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Policy Commentary

BEYOND HEALTH CARE REFORM: TACKLING THE SOCIAL DETERMINANTS OF HEALTH

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A wide and solid range of health care research and practice has demonstrated that poverty, inequality, early childhood development, housing, racism, sexism and other forms of social exclusion, and many other social and economic factors have a pervasive impact on health. If the ultimate goal is improving the health of all Ontarians, then these broader determinants must be addressed at the same time as health care delivery and planning is being reformed.

One problem in addressing the social determinants of health is the structure of government itself. Policies and programmes dealing with income, housing, racism or supporting community building are scattered throughout many Ministries and agencies, often working in isolation of each other. In important ways, the health system is charged with fixing the adverse impacts of public policy elsewhere.

What might be productive directions to incorporate social determinants of health into provincial policy and strategy? Here are four preliminary possibilities.

Overall Provincial Responsibility

First of all, the provincial government must take overall responsibility for developing cohesive policies and programmes to address inequality, homelessness and other determinants that have such an adverse impact on the health of so many. This means addressing the cross-sectoral disincentives to addressing broad issues such as the social determinants of health. A good recent example was the controversy in the spring of 2006 over special diet provisions for people on social

assistance. Research has solidly demonstrated that social assistance levels do not allow people to buy an adequate diet, and that the resulting poor nutrition contributes directly to ill health. This particular campaign involved medical professionals approving many welfare recipients for a special diet supplement for people with medical conditions, arguing that all on social assistance faced health risks as a result of what they could afford to eat. The government rejected the demands as not being the intent of the programme – which was technically correct – and restricted eligibility, but chose to avoid the underlying problem of assistance levels that were too low to sustain health.

However, lurking behind that particular policy decision was the structure of the government itself. In this case, the policy solution – increasing the basic level of social assistance – is a cost to the Ministry of Community and Social Services, even when it could lower the far higher emergency, hospital and other preventable costs of ill health incurred by MOHLTC. The silo structure of contemporary government creates disincentives to making expenditures whose benefits – and political credit -- are felt elsewhere.

Structural Innovations

The second direction is for the government to build structural mechanisms and processes to get beyond these silos. While an inter-Ministerial committee has been established, the Ministry of Health Promotion has focussed solely on promoting healthier and more active individual lifestyles; an important challenge, but one that does not address more fundamental structural determinants. Ontario could examine its own past: there have been various attempts at Secretariats and super-Ministries and other forms of coordination. The lessons of why these have not worked particularly well could be examined. There are many effective examples from other provinces of integrated regional planning of health and social services (Quebec), high-level inter-Ministerial coordination and planning of all human services (Saskatchewan) and other coordinated structures and action that take underlying determinants of health into account in planning and delivery. The best of these could be adapted to Ontario.

A Broader Health Strategy

Thirdly, health care providers must provide innovative programmes that address the impact of social and economic inequality; that provide better care for marginalized communities and people. For example, as primary care is being restructured, what would effective and responsive primary care for homeless people look like? What kinds of cultural and language competencies must be integrated into delivery to adequately support isolated immigrant seniors with little English? What about when these particularly vulnerable people are scattered across large suburbs with poor public transport?

The province has a real opportunity to put access and equity at the heart of health care planning and delivery. A new ten year strategy will be developed for health in Ontario over the coming months. The Ministry, working with residents, community partners and stakeholders, must ensure that this strategy is not just

about treatment and delivery, but about all the wider systemic issues that need to be addressed to ensure better health for all. In other words, the social determinants of health must be a fundamental principle of the new provincial strategy.

Making the Links

Finally, health care providers and institutions can address the social determinants on the ground. Some Community Health Centres try to build social determinants into their programming and to support clients in addressing the housing, income or other inequities that underlie their health problems. An effective front-line direction is for providers to create partnerships and joint initiatives with community groups working in poverty reduction, immigrant settlement, employment support, homelessness and other areas of social and economic inequality. For example, CHCs, hospitals and others who deal with the health problems homeless people face should work with housing providers and advocates to ensure homeless people have somewhere safe to after treatment. Governments have many levers to require action in these kinds of areas: for example, the Ministry could regulate that no hospital will ever discharge a homeless person to the streets. This would create serious incentives to coordinate with housing providers, and add the considerable institutional weight of hospitals to demands for more affordable housing.

A great deal of useful work is being done. A 2004 national survey by the Canadian Centre for Analysis of Regionalization and Health found that 80% of Regional Health Authorities in other provinces were working or planning to work with agencies from outside the health sector. Part of the new provincial health strategy could be that each LHIN will develop coordinating and resource sharing links with appropriate social service and other agencies in their region. This would both ensure that patients do not fall between those cracks that extend beyond the formal health care system (e.g. transportation and support to get to all the appointments and places entailed in even the most seamless continuum of care) And the LHINs must use their funding and coordinating powers to facilitate health providers getting linked up with other sectors to jointly address underlying determinants of health. So, for example, every hospital could be required to demonstrate how its programmes reflect the full diversity of the local population and incorporate culturally competent care that ensures access for all.

The LHINs and provincial government should also fund innovative work, from the CHCs, public health departments or any other agency, that address social exclusion or other determinants and barriers in their programme development, service delivery, outreach and advocacy. And the province should ensure the infrastructure and support so that when a LHIN or providers in one region are making some important headway in incorporating social determinants into their planning or have pioneered some productive innovations and experiments, then these insights and experience are quickly shared around across the province.