NIAGARA health planner

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Strengthening the Social Determinants of Health

In the Fall of 2002, a conference of over 400 Canadian social and health policy experts, community representatives, and health researchers met at York University in Toronto to a) consider the state of ten key social or societal determinants of health across Canada, b) explore the implications of these conditions for the health of Canadians, and c) outline policy directions to improve the health of Canadians by influencing the quality of each of these determinants.

The ten social determinants of health — early life, education, employment and working conditions, food security, health services, housing, income and income distribution, social exclusion, the social safety net, and unemployment and job insecurity — were chosen on the basis of their prominence in Health Canada and World Health Organization policy statements and documents.

The conference was a response to accumulating evidence that growing social and economic inequalities among Canadians are contributing to higher health care costs and other social burdens. The evidence heard at the conference reinforced the view that immediate and long-term improvements in the health of Canadians depend upon investments that address the sources of health and disease. This evidence indicated the following to be the case:

Early childhood development is threatened by the lack of affordable licensed childcare and continuing high levels of family poverty. It has been demonstrated that licensed quality childcare improves developmental and health outcomes of Canadian children in general, and children-at-risk in particular. Yet, while a national childcare program has been promised, 90% of Canadian families with children lack access to such care.

Education as delivered through public education systems has helped to make Canada a world leader in educational outcomes, but our education systems are now at risk due to funding instability and poorly developed curriculum in many provinces. These conditions may weaken the trend toward greater numbers of students graduating despite evidence that those who do so show significantly better health and family functioning than non-graduates.

Employment and working conditions are deteriorating for some groups — especially young families — with potential attendant health risks. One in three adult jobs are now either peripheral or precarious as a result of increasing contracting out of core jobs and privatization of public employment. These jobs are often temporary, with low pay and high stress. Precarious working situations are directly related to the weakening of labour legislation in many jurisdictions. These changes threaten the gains made by workers in the past, jeopardizing their health and well-being.

Food security among Canadians and their families is declining as a result of policies that reduce income and other resources available to low-income Canadians. In Canada, food insecurity exists among 10.2% of Canadian households representing 3 million people. Monthly food bank use is 747,665 or 2.4% of the total Canadian population, which is double the 1989 figure; 41% of the food bank users or 305,000 are children under the age of 18.

Health care services can become a social determinant of health by being reorganized to support health. Many examples of effective — but all-too-rarely implemented — means of preventing deterioration among the ill through chronic disease management and rehabilitation are available.

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Screening that has been carefully assessed for its effectiveness can support health. Preventing disease in the first place by promoting the social and living conditions that support healthy lifestyles has also been neglected.

Housing shortages are creating a crisis of homelessness and housing insecurity in Canada. Lack of affordable housing is weakening other social determinants of health as many Canadians are spending more of their income on shelter. More than 18% of Canadians live in unacceptable housing situations and one in every five renter households spent 50% or more of their income on housing in 1996, an increase of 43% since 1991.

Income and its equitable distribution have deteriorated during the past decade. Despite a 7-year stretch of unprecedented economic growth, almost half of Canadian families have seen little benefit as their wages have stagnated. Governments at all levels have let the after-tax-and-transfer income gap between rich and poor grow from 4.8:1 in 1989 to 5.3:1 in 2000. The growing vulnerability of lower-income Canadians threatens early childhood, education, food security, housing, social inclusion, and ultimately health. Low-income Canadians are twice as likely to report poor health as compared to high-income Canadians.

Social exclusion is becoming increasingly common among many Canadians. Social exclusion is the process by which Canadians are denied opportunities to participate in many aspects of cultural, economic, social, and political life. It is especially prevalent among those who are poor, Aboriginal people, new Canadians, and members of racialized (or non-white) groups. As our racialized composition grows, it is unacceptable that these groups earn 30% less than whites and are twice as likely to be poor. These trends contribute to social and political instability in our society.

Social safety nets are changing in character as a result of shifting federal and provincial priorities. The 1990s have seen a weakening of these nets that constitute threats to both the health and well-being of the vulnerable. The social economy may provide opportunities for community organizations to provide services in more democratic, transparent and community sensitive ways. It may, however, be unable to meet emerging needs without further burdening caregivers in the community, many of whom are women, or inadequately compensating them.

Unemployment continues at high levels and **employment security** is weakening due to the growth of precarious, unstable, and non-advancing jobs. Higher stress, increasing hours of work, and increasing numbers of low-income jobs are the mechanisms that link employment insecurity and unemployment to poor health outcomes. Unionized jobs are the most likely to help avoid these health-threatening conditions.

Based upon this evidence, conference participants drew up a Toronto Charter for a Healthy Canada which requests governments at all levels to review their current economic, social, and service policies in order to consider impacts upon the social determinants of health. Areas of special importance in the Charter are the provision of adequate income and social assistance levels, provision of affordable housing, development of quality childcare arrangements, and enforcement of anti-discrimination laws and human rights codes. Also stressed is increasing

support for the social infrastructure which includes public education, social and health services, and improvement of job security and working conditions.

Last spring, the Charter for a Healthy Canada was endorsed by the Toronto Board of Health and adopted by the Toronto City Council. It was forwarded to the federal and provincial governments with a request that they implement the recommendations contained therein. Upper tier governments such as the Regional Municipality of Niagara are being encouraged to consider actions similar to those of Toronto.

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Recent Reports from the Niagara District Health Council

The following reports are now available from Council:

- *Analysis of Suicide Deaths and Hospitalizations Due to Suicide Attempt for Residents of Niagara*
- *Blueprint for the Utilization of Nurses in Extended Roles*
- *Assessment of End Stage Renal Disease and the Demand for Dialysis in Niagara*
- *Volunteer Transportation Study*

Long Term Care Multi-Year Plan Being Developed

Long-term care refers to the broad range of personal care, support and health services provided to people who have limitations that prevent them from participating independently in everyday activities. The people who use long term care services include:

- Older persons in need of long term care and support services;
- Adults (16 years or more) with physical disabilities who need help to work, go to school or take part in day-to-day activities;
- Children and adults of any age who require health services at home or at school including those who need care at home for short periods while recovering after being hospitalized.

These short descriptions don't fully reflect the scope of the services provided or the diversity of the target populations. Persons who receive long term care services include those with acquired brain injury, those with HIV/AIDS and those living with terminal illnesses. In addition, some people with developmental disabilities or with long-standing mental health problems who are aging and need services available for seniors, people with two or more disabilities and people with degenerative conditions and cognitive impairments are also included in the target population groups. Individuals within these groups share similar needs but also have unique requirements, and planning must address this.

District health councils have been charged with the responsibility for developing strategic multi-year and annual district service plans for community long-term care services. The strategic multi-year plans address the unique service needs and system developments of each district over a 3 to 5 year period. The annual district service plans are sub-components of the multi-year plan and are intended to outline service improvements and changes required for the next year.

This year, the Ministry of Health and Long Term Care (MOHLTC) has requested that each of the district health councils within the Central South Region undertake a community long term care multi-year planning study to examine community programs and services for the next 5-year planning horizon. Over the next several months, the Niagara District Health Council will be gathering information that will help identify the need for long term care services and supports that promote the health, well being and independence of Niagara residents.

The plan has been designed to advise the MOHLTC of the extent of Niagara's existing services and point to future needs. It will identify priority areas that could require closer examination on a special project basis. The plan will also serve as a reference document for Niagara's community-based service providers in preparing their annual service plans.

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Long Term Care Census Conducted By District Health Councils

As our local population continues to age, planning for our future long-term care programs becomes critical in order to meet the growing demands for service. However, quality data about existing long term care community services is often unreliable and inadequate. Many services are provided by groups of volunteers and charitable organizations which lack the infrastructure necessary to consistently collect such data on a regular basis.

To help address this issue, a number of district health councils are working together with the Central West Health Planning Information Network (CWHPIN) and the Central South Regional Office of the Ministry of Health and Long-Term Care (MOHLTC) to gain information about long term care services in our communities. Hamilton, Grand River, Waterloo Region-Wellington-Dufferin and Niagara District Health Councils conducted a one-day census of MOHLTC funded long term care agencies to determine where people were and what funded service(s) they received on that particular day. Participants in the census included hospitals (for alternate level of care beds), long term care facilities, Community Care Access Centres, supportive housing programs, and community services.

Each organization providing long-term care and funded by the Ministry of Health and Long-Term Care was asked to complete a census form with the number, age and gender of people that received service on September 24, 2003. This data will provide critical baseline information to district health council planners and should also prove to be a sustainable resource to describe and monitor local systems of long-term care.

The information collected will be compiled and shared with the participating agencies and local communities in the new year.

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Volunteer Transportation Studied

At the request of the Ministry of Health and Long Term Care, DHC staff conducted a volunteer transportation study. The purpose of the study was two-fold:

1) to analyze the capacity and utilization of Ministry funded volunteer transportation (which in Niagara is provided by two agencies, the Canadian Red Cross and Community Support Services Niagara (CSSN)); and

2) to clarify the current means of accessing adult day programs, which in Niagara are offered at ten sites by the Regional Municipality of Niagara Community Services Department, and to explore the possibility of using volunteer transportation.

Volunteer transportation is a support service that provides escorted transportation to medical appointments, shopping and various social activities and programs. Transportation is provided by volunteers using their own vehicles. Those using the service are generally seniors and people with disabilities who are ambulatory (i.e., they can transfer from a wheelchair independently). Some clients require an escort in addition to the volunteer driver (e.g., if they suffer from confusion or dementia).

Adult Day Service is a support service that provides supervised individual programming in a group setting for adults to assist them to achieve and maintain their maximum level of functioning, to prevent premature and inappropriate institutionalization, and to provide respite and information for caregivers. Components of the service include planned social, recreational and physical activities, meals, transportation (if required), personal support/attendant care, and minor health service. In Niagara, the Ministry funds integrated programs for the frail elderly and adults with Alzheimer Disease and other progressive cognitive disorders or dementias.

Summary of Key Findings — Volunteer Transportation

- In 2002-2003 11,236 volunteer rides were provided to 668 residents of Niagara. However, the study determined that the need for volunteer transportation exceeds the existing capacity as evidenced by unmet requests for service, particularly for the Red Cross due to budget restrictions.
- The study confirmed that the biggest users of volunteer transportation are the elderly population, with 77% of clients in 2002-2003 age 65 or over. Demand can therefore be expected to increase as the percentage of Niagara's seniors population grows.
- The two providers serve distinct parts of the region: Red Cross serves all areas except Welland/Pelham, which is served by CSSN, and both agencies serve West Niagara.
- Residents of West Niagara use the volunteer transportation service disproportionately more than other parts of the region.
- 80% of all trips in 2002 were for medical purposes, and 20% for non-medical purposes such as grocery shopping, attending social functions, or visiting a spouse in a long-term care facility.
- Transportation for dialysis clients comprised 19 % of all rides in 2002-2003 and demand is expected to increase from these clients as the population grows older.
- 84% of trips were provided within Niagara, and 16% were provided out of the region, most often to Hamilton, Toronto, or London.
- Future changes in the location of hospital beds/programs and long term care beds will have impact on the volunteer transportation services.

Summary of Key Findings — Adult Day Programs

- There were 19,530.5 units of service provided to a total of 393 clients across all Adult Day Program sites in Niagara in 2002.
- 92% of clients were age 65 or older and 73% of clients had some form of dementia
- During the study week of June 2 to 9, 2003, 78% of clients used the bus service provided by the Region through contract with Laidlaw and 21% were transported by family or friends
- Total travel time on the bus service used to transport clients during the study week was, on average, a little more than one hour each way
- The longest travel time was for clients attending the Grimsby and Welland programs.
- In the judgement of the Day Program Coordinators, a substantial number of clients registered during the study week potentially could have used volunteer transportation, either with or without an escort in addition to the volunteer driver. The study therefore noted that further exploration of the use of volunteer transportation to access adult day programs was warranted, subject to consideration of a number of conditions such as consistency and level of commitment of the volunteer, adequate training, appropriate vehicles, and adequate liability coverage.

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Heart Disease and Socio-economic Status

According to the Central West Health Planning Information Network (CWHPIN), heart disease is the leading cause of mortality in Ontario and leaves a devastating wake of disability and economic costs for Canadians. It is estimated that one in four Canadians either has or is at risk for some form of cardiovascular disease (CVD). As well, it has been predicted that deaths from heart disease will almost double by the year 2018 (due to population growth and aging) unless current conditions change.

It has long been known that lifestyle variables such as smoking, physical inactivity, high blood pressure and being overweight increase the risk of CVD. However, an extensive body of research now indicates that the economic and social conditions under which people live their lives are actually more significant in determining whether they develop cardiovascular disease.

In a recent study, CHWPIN explored the relationship between heart disease and death from CVD or heart attack and 23 Socio-economic status (SES) factors, including income, education, occupation, unemployment and living conditions for counties in Ontario. As well, the impact of an unequal distribution of income, education and occupation across each county was investigated. The influences of traditional lifestyle factors were also considered. Even when accounting for lifestyle risk factors, SES variables explained approximately half of the variation in hospitalization rates for angina, congestive heart failure, heart attack and heart attack mortality.

To date, there has been little public consideration of the role that socio-economic variables play in the incidence of cardiovascular disease. Recent studies such as the one done by CHWPIN provide a basis for re-examining both heart health programming and public policy development. It is clear that comprehensive programs and policies to reduce cardiovascular disease must address issues of socioeconomic status as well as risk factor modification.

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Provincial Health Human Resources Forum Held

In our last issue, we mentioned that a provincial Health Human Resources (HHR) forum would be held on June 11, 2003. This event was preceded by local forums throughout the 16 DHC planning regions which were aimed at identifying strategies to increase health human resource capacity and utilization in the face of health human resource challenges.

Strategies identified in Niagara, similar to those from many other areas of the province, included such things as introducing new models of service delivery and technology, expanding scope of practice/skill set, introducing efficiencies or changing staff utlilization practices, training and educational strategies, early exposure to health careers, healthy workplace strategies, and using volunteers.

The provincial forum included sharing of selected strategies and discussion of key policy or organizational barriers and ways to facilitate innovative HHR practices.

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Population Health Approach to Mental Health

According to the recently released Canadian Community Health Survey: Mental Health and Well-Being (Statistics Canada, 2003), 10.4% of Canadians 15 years and over reported symptoms consistent with any of five identified mental health disorders in the previous twelve months. The five disorders under consideration were major depressive disorder, mania disorder, panic disorder, social anxiety and agoraphobia, and alcohol or illicit drug dependencies. The World Health Organization estimates that more than 25% of individuals will develop one or more mental or behavioural disorders during their lifetime and that in less than twenty years, depression will become the second-leading cause of disability in the world.

New approaches are required to combat these alarming statistics, approaches that shift away from reacting to the growing incidence of mental health disorders only by providing costly treatment. It is becoming increasingly apparent that there are many factors that contribute to mental health. A population health approach aims to reduce the incidence of mental disorders in individuals by addressing the factors that maintain and improve the mental health of the entire community.

The factors comprising a population health approach to mental health include education, employment/working conditions, income and social status, social support networks, social environments, physical environments, healthy child development, personal health practices and coping skills, biology, gender, culture, and health services.

To enjoy optimal mental health, individuals must be able to meet their physical, mental, social and spiritual needs. Health planning can aid in this endeavour by better addressing the multiple factors affecting these needs.

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End Stage Renal Disease and the Demand for Dialysis

Niagara District Health Council staff recently prepared a report which provides an estimate of the prevalence of End Stage Renal Disease (ESRD) and the demand for dialysis services in Niagara.

ESRD is a slow, progressive, and usually irreversible deterioration of kidney function. The prevalence of ESRD increases with age. Individuals with ESRD must rely on renal replacement therapy (dialysis or kidney transplantation) to survive.

Niagara residents display relatively high rates of End Stage Renal Disease and dialysis, compared to provincial and national averages. Niagara's high rates are due to an ageing population, the prevalence of risk factors for ESRD, and poor socio-economic status.

Seniors aged 65+ comprise 17% of Niagara's population of ~430,000, compared to 12.9% in Ontario. In contrast to an overall growth of 4.4% projected for Niagara between 2003 and 2013, the 65+ population is projected to grow 14.3% (to 80,000+) during this period. Niagara residents display relatively high rates of diabetes, hypertension and cardiovascular disease, the leading risk factors for ESRD. Obesity, physical inactivity and poor dietary practices contribute to the prevalence of these risk factors in Niagara.

Research has shown that populations with poor socio-economic status and inadequate access to primary care are more likely to have high rates of End Stage Renal Disease. Compared to the provincial average, Niagara residents have lower incomes and less education. Niagara has an insufficient supply of affordable housing and inadequate public transportation. Approximately 30% of Niagara seniors live alone. With 77 vacancies for Family Physicians, about 5% of Niagara's population is without a family doctor.

With the growing prevalence of ESRD and its risk factors, the number of End Stage Renal Disease patients in Niagara is projected to increase by 87% by 2008, with a further 39% increase between 2008 and 2013. To meet the needs of these patients, local dialysis capacity must increase.

Future planning for dialysis services will take into consideration the distribution of Niagara's population, the health and dwelling status of dialysis patients, the accessibility of services, and opportunities for increasing the availability of more cost-effective treatment modalities. Further planning should also include strategies for slowing the rate of growth of ESRD in Niagara through interventions designed to identify and treat the population at high risk of developing this disease.

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Ontario District Health Councils Celebrating 30 Years

In 1973, the first district health council was established in Ottawa-Carleton to provide the Minister of Health with advise on health service needs and expenditures. Two years later, the Niagara District Health Council became the third such planning body in the province. Now, thirty years on, there are sixteen district health councils serving all of Ontario by providing neutral advice on major health matters.

Niagara District Health Council

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