick Children

Leila Monib, Toronto Public Health

Linda Ferguson, InTO Health

Lucy Nyman, Anne Johnston Health Station

Martine Mangion, Canadian Working Group on HIV and Rehabilitation

Marilyn Kanee, Mount Sinai Hospital

Mira Dody, Flemington Health Centre

Monica Campbell, Toronto Public Health

Murray Jose, Toronto People with AIDS Foundation

Nancy Henderson, Parkdale Community Legal Services

Natacha Castor, Centre Francophone de Toronto

Nene Kwasi Kafele, Health Equity Council

Pam Lahey, Canadian Mental Health Association, Ontario Division

Pat Capponi, Voices from the Street

Paulina Salamo, Toronto Public Health

Phil Jackson, Toronto Public Health

Rick Edwards, St. Joseph's Health Centre

Robert Huff, The Centre for Environmental Health Equity

Ruby Lam, Toronto Public Health

Sarah Hobbs, Planned Parenthood Toronto

Sheila Block, Wellesley Institute

Sheila Braidek, Regent Park Community Health Centre

Simone Atungo, Mount Sinai Hospital

Siu Mee Cheng, Ontario Public Health Association

Steve Barnes, Wellesley Institute

Vaijayanthi Chari, Toronto Board of Health

Wendy Porch, Canadian Working Group on HIV and Rehabilitation

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