



# **BOARD REPORT**

Friday, November 18, 2011

# PROGRAM REPORT NOVEMBER 2011



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**We work with the Grey Bruce community to protect and promote health.**

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## HEALTHY COMMUNITY DEVELOPMENT

### **Infection Control in the Dental Office**

Oral Health Services has expanded to offer preventive and treatment clinics. With these new services, infection control remains a priority. We also recognize it is important to pass on the knowledge and best practices to dental offices in our communities.



On September 22, Public Health hosted *Infection Control in the Dental Office*, the first workshop of its kind in Grey Bruce focusing on infection control in the dental office. This workshop offered staff from dental offices across Grey Bruce an opportunity to earn continuing education credits, increase their knowledge of infection prevention and support dental practices to comply with infection control principles. Keynote speaker Jim Gauthier, lecturer in the Department of Pathology and Molecular Medicine at Queen's University, discussed basic microbiology and infection prevention and control specific to the dental office.

Over 110 dental professionals including dentists, dental hygienists, dental assistants and office managers attended. The workshop also offered a forum for dental staff to network with other offices, as well as an opportunity to promote our expanded Oral Health Services. This initiative fulfills the requirement of the *Ontario Public Health Standards* to work with community partners to support the creation or enhancement of supportive environments. Evaluations of the workshop were very positive with many attendees asking for more Public Health workshops in the future.

## Legionella and Cooling Towers

Legionella, or Legionnaire's Disease, is an acute bacterial respiratory illness that usually attacks elderly people, especially those with serious, underlying respiratory conditions. Legionella often takes the form of severe pneumonia which can be fatal. The name Legionnaire's Disease relates to a Legionnaire's Conference held in Philadelphia in 1976 where the disease was first identified.

On September 29, 2011, Dr. Arlene King, Chief Medical Officer of Health for Ontario, advised local Medical Officers of Health of an increase in Legionella cases across the province, "Since August 1, 2011, there have been 42 cases of Legionella reported in Ontario. In 2010, there were a total of 33 cases reported for August and September." Dr. King's advisory notes a relationship between Legionella and cooling towers and asks that local Medical Officers of Health take measures to mitigate the associated risks.



Legionella outbreaks have frequently been traced to cooling tower water. Cooling towers provide an ideal environment for Legionella bacteria to survive and multiply. People can be exposed to the bacteria in aerosols released by the towers. Late summer weather conditions, including high heat and temperature inversions, increase the potential for aerosol exposure.

Grey Bruce has a very low occurrence of Legionella. There have been no cases reported this year and only one case was reported last year. However, it is prudent to know the number and location of cooling towers in the region and to provide tower operators with maintenance information designed to reduce Legionella levels.

Staff will be working over the winter months to compile an inventory of cooling towers and to supply operators with the maintenance information. As well as reducing the risk of local exposure to Legionella, these measures would assist in the investigation of any future cases of the disease that may occur.

## CLIENT SERVICES

### Universal Influenza Immunization Program

Ontario's Universal Influenza Immunization Program (UIIP) saves lives. Since the introduction of the program in 2000, there has been a significant decline, both locally and province-wide, in illness and death due to influenza and pneumonia.

Flu vaccine for the 2011/12 Universal Influenza Immunization Program is being distributed to doctors, family health teams, nurse practitioners, long-term care homes and retirement homes. There are three flu vaccine products this year: Fluad, for those 65 years and over; Agriflu, a single dose product; and Vaxigrip, a multi-dose vial. Public Health will host fifteen Community Flu Vaccine Clinics across Grey Bruce beginning October 27 and running through to November 30. The complete schedule is posted on [www.publichealthgreybruce.on.ca](http://www.publichealthgreybruce.on.ca)



*Continued...*

Public Health has initiated some new collaborations for flu vaccine clinics this year. We will partner with Markdale Community Health Center, Kincardine Medical Clinic and Rockwood Terrace Long-Term Care to offer joint clinics. Partnerships have also been formed in Owen Sound to offer flu vaccination to priority populations attending the Methadone Clinic, Safe and Sound Homeless Initiative and the Victorious Living Center.

A workplace strategy has been implemented to encourage 100 per cent staff uptake for influenza vaccine. Regular emails reminders, convenient staff only flu clinics, visual displays of the percentage of staff immunized and policy review are some of the components of our workplace strategy. Results of these initiatives will be evaluated at the conclusion of flu season.



## **ENFORCEMENT/RESEARCH/SURVEILLANCE**

### **Recreational Water – Public Swimming Pools**

Following a number of drowning deaths in 2010, the Chief Coroner of Ontario produced a report *Drowning Death Review*, released this past summer. The *Review* identified common factors that may have played a role in the deaths due to drowning and made recommendations to prevent deaths in similar circumstances in the future. The *Review* noted a disturbing trend in deaths of children less than five years of age. The report concluded that, in some cases, the drowning deaths may have been prevented if the attendants had stayed and supervised the child.

In response to the *Review*, the Coroner's Office revised *Admission Standards* for public pools to assist lifeguards in maintaining adequate surveillance of young bathers. Although the *Admission Standards* are not required under regulation, pool owners/operators are encouraged to implement these standards as a means of preventing accidents and/or drowning.

In June 2011, the Ministry of Health and Long-Term Care asked Health Units to assist in providing information and advice to pool operators. In addition, they were asked to collect information about admission standards at Class A pools in their jurisdiction. Class A pools are open to the general public and are supervised by appropriately trained lifeguards. About 80 per cent of Class A pools in Ontario have some form of admission standards.

Grey Bruce has 121 public swimming pools; all are inspected by Public Health. Of these public swimming pools, 23 are Class A. The others are unsupervised Class B pools typically found at hotels and campgrounds. Although all of the Class A pools in Grey Bruce do have admission standards, it was noted that in many cases these standards were not as stringent as the Coroner's recommendations.

Recognizing that supervision is vital to the safety of all bathers, the Grey Bruce Health Unit will continue to promote the use of the Coroner's Office revised *Admission Standards*. The Lifesaving Society of Canada encourages all parents or guardians to stay "within an arm's reach" of their children during aquatic activities.



## Mandatory Blood Testing

The *Mandatory Blood Testing Act* (2006) allows individuals to apply to the Medical Officer of Health to have a blood sample of another person tested for certain communicable diseases, if the applicant came into contact with a bodily substance of this person. While it doesn't happen often, less than five requests per year, it requires immediate and rigorous follow-up to respond to this urgent issue.

Emergency Service Workers (police, fire fighters, and paramedics), correctional services, nurses and physicians are at an increased risk of being exposed to possible communicable diseases through the course of their regular duties. These contacts can include the blood-borne diseases, HIV, hepatitis B and/or hepatitis C as well as tuberculosis, meningococcal disease and Group A streptococcal infections.

The *Act* reduces the time required to process a request for a blood sample and can be used in certain circumstances if the source person has not agreed to voluntary testing. Public Health Nurses immediately assist this process and provide information to both the applicant and the source. They also support Designated Officers to assess and manage communicable disease exposures in order to protect the health of workers and to prevent further spread of infectious organisms.




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## Eastern Equine Encephalitis

*Eastern Equine Encephalitis virus* (EEEV) is normally found in wild birds and occasionally spreads to horses and humans through mosquitoes. It affects the central nervous system and can cause severe complications and death.

In October 2010, the Grey Bruce Health Unit was notified of an equine death as a result of EEEV infection. In 2008, there was an equine death due to EEEV within 5 km. of the 2010 equine case. Both cases are located within proximity of a swamp/wetland. In 2004, a flock of emus was infected with EEEV; 7 of 15 birds died.



In September 2011, the Grey Bruce Health Unit conducted a three week surveillance program for EEEV. Four light traps were placed in three different locations where the virus had been previously identified or suspected. Mosquitoes were sent to Entomogen Inc, St. Catharines, for species identification and viral testing. Public Health Ontario has identified an order of preference for mosquito testing based on EEEV vector species of concern in Ontario. Although equine cases have been reported within Grey Bruce, active mosquito surveillance in 2009 and 2011 did not identify EEEV. The 2011 trapping program identified mosquitoes that can carry and transmit EEEV; however, these mosquitoes were found in extremely low numbers and all were negative for EEEV.

Future trapping programs are warranted in response to positive equine or human cases. Baseline trapping should be conducted where financial and human resources are available.

Public education focusing on personal precautions and preventing mosquitoes from establishing is a key component in EEEV and other mosquito-borne disease management.



Medical Officer of Health

## REPORT TO THE BOARD

Friday, November 18, 2011

### **“Occupy” Movements**

The recent ‘occupation’ of many of the financial districts in larger cities has raised the awareness of the increasing gap between the wealthy and the poor in many countries including Canada. Canadians have been at the leading edge of looking at the difference between Gross Domestic Product (GDP) measurement of our country’s financial wellbeing and the true index of Canadian wellbeing.

### ***What is the Canadian Index of Wellbeing?***

*The Canadian Index of Wellbeing (CIW) is a new tool for measuring changes in our quality of life – overall, and in eight specific categories including: our standard of living, our health, the quality of our environment, education, time use, community vitality, democratic engagement, and the state of leisure and culture. It provides a much more complete picture than narrow economic measures like GDP.*

### ***Why is this such a big deal?***

*Over the past couple of decades there has been a global movement, led by the OECD (Organization for Economic Co-operation and Development), to adopt more comprehensive and integrated ways of measuring the progress of a country. Canada has been a leader in that movement and we are one of the first countries to develop a tool for measuring the wellbeing of its people in all of its dimensions.*

*Now, for the first time in our country's history we have a way of using hard data to judge whether we're moving closer to, or further away from, our vision of ourselves as a people and a country.*

The FAQ above are taken from the website for the Index; [www.ciw.ca](http://www.ciw.ca) which is useful in looking at the 64 indicators and giving possible direction for improving them. I really encourage you to take a look at this information.

“Most Canadians are “running so fast, and basically standing still, that we do not have the opportunity to enjoy things that really matter in life,” says Roy Romanow, former Saskatchewan premier and chair of the advisory board of the index, based at the University of Waterloo.

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The wellbeing index is really a statistical account of the kinds of pressures that are driving people to protest movements like Occupy Toronto. But it must be used as more than a gauge of the mood of our times. That 15 years of economic growth resulted in fairly modest improvements to the lives of average Canadians should be a wake-up call for politicians and policy-makers.”

There has been a commission recently established to review social assistance in Ontario and I will also include a brief from the Wellesley Institute which was prepared for the commission and deals with the topic of enabling health and health equity. The briefing addresses many of the concerns that we have when working in ‘rural public health’ and particularly as we look at the determinants of health and some of our neediest citizens.

*Hazel Lynn*

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# Towards a Social Assistance System that Enables Health and Health Equity:

## **ACTION SUMMARY**

### Brief to the Commission for the Review of Social Assistance in Ontario

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September, 2011



*Hospital Collaborative for  
Vulnerable Populations*



# Towards a Social Assistance System that Enables Health and Health Equity: Brief to the Commission for the Review of Social Assistance in Ontario

Prepared by Bob Gardner and Steve Barnes

## Introduction

People with low incomes and on social assistance face a daunting range of challenges to their well-being — one of which is systemic and damaging health inequities that result in poor health.

There is an enormous body of research demonstrating that those with low income, low education, and who experience social inequality and exclusion have poorer health. These inequities are not because of individual behaviour or lifestyle, genetics or bad luck, but are rooted in structural features of contemporary Canadian society far beyond individuals' control. Systemic health inequities are caused by 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. Thus there is a social gradient of health whereby people who face barriers to full social and economic inclusion have poorer health than those who do not.

Given their very low income, poor living conditions and limited opportunities, people on social assistance are at the most disadvantaged end of the social gradient of health. Unfortunately, the current social assistance system exacerbates many institutional barriers to 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 collaboration of health institutions, front-line service providers, policy experts, researchers and practitioners. In addition to conducting an extensive review of local, Canadian, and international literature, we also hosted several focus groups and a roundtable of

49 health sector experts from 33 organizations, including from hospitals, Community Health Centres, public health, and other service providers.<sup>1</sup>

We came together to support the Commission by providing 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 provide 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. Our brief:<sup>2</sup>

- 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;
- Draws on lessons learned from the health system that may be relevant to social assistance policy and program reform;
- Identifies reforms that will enhance opportunities for good health of people on social assistance and the key policy and program levers to implement them; and

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1 See Appendix I for a description of the Roundtable and list of attendees.

2 Our full brief provides detailed analysis and evidence to support our recommendations. This action summary is intended solely to highlight our conclusions, key principles and concrete recommendations.

- Includes actionable recommendations for social assistance reform that will improve population health and health equity.

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

While social assistance cannot itself shift fundamental structures of social inequality and determinants of health, a more effective and responsive system could reduce the greater health risks and burdens facing people with low income. 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.

We set out policy options and directions that can address these problems and show how a health-enabling social assistance system could mitigate the adverse impact of social determinants and contribute to better health opportunities for people on social assistance.

## 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 aware of the health impact of poverty and insecurity. A complementary goal should be that social assistance will also support basic health security. This means:

- Providing living conditions, support and other factors that enable good health;
- Enhancing access to critical health and social services that will ameliorate the impact of health inequities; and
- Contributing to reducing the impact of wider poverty, income inequality, social exclusion and other social determinants of health.

But the system must go beyond ensuring basic health security, to also enhance the opportunities for well-being and good health for all people on social assistance.

### 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 with the current social assistance system is that people on social assistance do not have sufficient income to afford the shelter, food, and other elements of an adequate standard of living. The long-term policy goal must be to ensure that the total income available to people on social assistance will provide adequate living conditions such as housing and nutritious food, access to transportation, child-care and other crucial enablers of opportunity, and the ability to live a healthy and active life.

### 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. Specifically:

#### INCOME SUPPORTS

- a) 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
- b) An increased child tax benefit that accounts for

the real cost of raising healthy children in Ontario.

#### **HOUSING SUPPORTS**

c) 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**

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

e) 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 SUPPORTS**

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

g) 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

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

Policy challenges such as poverty and inequality require comprehensive solutions. Many of the components of this basket of supports can be achieved by reforming the social assistance system. Others require concerted policy action across government, and local partnerships and collaborations with service providers from multiple spheres.

#### **ENHANCED OPPORTUNITIES**

Social assistance should not solely be concerned with guaranteeing the adequate income security necessary for good health, but should also work to ensure wider opportunities for people on social assistance to find employment or pursue further training or education.

#### **RECOMMENDATION 3**

The Commission should recommend a continuum of support services designed to enhance opportuni-

ties for education, training and support, including:

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

b) Skills training and retraining aligned with career goals;

c) 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;

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

e) 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.

Social assistance also needs to ensure access to key enablers of opportunity and good health such as transportation and childcare. Early childhood education has been proven to be critical for child development. Moreover, for low income parents, especially women, access to childcare is a major factor in their ability to enter the workforce.

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

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

h) 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; and

i) 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**

Key provisions of the current social assistance system act as disincentives that make it difficult for people on social assistance to move into employment or education. One of the major barriers to moving into employment is the possible loss of health benefits; many of the jobs that those on social assistance transition into are insecure and do not offer benefits. Without allowing people to retain their health benefits for an extended period after they exit social assistance many are forced to stay on social assistance rather than lose those vital supports. For people on social assistance, being able to earn money is often the first step out of poverty and into better health. However, earning claw-backs are steep and punitive.

### **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 that people have different needs and risks, that there are different pathways and drivers of health and health inequities, and therefore that there is a need for different policy levers and solutions over the course of peoples' lives and for specific populations. 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 groups, newcomers and so on — and that suitably adapted programming is necessary. The goal of this flexible and person-centred support must be to empower people to enhance control over their lives.

### **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.

Our research highlighted the importance of innovative means of embedding person-centred service provision and enhancing accountability.

### **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.

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**

A corner stone of person-centred support is fair access. People need to be aware of available benefits and services, and they must be supported by effective case management to navigate through the system.

#### **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**

The adverse impact of health inequities can be reduced by policy and program interventions in many spheres. Our recommendation above highlights the importance of the social assistance system being well coordinated with other key social and health services needed by people on assistance. For example, one of the most effective levers is to enhance access to primary care for disadvantaged populations. A key model and network of services that can be built upon are Community Health Centres.

Leading health policy experts and researchers consistently emphasize the importance of preventative 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 preventative services.

It is also essential to build community opportunities and capacities — 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. There are many collaborative community-building initiatives that local and regional social assistance providers should partner with. 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.

#### **RECOMMENDATION 9**

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

Social assistance reform will be more effective — and more likely to succeed — if it is well aligned with existing policy priorities and directions. This also needs to involve both on the ground service delivery integration, and a more coordinated approach to addressing social determinants of health across policy spheres.

#### **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 childcare, labour market security, and employment conditions.

#### **BUILD A LEARNING AND INNOVATIVE SYSTEM**

Even the most comprehensive strategy 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 evaluation strategies. We need to know how effectively training and education supports have been in enhancing employment opportunities, how effective enhanced living supports have been in improving health outcomes, etc. We need to collect the right data on system performance.

#### **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.

#### **BUILD AN EQUITABLE AND HEALTH-ENABLING SYSTEM**

The Commission needs to ensure that health and health equity are taken into account at all stages of its deliberations. There are a range of evidence-based tools and interventions that can be used to ensure that health is deeply embedded in social assistance reform, including a Health Equity Impact Assessment model that has already been developed by the Ontario government.

#### **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 policies 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 to guide building 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.

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## 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

Vaijyanthi Chari, Toronto Board of Health

Wendy Porch, Canadian Working Group on HIV and Rehabilitation