Placing Health in Welfare Policy: A HIAP Approach in Ontario Canada

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Abstract

Increasingly, the relationship between social factors and health has been reflected in social policy. Through a focus on social determinants of health (SDOH), there has been a shift towards health promotion. However, there is little understanding of how extensively considerations of health impacts have been taken up in social policy. Such understanding would identify where more attention to SDOH could better address the needs of those most at risk for poor health. The purpose of this paper is to explore how SDOH are considered within Ontario's Social Assistance government policies and reflections on Ontario's Social Assistance (SA) Program through a health-promotion lens.

This examination will facilitate a proposal on how Ontario's social assistance program can be aligned with a Health-in-all-Policies (HiaP) approach to strengthen health outcomes within SA. A policy analysis was conducted on publicly available Ontario social assistance program documents. Twenty-two documents were analysed using the principles of interpretative description. Four main themes emerged: 1) a health-enabling social assistance system improves population health outcomes; 2) overlooking the role of social determinants of health produces health inequities 3) protecting and promoting health is a central goal; and 4) a cross-ministerial approach to health outcomes is desirable. These four themes were checked against the HiaP checklist (developed for this paper and presented in table 2) to ensure the themes that emerged from this study themes that emerged aligned with the HiaP features identified in the checklist established. Findings reflect the extent to which this approach is adopted in social assistance policy and highlight the need for a deliberate and integrated strategy to address SDOH and improve health equity through social policy.

***Keywords**: social assistance, policy analysis, health-in-all-policies, social determinants of health*

Résumé

La relation entre les facteurs sociaux et la santé se reflète de plus en plus dans la politique sociale. Grâce à l'accent mis sur les déterminants sociaux de la santé (DSS), un basculement vers la promotion de la santé s'est produit. Pourtant, il est difficile de déterminer le degré d'implication de la prise en compte des impacts sur la santé dans la politique sociale. Une telle compréhension permettrait d'identifier comment donner plus d'attention aux DSS afin de mieux répondre aux besoins des plus vulnérables. Le but de cet exposé est d'évaluer comment sont considérés les DSS au sein des politiques gouvernementales sur l'aide sociale de l'Ontario et des réflexions sur le programme d'aide sociale (AS) de l'Ontario dans l'optique de la promotion de la santé. Cette analyse rendra possible un projet par lequel le programme d'aide sociale de l'Ontario s'accordera avec l'approche de la Santé dans toutes les politiques (SdTP) pour renforcer les résultats sur la santé au sein de l'AS. Une analyse politique a été effectuée sur les documents publics en lien au programme d'aide sociale de l'Ontario. Vingt-trois documents ont été analysés en utilisant une approche interprétative. Quatre principaux thèmes revenaient :

un système d'assistance sociale favorisant la santé améliore les résultats sur la santé de la population ; négliger le rôle des déterminants sociaux de la santé créé des inégalités en matière de santé ; protéger et promouvoir la santé sont des objectifs clés ; et une approche interministérielle sur les résultats sur la santé est encouragée. Ces thèmes ont été vérifiés selon la liste SdTP, un outil développé dans le cadre de cet article afin de s'assurer que les thèmes correspondant aux caractéristiques établies d'une approche SdTP. Les résultats illustrent à quel point cette approche est utilisée dans la politique d'aide sociale et soulignent aussi le besoin d'une stratégie réfléchie et cohérente afin de répondre aux DSS et d'améliorer l'égalité de la santé à travers la politique sociale.

Mots clés: assistance sociale ; analyse des politiques ; santé dans toutes les politiques ; déterminants sociaux de la santé

Introduction

A longstanding concern in the literature has been a lack of interconnectedness between health and social policies that serves as a barrier to optimizing population health. The inability to successfully support population health through purely medical means is reflected in the following parable:

> Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore, and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in (McKinlay as cited in Rudolph, 2013).

This short parable exemplifies the weaknesses of a health system that is designed to fix presenting health problems rather than consider the root causes of these issues (Chief Medical Officer of Health, 2010; Keon & Pepin, 2009), which often stem from social factors – or social determinants of health (SDOH) - that sit "upstream" (Marmot, Bell, Houweling, Taylor, 2008; Raphael, Brassolotto, & Baldeo, 2015; WHO, 2010). SDOH are essential for health promotion (Raphael, Brassolotto, J, & Baldeo, 2015). A failure to address SDOH can increase health disparities among the most vulnerable populations, such as those living in poverty. The purpose of this paper is to explore how SDOH are considered within Ontario's Social Assistance government policies and reflections on Ontario's Social Assistance (SA) Program through a health-promotion lens.

Various health promotion approaches have been suggested to address complex health challenges conducted through a SDOH lens (Shankardass, Solar, Murphy, Greaves, O'Campo, 2012). One such approach gaining more traction in Canada is the Health-in-all-Policies (HiaP) approach (Shankardass, Murphy, Freiler, Bobbili, Bayoumi, O'Campo, 2011). The World Health Organization [WHO] (2014) defines HiaP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity" (p. 3). Conceptualized over three decades ago, this approach considers how non-health ministries can incorporate health in their policy development process given that health is affected by many factors beyond clinical treatment for health conditions (Drummond, 2012; Raphael, 2011). The Standing Senate Committee on Social Affairs, Science and Technology in Canada affirmed the importance of this type of approach: "Income, level of education, occupation, social hierarchy and housing, which are all determinants of health, have direct and indirect consequences for the health and well-being of the population"(Keon & Pépin, 2009, p. 4). The HiaP approach requires government action focused on the equitable distribution of resources.

The delivery of social determinants of health, such as housing, income, education, and employment are within the purview of multiple ministries in Ontario (and in other jurisdictions), each with their own mandates, budgets, and expected outcomes. This siloed approach to government poses a challenge to developing policies that will benefit a specific target population such as social assistance recipients when the budget for the needed expenditures are spread across different ministries. Researchers have argued that evidence supporting the value of a shared government mandate for health promotion is needed (Greaves & Bialystok, 2011). This paper contributes to this effort by examining the social policies that have a major impact on the health of those who experience significant health disparities, namely social assistance recipients. These policies fall under Ontario's Ministry of Community and Social Services (MCSS), an ideal site for application of the HiaP agenda (Labonté, 2014).

Background

The early signs of a paradigm shift to a broader definition of the determinants of health can be seen in the Ottawa Charter for Health Promotion (Potvin & Jones, 2011; World Health Organization & Heath and Welfare Canada, 1986). However, it was not until the early 2000s that the consideration of SDOH began to be included as part of a larger health strategy. Indeed, health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). Therefore, a consideration of SDOH is not only prudent; it is essential to capture a holistic view of health. Since 2006, sixteen jurisdictions across the globe (including Quebec) have implemented a HiaP approach (Shankardass, Solar, Murphy, Greaves, & O'Campo, 2012). Finland was the first government to formally adopt the language and philosophy of HiaP in its public policies, with Ministry of Social Affairs and Health leading the charge for taking on a new role for the health sector (Melkas, 2013). Other countries have since followed suit, igniting the discourse of HiaP and positioning it as a possible solution for addressing health disparities and reducing rising health care costs, while promoting economic growth (Labonté, 2014).

In 2009, the Canadian Standing Senate Committee on Social Affairs "estimated that only 25 per cent of the population's health outcomes can be attributed to the health care system on which we lavish such attention" leading them to recommend that provinces should assess the health outcomes of all government policy before implementation (Keon & Pépin, 2009, p. 7). Seven years earlier in 2002, Quebec was an early leader when they amended their public health act to include a mandate that all government ministries undertake a health impact assessment as part of the policy process, stating that any policy identified with an adverse health outcome would not be adopted (National Collaborating Centre for Healthy Public, 2014; Shankardass, Solar, Murphy, Greaves, and O'Campo, 2012). Greaves & Bialystok, (2011) suggests that a HiaP approach is being considered in various jurisdictions because of a growing understanding that considering the impact of SDOH in public policy leads to better health (Greaves & Bialystok, 2011).

To better understand how health and social policy is integrated in other health and social policy jurisdictions, Shankardass, Murphy, Freiler, Bobbili, Bayoumi, O'Campo, (2011)

conducted a scoping review of inter-sectoral action across forty-three countries. The findings of the review suggest that "upstream" interventions such as redistribution of income or power was the exception, occurring in less than a third of all policies (Shankardass, Murphy, Freiler, Bobbili, Bayoumi & O'Campo, 2011). Some researchers have claimed that despite the evidence that investments in social policy can improve health outcomes, action to embed health outcomes in social welfare policies have been largely overlooked (Stuckler, Basu, Suhrcke, Coutts, McKee, 2009). We examine whether this is the case in policies within Ontario's social assistance program.

Ontario's social assistance system is governed by two separate branches: The Ontario Disability Support Program (ODSP) and Ontario Works. ODSP is for persons with disabilities who have been assessed to be unable to work due to a disabling condition. By contrast, Ontario Works (OW) is for individuals who are unemployed and have no other source of income. Both ODSP and OW are considered supports of last resort for Ontarians in need, with a shared purpose of providing income and employment supports to eligible persons, and serve Ontarians who need assistance. These programs, governed by the Ministry of Community and Social Services (MCSS), are the focus of our policy analysis.

Methodology

The Qualitative Approach

We used an interpretive qualitative approach, interpretive description (ID), to undertake an analysis of public policy documents that pertain to Ontario's social assistance system in order to examine how SDOH are being addressed in a non-health arena. The ID approach acknowledges the theoretical and practical knowledge that researchers bring to a project (Ritchie & Spencer, 2002; Thorne, 1997; Thorne & O'Flynn-Magee, 2004). It provides a systematic and logical approach for the study of public policy (Ritchie & Spencer, 2002), drawing on available policy documents as data (Benoit, Laver, Mikhaylov, 2009; Wesselink, Buchanan, Georgiadou, & Turnhout, 2013). While the ID methodology is said to "borrow heavily" from more traditional qualitative methodologies such as grounded theory, the purpose of using ID is to generate credible and meaningful disciplinary knowledge through a critical examination of the data (Hunt, 2009; Thorne & O'Flynn-Magee, 2004). A priori theory and data interact to discover patterns and themes used to inform real world decisions. The task of the analyst, is to "engage in a dialectic between theory and the data, avoiding theoretical imposition on the one hand, and a theoretical description on the other, in the quest for a coherent rich interpretation that allows *a priori* theory to be changed by the logic of the data" (Thorne & O'Flynn-Magee, 2004, p. 11). In adherence to the tenets of ID and a constant comparative approach, we used our knowledge of policy documents in Ontario to inform our data collection and analysis processes.

Data Selection

The following four government sites were searched: The Ministry of Community and Social Services, The Ministry of Finance, The Ontario Premier's Office and the Legislative Assembly of Ontario. This yielded 647 articles. Duplicates were removed and documents were

checked against inclusion/exclusion criteria. This process resulted in twenty-two being retained for analysis. A list of these documents can be found in Table 1 below.

HiaP Policy Documents by Type			
Title	Government (includes commissioned reports)	Community Orgs	
		Health	Non-health
1	Realizing Our Potential Ontario's Poverty Reduction Strategy 2014-2019	✓	
2	Drummond Report Chapter 5	✓	
3	Drummond Report Chapter 8	✓	
4	BACKGROUNDER: Ministry of Finance Supporting a Fair Society	✓	
5	Premier's 2014 Mandate letter to MCSS	✓	
6	Premier's 2014 Mandate letter to MOHLTC	✓	
7	Oral Deputation to the Standing Committee on Finance and Economic Affairs 2012		
8	2010 Annual Report of the Chief Medical Officer of Health of Ontario to the	✓	

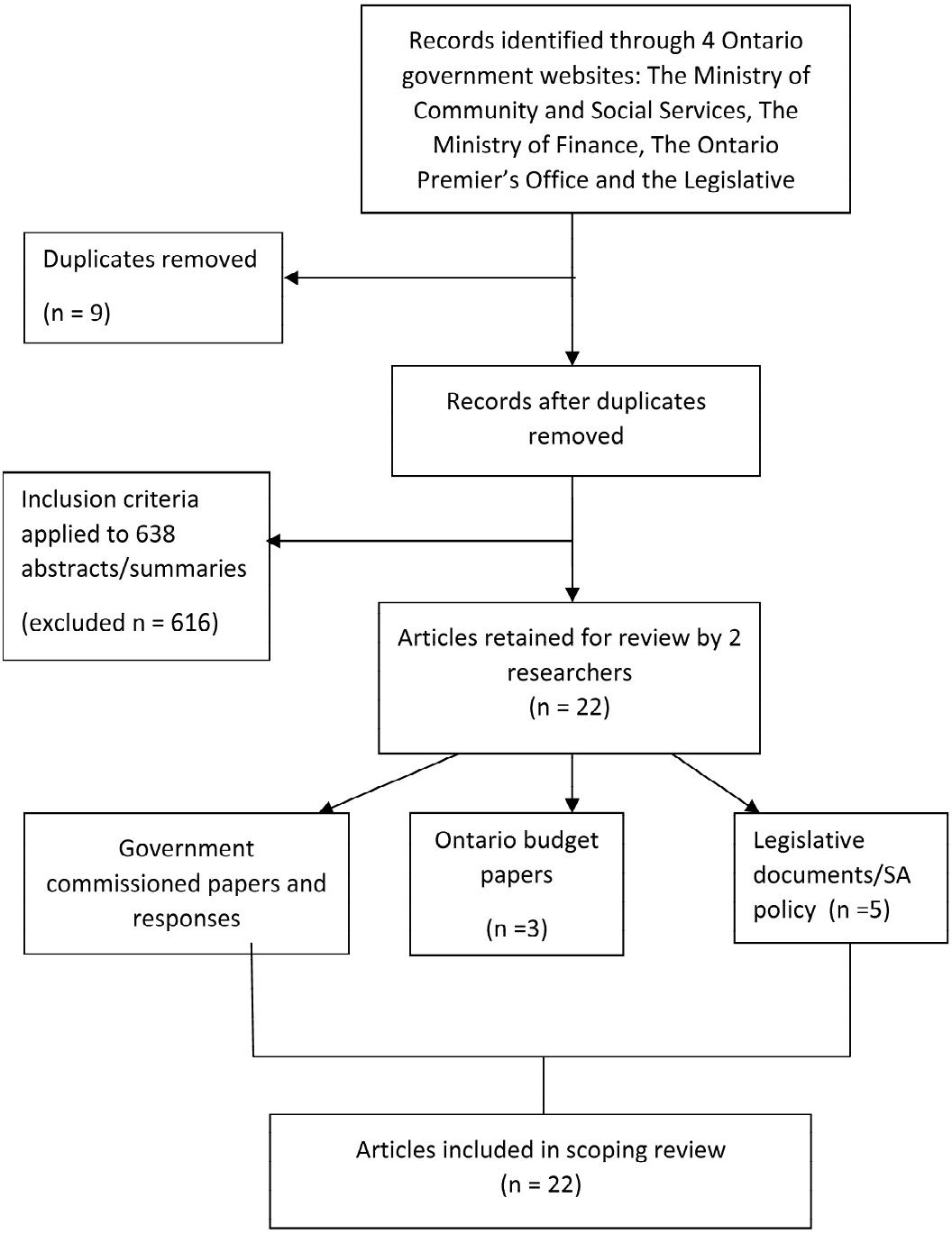
	Legislative Assembly of Ontario			
9	2013 Ontario Budget Section B: A Fairer Society	✓		
10	2014 Ontario Budget Section D: A Fair Society	✓		
11	2016 Ontario Budget: Jobs for Today and Tomorrow	✓		
12	Ontario Disability Support Program - Income Support: Directives; 4.2 - Real Property	✓		
13	Improving Ontario's Social Assistance System Response to: "Discussion Paper 2: Approaches for Reform" A submission from Canadian Mental Health Association, Ontario		✓	
14	Improving Ontario's Social Assistance System Response to: "A Discussion Paper: Issues and Ideas" A joint submission from Canadian Mental Health Association, Ontario and Schizophrenia Society of Ontario		✓	

15	Commission for the Review of Social Assistance in Ontario: Terms of Reference	✓		
16	Brighter Prospects: Transforming Social Assistance in Ontario	✓		
17	Ontario Public Health Association 2012		✓	
18	Ontario Spinal Cord Injury Solutions Alliance: Change and Consequence: Official Response to the Commission for the Review of Social Assistance in Ontario's		✓	
19	Ontario Works Policy Directives 2.4 Referral to ODSP 3.6 Trusteeship 11.3 Cost-sharing	✓		
20	Registered Nurses Association: Ontario's Most Vulnerable Need Income Security for Health and Human Dignity		✓	
21	Wellesley Institute and Partners: Ontario's Most Vulnerable Need Income Security for Health and Human Dignity		✓	

22	Ontario Association of Social Workers: Social Assistance in Ontario			

We identified the four government websites in which to apply our search terms as they were known to the principle author as containing data relevant to the research question (Thorne, 1997). We searched for government and government-commissioned documents with the following keywords: “health in all policies,” “health lens,” health outcomes,” and “social determinants of health”. The inclusion criteria applied to documents that referenced the Ministry of Community and Social Services (MCSS) and that were published after 1998 (with the establishment of the ODSP program). Only those documents pertaining to the role of social assistance delivery were retained for analysis. Documents were excluded if they referenced MCSS functions outside of the social assistance system. The detailed data collection process is illustrated in the HiaP data collection flowchart (Figure 1). Eight of the twenty-two documents are from organizations with a health mandate. This is to be expected, as health outcomes are typically within the purview of health organizations.

HiaP Search Process Diagram



Data Analysis

Documents were coded, sorted and analyzed in Dedoose, an online software for sorting and categorizing qualitative data. Analysis began with multiple readings of the documents (Thorne, 1997), and focused on exploring how the key ideas centred on health emerged and were presented in social assistance policy. An initial coding structure emerged inductively from this process. Excerpts from the documents were further organized to develop themes (Hunt, 2009; Thorne, & O'Flynn-Magee, 2004). Interpretations of the documents were compared against an HiAP checklist to ensure that the themes emerging from the data were consistent with the features of a HiaP approach (Table 2).

Table 2: HiaP Checklist

Health-in-all-Policies Checklist in Non-Health Ministries
Does the (proposed) policy specifically mention improved health and well-being as a program outcome? Are there provisions pertaining specifically to population health?
Does the (proposed) policy establish a cross-government partnership or approach to achieve economic security as a means of improved health outcomes for program recipients? I.e. Is there is a shared policy agenda and/or shared funding arrangement to realize a shared goal?
Are there public and expert voices championing the adoption of a health focused policy?
Does the (potential) policy discuss the positive and negative impacts to population health?
Are challenges to implementing a HiaP approach addressed?

This checklist was informed by several established instruments for policy analysis, namely: The Health Lens Analysis Tool (Kickbusch & Buckett, 2010); the Health Impact Assessment tool (Cole & Fielding, 2007); and the Ontario Ministry of Health and Long-Term Care's [MOHLTC] Health Equity Impact Assessment Tool (2011). These tools build upon each other, each adding in a new element. For example, the Health Impact Assessment tool was the foundational tool upon which the checklist was built. Incorporating the MOHLTC document strengthens this methodological tool by adding the concept of health equity (e.g. impact on population health). It also offers a way to operationalize assessments in the Ontario context. The health lens analysis ensured targeted populations were considered.

Findings

A significant number of the documents revolve around the final report from Ontario's Social Assistance Review [SAR] (Lankin & Shiekh, 2012). This finding is not surprising given that the search terms were expected to return documents that address health within Ontario's social assistance program, so reports pertaining to the program were expected. In addition, the most significant document to be published by this Ministry in recent years in which health and social policy intersect is the 2012 social assistance reform report. It is therefore inevitable that nine out of twenty-two documents pertain to the SAR. The analysis revealed four overarching themes: 1) a health-enabling social assistance system improves population health outcomes; 2) overlooking the role of social determinants in health produces health inequities; 3) protecting and promoting health is a central goal, and 4) a cross-ministerial approach to health outcomes is desirable. In the discussion that follows, each theme is presented beginning with a quote from the data to highlight the meaning. The themes are discussed in terms of: a) the impact on health outcomes, and b) voices of support/abstention.

A health-enabling social assistance system improves population health outcomes

An ad-hoc committee made up of Toronto-based social agencies developed a response to the social assistance review. This committee called for adequate supports that would address the health consequence of a welfare system that is literally making people sick.

> 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 (Barnes, Gardner, and Shapcott, 2013, p. 10).

A prominent message within the majority of documents is that, if the system is reformed to take into account the health outcomes of recipients, then recipients will experience better health, thus reducing health care utilization. Improved health would ultimately translate into savings for the broader system (a primary goal of public policy reforms and the SAR review).

<u>The impact on health outcomes</u>

Documents associated with OW and ODSP specifically acknowledge that access to key SDOH under their purview is necessary in order for recipients to remain healthy. However, neither program is legislated to consider the impact of their policies on population health. Given that the language of health promotion is absent in social assistance legislation, it is perhaps not surprising that health is rarely considered in the governing policies. Moreover, while the 2012 SAR's vision informing the recommendations for system reform focuses on social inclusion and human capital, it is largely silent on considerations of health influencing factors: "Ontario's social assistance review is guided by a vision of a 21st century income security system that enables all Ontarians to live with dignity, participate in their communities, and contribute to a

prospering economy" (Commission for the Review of Social Assistance in Ontario, 2011, p. 12). Where health is factored into proposed policy options, it is largely positioned as a by-product of other primary program outcomes.

Employment is the most commonly cited SDOH within the documents. The idea that employment will lead to greater independence and self-sufficiency is explicitly espoused in government directives and information documents. For example, in an ODSP informational piece promoting work, independence was seen as the desired end goal: "Getting a job can be the next step towards a better life. Not only will it mean more money for you, but "working can also improve your health and well-being, help you build skills and confidence, and lead to greater independence" (ODSP Information Sheet, n.d.). While employment can lead to a better quality of life, its role in health is not emphasized. Employment is expressed in government documents as a valuable asset for improved earnings, but its emphasis as a vehicle for self-sufficiency is favoured over its role as a determinant of health. Conversely, community submissions to the SAR caution the government to ensure the health of the individual is not compromised by precarious employment. To have a health benefit to the worker, a job has to offer security (Gardner, Barnes, and the Social Assistance Review Health Working Group, 2011; Canadian Mental Health Association & Schizophrenia Society of Ontario [SSO], 2011).

While improved health is acknowledged by the government as one among many desired effects of social assistance and income security, it is not factored into system design as a valuable outcome in its own right. In fact, where "well-being" is mentioned at all, it is economic well-being that is sought. This is perhaps no more evident than in the document, "The Commission on the Reform of Ontario's Public Services" (more commonly referred to as the Drummond Report). Drummond's mandate was to look explicitly at the fiscal impact of policy options across all Ministries - not to determine the health impact of these options. Regardless of this mandate, Drummond did address the value that social assistance services have on population health and the consequences for long-term economic savings should a health lens be taken in the restructuring of system design. Specifically, Drummond (2012) urged the government to consider the cost of health outcomes that lie outside the healthcare system:

> The health care system is only part of the picture: Only 25 per cent of the population's health outcomes can be attributed to the health care system. Yet amazingly, three-quarters of environmental factors that account for health outcomes, such as education and income, barely register in the health care debate (Drummond, 2012, p. 17).

Drummond's report is the one non-health document that (surprisingly) puts a prominent focus on health outcomes, linking enhanced delivery of SDOH across ministries with improved health outcomes, thus achieving the expenditure growth he was mandated to address. However, despite the growing expenditures within social assistance and his acknowledgement that socio-economic factors account for 50% of population health outcomes, Drummond's recommendations fell short of advising policy-makers to consider the impact of health on a transformed SA system, which is responsible for the socio-economic situation of many Ontarians.

In the majority of documents, the SDOH are positioned as pre-requisites to economic prosperity, as opposed to pre-requisites for good health. Prior to the provincial SAR, there was little evidence of health outcomes having been considered in the formative stages of public policy development within social assistance. The low rate of benefit levels and the need for more robust employment supports were raised in numerous documents (Public Health Association of Ontario, 2012; Gardner, Barnes, and the Social Assistance Review Health Working Group, 2011; CMHA & SSO, 2011; Lankin & Shiekh, 2012; Ontario Ministry of Children and Youth Services Services, 2014); however, the need for more adequate supports was tied to the goal of financial independence, not improved health. Health outcomes were seen as a positive consequence of a restructured system, rather than a targeted outcome.

Voices of support/abstention

A health enabling system was perceived differently across stakeholder groups. Often positive health outcomes were thought to be the end result of strengthening an individual's capacity to participate in the social and economic spheres. This engagement was seen as the route out of the poverty perpetuated by social assistance income benefits. Documents including Ontario's Poverty Reduction Strategy, the SAR submission from the Social Assistance Review Health Working Group, and the 2010 Annual Report of the Chief Medical Officer of Health [CMOH] suggest that reduction of poverty is the natural outflow if enhanced access to social and economic resources are provided, and that this subsequent reduction in poverty will in itself lead to better health (Gardner, Barnes, and the Social Assistance Review Health Working Group, 2011; CMOH, 2010).

However, there appears to be a tension between the goal of self-sufficiency and the recommendations to remove health-enabling supports from the system. For example, let us consider SAR recommendation # 107: "Set a target for reducing the rate of growth in the number of people with disabilities receiving social assistance, and that the savings arising from these caseload growth reductions be invested, as a priority, in the introduction of a disability benefit *outside* social assistance" (Lankin & Shiekh, 2012, p. 37). It is disappointing that there was not a clearer focus on improving health outcomes - or safeguarding existing health resources - in a reformed system, given the role of health in many of the SAR submissions. However, it seems that the goal of recipient self-sufficiency trumps all other goals. In fact, as a goal, recipient self-sufficiency appears at times to be recommended in the context of a more streamlined system that removes benefits from the broader system (in order to save money) and (at least within the government documents) provides a sense of fairness for recipients and all low-income Ontarians (Commission for the Review of Social Assistance in Ontario, 2011; Ontario, 2014; Ontario Association of Social Workers, 2012). There is a call to have some benefits moved outside the system to strengthen the supports to recipients and thereby facilitate their transition off of assistance. Fairness to all working age adults is an important consideration, but it should not come at the expense of social assistance recipients who may always need to receive government benefits due to the nature and/or severity of their disability. Moving benefits outside the system has historically been done one benefit at a time. This approach will slowly erode the benefit system for those who are unable to earn sufficient income on their own and will force them to

rely on all the available benefits to piece together a survival allowance. As the Ontario Public Health Association states "Fairness should be directed more at redressing the increased inequality in incomes, rather than at pitting those on SA against low-income workers" (2012, p. 6).

While not listed in the recommendations, there seem to be an acknowledgment that inter-ministerial collaboration is required on some level. The SAR report recognizes that the MCSS is already delivering health benefits that they feel should be the purview of the health ministry: "Other ministries are responsible for programs that affect the Province's goals for social assistance. Perhaps the most critical is the Ministry of Health and Long-Term Care (Lankin & Sheikh , 2012, p. 101)." This prompts them to suggest a stronger collaboration to ensure health outcomes are not lost between the individual ministry mandates: "It will be important to establish mechanisms to strengthen the linkages between MCSS and MOHLTC" (Lankin & Sheikh, 2012, p. 101). However, while SAR identifies improved client outcomes as the impetus for the social assistance review, and health outcomes are acknowledged to a limited extent, they do not factor into any of the 108 recommendations listed in SAR's final report (Lankin & Sheikh, 2012).

Overlooking the role of social determinants of health produces health inequities

> Access to housing, income and other social assistance benefits need to be viewed through a health lens to maximize health benefits and reduce the exacerbation of health disparities from policy changes (Ontario Public Health Assocation, 2012, p. 6).

This quote comes from one of the seven health-focused responses to the SAR report selected for analysis. Ontario Public Health Association (OPHA) echoed other submissions when it proposed policy changes that would tie SDOH to health outcomes. Further they argued that failure to acknowledge the role of SDOH as a health measure will contribute to widening the health inequity gap that already exists between social assistance recipients and other Ontarians. While health inequity permeates all the themes, its goal as a feature of HiaP approach necessitates that this issue of health inequity is addressed directly.

The impact on health outcomes

Health inequity is a concept that is embedded in population health, a broader concept that addresses the "social structural nature of health influences" that transcend the health outcomes of individuals (Dunn and Hayes, 2017, p. S7.) An article published by the Toronto-based Wellesley Institute addresses the poor health of social assistance recipients by pointing out the health gap that exists between them and other Ontarians. The Wellesley Institute views this gap as "avoidable differences in health outcomes that has its roots in the wider SDOH such that specific populations with the least access to adequate social and economic resources experience the greatest health inequities" (Haber, 2010). Given that health inequities are embedded in health discourses, it is not a surprise that five of the twenty-two documents that used the language of health inequities were from health mandated organizations (Chief Medical Office of Health, Ontario, 2010; Gardner, Barnes, and the Social Assistance Review Health Working Group, 2011; Ontario Public Health Association, 2012; ; Lankin & Shiekh, 2012; Barnes, Gardner, Shapcott, 2013). Moreover, the discourse of health inequity is at an "embryonic" stage in social policy

(Oliver & Mossialos, 2004). Therefore, while the lexicon of "health inequities" did not get raised, equity in a more generic sense was addressed in many of the documents. For example, the OASW called for equitable access to a variety of resources – for example, the special diet allowance. This said, it is the *concept* of health inequity that came across the strongest in the documents.

In the SAR Health Working Group report, a 2005 Canadian Community Health Survey is cited which found that recipients of public income benefits in Ontario have the greatest health disadvantage of all Ontarians owing to drastically low rates of income and other economic resources (Gardner, Barnes, and the Social Assistance Review Health Working Group , 2011), and that the current structure of benefits actually reinforces and even widens existing health inequities. As such, there is a strong call for addressing health inequity through increased income benefits that reflect the true costs of living. For example, the Ontario Association of Social Workers [OASW] (2012) called on the MCSS to "increase substantially current income benefits to be realistically based on the cost of living, inflation and the Social Determinants of Health" (p. 3). Again, while non-health organizations are not a frequent voice in the analysis, when they did appear, they called for the strengthening of health outcomes through the investment in SDOH. This message resonated in many documents. Inadequate or inaccessible SDOH is also closely associated with health inequities. OPHA stated that "improving the income security of Ontarians will reduce health inequities and have positive long-term impacts on the health care system" (OPHA, 2012).

Attention to other the SDOH that contribute to closing the health equity gap were also prominent in the documents. For example, there was a strong message for the provision of benefits that would allow for a healthy diet. As the Commissioners of the SAR found during their provincial consultations: "approximately 25 municipal councils had passed resolutions calling on the Government of Ontario to introduce and fully fund a $100 per month Healthy Food Supplement for all adults receiving social assistance as a first step toward meeting basic needs" (Lankin & Shielkh, 2012). The call for a nutritious diet allowance was also present in a range of documents. For example, as two mental health organizations stated:

> All social assistance recipients need and deserve a healthy diet. Unfortunately, under the current benefit levels, that is still not the case. The [special diet allowance] therefore remains an important factor in income adequacy, particularly for recipients with mental health disabilities who have specific dietary requirements resulting from co-occurring physical disabilities or medication side-effects (CMHA & SSO, 2011, p. 8).

In short, the SDOH play a vital role in health. The CMOH illustrates the importance of the role that the social determinants of health play in health care conversations:

> Put any 100 experts in a room to talk about how to alleviate these threats, and you won't hear about wait times. You won't hear about doctor shortages. You will hear about promoting healthy behaviours. You will hear about reducing poverty. You will hear about healthy child development and eliminating health inequities and food insecurity. You will

> hear, in other words, a conversation about a great many things, few if any of them related to actual health care (CMOH, 2010, p. 2).

Voices of support/abstention

A fair distribution of resources that would include those most disadvantaged was a core message. The Ontario Spinal Cord Injury Solutions Alliance called on the government to conduct an administrative review of policies to establish a SDOH framework within which the level of supports can be fairly distributed. Fair distribution of benefits acted as the proxy for the prevention of health inequities in other documents as well, including the SAR Commission who made a recommendation for a system that is "simple to understand and access, and provides basic income support for people in need in a fair and equitable fashion" (Lankin & Shiekh, 2012, p. 136). Moreover, the health authorities warned against negative health consequences that result when a health approach is not proactively used, encouraging policy makers to think about the long-term implications of health disparities. For example, in their 2010 annual report to government, the CMOH recommended the development of indicators to redress health inequities not just within social assistance but the province as a whole: "We need to settle on a finite list of these indicators that, studied properly, will paint for us a picture of how healthy we are, where geography, gender, culture and economic status are causing health inequities in our province, and how we might try to address these inequities" (CMOH, 2010, p. 25).

The concept that health-related benefits should be equally distributed was not disputed. However, the role that the MCSS should take in the delivery of these resources was fraught with tension. MCSS documents describe the role of social programming as ancillary, to be called upon to strengthen other Ministry activities. For example, the Premier's mandate letter calls upon the MCSS to:

> Support the work of the Minister Responsible for the Poverty Reduction Strategy in implementing Realizing Our Potential, Ontario 's Poverty Reduction Strategy…. Support the Minister of Municipal Affairs and Housing in the review of the Long Term Affordable Housing Strategy…. and as required, to deliver the second phase of Ontario's Mental Health and Addictions Strategy (Ontario Premier, 2014).

The MCSS was not expected to take a leading role in the administration of health influencing factors. When the role of the MCSS (in the delivery of benefits that influenced health outcomes) was mentioned in government documents, it was to suggest that benefits that have an impact on population health be moved out of the system or be eliminated. For example, the Community Start Up and Maintenance Benefit (CSUMB) was a mandatory homelessness prevention benefit delivered within social assistance that was eliminated in January 2013. This income benefit was provided to OW and ODSP recipients who needed help with housing costs, such as moving fees, and furniture replacement. According to the Wellesley Institute and the Income Security Advocacy Centre (who advocated for reinstatement of this benefit to a Legislative Standing Committee in 2012), the cost of taking away this monetary benefit was devastating: "eliminating this benefit has deprived 16,000 Ontarians of a vital support and increased the possibility of homelessness for the 900,000 recipients on social assistance"

(Laidley & Todorow, 2012, p. 1). Indeed, where health outcomes were acknowledged within the SAR report, the recommendation was to transfer health benefits out of the system, not ensure their continued role within welfare.

Protect and promote health as a central goal

> Given the current inadequacy of the rate structures for Ontario Works and the Ontario Disability Support Program, any changes to social assistance should operate under the principle of "Do No Harm" to recipients. It is essential that changes do not reduce incomes, create income instability, or remove vital supports to these vulnerable populations. (OPHA, 2012, p. 1)

This quote relates to the previous theme but is distinct in that it argues for the least damage to be done in restructuring social assistance - that no negative health impacts are incurred as a result of the transformation. This quote illustrates the complementary message to health promotion: that is, "Do no Harm" is the adage that eight of the documents addressed directly. Maintaining income benefits was seen as the common denominator upon which to begin building a social assistance system that is capable of achieving greater health outcomes. The call was intended to ensure that the resources that did remain were protected from further erosion.

The impact on health outcomes

As acknowledged by the CMOH, the MCSS delivers the "underpinnings of good health" (Chief Medical Officer of Health, 2010, p. 5) through Ontario social assistance programs (OW and ODSP). Given their delivery of a majority of SDOH resources, there are calls for the MCSS to take a more proactive approach by adopting a healthy public policy lens in policy formulation. Healthy public policy, as the CMOH states, "is what results when the conversation changes from health care to health. The trenchant point made by the Senate subcommittee and many other health care advocates is that healthy public policy must inform everything we do" (CMOH, 2010, p. 5). The SAR Health Working Group supports this view by speaking to the benefits of a social assistance system that is health-focused: "Investing in policies that help to raise the incomes of the poorest people in our society… pursuing these policies help to keep the most vulnerable members of our society from getting — and staying — sick" (Gardner, Barnes, and the Social Assistance Review Health Working Group). The documents suggest that if improved health outcomes cannot be guaranteed, then the focus should be on preserving the health of recipients and ensuring that recipients are not worse off following social assistance transformation (CMHA and SSO, 2011).

Voices of support/abstention

The voices of support for a health promotion framework were recognized in government reports. In making recommendations for curbing health care costs, the Drummond Report builds on the CMOH position by cautioning the Ministry of Finance to look outside the health care sector to a broader concept of health: "We also need to get past our myopic focus on health care to a broader view of health more generally. Health is much more than patching up people once something has gone wrong" (Drummond, 2012, p. 132). Indeed, Drummond acknowledges that much health promotion work happens outside the Ministry of Health and, therefore, these non-

health Ministries should share in the health promotion mandate. This caution was repeated in the 2014 budget: "Enhancing social services is smart public policy that can help people find and maintain employment, and contribute to improving the health of low-income individuals and families. These social gains then reduce pressures on other government program expense areas" (Ministry of Finance, 2014, p. 122).

To some degree, all documents addressed within this analysis saw it as imperative to promote health among social assistance recipients, or at a minimum, to prevent the further loss of benefits that are required for a decent quality of life. Government documents, such as the asset policies, recognize the importance of health when they allow recipients who enter the system to keep a primary residence as it is "deemed necessary for the health and well-being of the benefit unit" (MCSS, 2005, p. 1). However, many of the government documents place primary interest on potential human capital. For example, ODSP's employment directive states that "competitive employment is broadly defined as remunerative employment that can reasonably be expected to contribute to a person's economic well-being" (MCSS, 2006, p. 2). Moreover, the policies described in the documents do not advance beyond the mere nod to health outcomes. For example, the Premiers' direction to the Minister responsible for social assistance delivery acknowledges health as follows: "Your goal is to deliver co-ordinated, timely and quality services that support healthy, resilient and inclusive communities" (Ontario Premier, 2014 p. 1).

Cross ministerial approach to health outcomes is desirable

> The key to the development and implementation of healthy public policy is the development of relationships to enable collaboration across government, different sectors and communities. We need to tear down the structural impediments to collaboration that are in place throughout our province. These are created by the lack of alignment of boundaries between the municipal sector, health sector, education, social services, environment, transportation – some of the key sectors/ministries that need to work together to improve health (CMOH, 2010, p. 22).

This quote speaks to one of the central features of a health-in-all-policies approach to public policy: the need for inter-sectoral action. This theme is consistent with the features itemized in our HiaP checklist. The documents highlight a clear recognition that health outcomes are affected by the work of multiple ministries, with little indication of movement toward cross-ministerial action.

The impact on health outcomes

Despite the absence of shared mandates that can foster a HiaP approach, there have been some past government initiatives that suggest the beginnings of inter-ministerial efforts. The SAR Health Working Group referenced a cross-ministerial approach to health equity that has been piloted by several Local Health Integration Networks across (LHINs) Ontario (Gardner, Barnes, and the Social Assistance Review Health Working Group); however, the tool does not consider policies that extend beyond initiatives in the healthcare sector. In order for a health outcomes approach to be adopted by multiple ministries, pilots outside the bounds of the healthcare sector must be considered. As the SAR Health Working Group states, "Population

health should not be confined to the Ministry of Health as SDOH is the foundation of social policy which is the purview of the Ministry of Community and Social Services" (Gardner, Barnes, and the Social Assistance Review Health Working Group 2011, p. 7). While this tool was intended to be used by ministries whose policies could have potential health outcomes on the population served, there is no indication that this has transpired in practice.

Coordination of cross-ministerial policies are a pre-requisite to the implementation of the health lens that OPHA advocates: "Use a health lens when applying social assistance rates so that potential health benefits and savings to the health system are identified and incorporated into the creation of an adequately funded social assistance program" (OPHA, 2012, p. 11). To take action toward the adoption of a HiaP approach, collaborative efforts can begin at the most fundamental level by aligning benefits delivered outside social assistance with those administered inside so that unintended consequences do not occur (Stapleton, 2010). As an example, rent-geared-to-income policies for subsidized housing should be aligned with earnings exemption policies within social assistance so that an increase in earnings from employment is not negated by an increase in rent (CMHA & SSO, 2011; Ministry of Finance, 2014).

Voices of support/abstention

Many documents addressed the need for a governing framework, as well as an inter-ministerial approach in social assistance, such as a SDOH framework, a human rights lens, and equity lens (Lankin & Shiekh, 2012). The SAR Health Working Group asked the Commissioners for the Review of Social Assistance to,

> advocate that the province implements 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 (Gardner, Barnes, and the Social Assistance Review Health Working Group 2011, p. 26).

Other voices suggested a collaborative approach that would enhance supports delivered by the social assistance system. For example, the Ontario government's poverty reduction strategy (created three years before the SAR began) committed to support collaborations and partnerships that identify and remove obstacles to employment for persons with disabilities (MCYS, 2014). The CMOH acknowledged that poverty and poor health are linked and called on the government to address this issue in concert with other ministries:

> a Health Minister, or a Chief Medical Officer of Health, might be very clear on the fact that poverty is causing ill health in the population, but solving that problem lies well outside his or her sphere of responsibility and influence. What we need in Ontario, and in Canada, is a comprehensive plan to address the disconnect between what we know needs to be done and our ability to do it" (CMOH, 2010, p. 24).

The CMOH also stated that a social assistance system founded on health principles would maximize existing benefits: "We need to start applying a health lens to every program and

policy in this province, at the provincial, regional and municipal levels, so we can be clear on the health benefits or potential impacts of everything we do." (CMOH, 2010, p. 27).

Despite the call for inter-ministerial initiatives, initial exploratory research conducted by the MOHLTC, and the urging by the Ministry's own CMOH, social assistance policy directives are devoid of collaborative partnerships in meeting their objectives. Lack of cross-ministerial approaches to date presents a challenge to implementing collaborative initiatives, such as a HiaP approach. The MCSS's role in initial cross-ministerial collaboration efforts seems to be limited to supporting the work of other ministries: "You will work with stakeholders, municipalities and other ministries to revise key benefits to improve the accountability and integrity of the social assistance system" (Ontario Premier, 2014, p. 1).

Discussion

This analysis demonstrates that while a HiaP approach is recognized by many Ontario stakeholders as important for improving population health, it is not yet fully on the government's agenda. For example, one of the largest government initiatives in the last several years, the SAR, provided an opportunity to take a health outcomes focus. While it is disappointing that it did not, it is also not surprising given that the province has not committed to a HiAP approach. Further, in spite of the fact that some features of HiaP are present in select government initiatives, there is no coordinated strategy to ensure the use of HiaP across Ministries.

As illustrated by the four themes discussed here, health is not explicitly referenced in the social assistance legislation that serves as a road map for Ministry policies (Beland, 2005). Key HiaP features such as coordinated inter-ministerial strategies are also absent. This lack of commitment to cross-ministerial health outcome approaches can be illustrated with the removal of benefits (such as CSUMB) and the proposed removal of ODSP's work-related benefit. These two benefits increase income-related supports and lead to improved health outcomes.

The idea that health equity should be a principle outcome of a HiaP approach permeates the four themes that emerged from this analysis. Social assistance policy is a key action to address health inequalities and improve access to key SDOH. In particular, the findings show that negative health impacts result from inequitable distribution of socio-economic resources. Consistent with findings reported by Lightman, Mitchell and Wilson (2009) in a study of low income Ontarians, these inequities have disproportionate health impacts on the recipients of Ontario's social assistance system. These authors referred to Ontario's social assistance system as "an illness producing system" (Lightman, Mitchell, and Wilson, 2009, p. 16). Recommendations to move key elements associated with SDOH outside the social assistance system might be one means of improving access. However, a mechanism to preserve and strengthen such benefits for those who need them must be in place. For example, enhancing income and employment supports within Ontario's social assistance programs can begin to narrow the gaps between and among recipients and other Ontarians, addressing the principle of equitable access to these health-enabling resources.

Despite the recognition that health and social policy are dynamic, health outcomes are considered the domain of the formal health care system and any attempt to collaborate took place

within this sphere, regardless of the multiple levers available within MCSS to address health (Shankardass, Muntaner, & O'Camp, 2014). This finding is also consistent with the broader literature. A World Health Organization report states that health continues to be seen through the traditional lens of health care in that the health portfolio is the only one equipped to deal with health issues (Kickbusch & Buckett, 2010). This mindset needs to change if a paradigm shift from health care to health promotion is to be reflected in the policies of government ministries lying outside the formal health care system.

There are many other factors that have stalled a HiaP approach in Ontario such that it has not moved beyond the gathering of evidence. A combination of government workload, inconsistencies between health and other sectors' objectives, political timelines to achieve goals, the belief that only the Ministry of Health is responsible for health, and - perhaps the most pervasive of all - the belief that health is the individual's responsibility and therefore not thought of as having a collective solution (Gagnon & Dallaire 2008; Greaves & Bialystok, 2011), illustrates the myriad of factors that prevent implementation of such an approach. While there is acknowledgment that these factors exist – for example, Canada's mental health strategy recommended that siloes be dismantled to achieve cross ministry mandates (Mental Health Commission of Canada, 2012) - there has been little traction on making structural changes that would achieve this goal. Some of these challenges can be alleviated by combining the mandates of social services and health care into one single ministry, as has been done in two Canadian provinces and both territories. Situating social and health policy under one unified authority may produce policies that achieve the same objectives (Kasza 2002). The 2016 budget promised a new academic Centre for Evidence in Health in All Policies "that would provide government with an external network of experts to formalize an intersectoral collaboration across ministries to promote evidence based decision making." Though the Centre has yet to be established, this initiative could be the impetus for intersectoral action on the development of shared health outcomes.

However, there are non-legislative changes that can also enhance population health. For example, in 2014 British Columbia changed the earning exemptions rules to allow recipients with disabilities to earn significantly more money from employment, providing the opportunity to achieve higher income. The impact of such changes should be examined through a broad health equity lens.

Despite the movement toward features consistent with a HiaP approach, these actions have not resulted in implementation of healthy public policy across Ontario ministries. Shankardass Solar, Murphy, Greaves, and O'Campo asserted that "far more needs to be done to embed shared (health) outcomes in the actions of government policies across multiple ministries. However, lack of political will may stymy efforts" (Shankardass, Solar, O., Murphy, Greaves, and O'Campo, 2012 p.2). Shankardass (2014) argues that the Health Impact Assessments should be used to "assess the positive and negative health impacts of social assistance and other programs using the MOHLTC's Health Equity Impact Assessment Tool." However, he cautions that, for this to happen, government has to change their thinking around protecting their own mandates. This analysis highlights the need for a move away from the mindset of siloed ministry.

It may well take a cultural shift before all ministries embrace an intersectoral approach to health outcomes. Ministries need to include health outcomes in their policies. This practice needs to be ingrained across ministries - become a habit, as Shankardass suggests. As he concludes, this practice is "usually the result of learning, repetition, and practice" (Shankardass, 2014, p.19)

Returning to the opening parable, this paper has attempted to go upstream to identify whether Ontario's social assistance system is structured in such a way as to prevent recipients from being thrown into the river and, thus, having to be rescued downstream. The findings show that there has been initial discourse on what is needed to strengthen the safety net using features consistent with a HiaP approach, but a deliberate and integrated strategy is lacking, and would have to be put in place if we are to prevent recipients from being pushed into the river.

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