Can a Health Unit Take Action on the Broad Determinants of Health?

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Note: Letter to be included that contains all signatures of the authors (fax signature OK)

Submitted to the *Canadian Journal of Public Health*

Abstract (250 words)

Socioeconomic factors such as poverty are among the primary determinants of health. Public health units have significant challenges and barriers in addressing these issues. Systemic indicators of health can be addressed, in part, through the establishment of co-ordinating organizations that promote cooperation between social and health agencies.

Community agencies in Lanark, Leeds and Grenville (LLG) formed a Health Forum formed in the spring of 2000 as a means of pursuing this type of approach. The goals of this Health Forum, composed of some 80 community agencies included evaluating the health of the population of the Leeds, Grenville and Lanark district over a five year period with regard to the broad determinants of health, identifying activities within an overall strategic plan to address needs, pursuing ongoing resources to conduct interventions, and assessing their effectiveness and impact on health and modify plans and activities accordingly.

Through the duration of its lifetime the Forum proved to be both active and productive leading to many cooperative ventures. The modest funding required was primarily used to hire a Health Planner. Unfortunately the activities of the Forum proved to be unsustainable with the loss of ongoing funding for the Health Planner. The experience of the LLG Health Forum offers a practical, efficient and effective model for addressing some of the fundamental determinants of health, as well as some insights into the requirements to sustain such a model.

Introduction

Poverty, unsustainable livelihoods, social marginalization and a host of other related factors have long been considered some of the primary challenges to achieving optimal health. [i] [ii] Public health units are local agencies with a mandate to address the fundamental determinants of health. In order to foster optimal health and wellbeing these agencies need to consider the linkages between health and economic and physical security, a feeling of personal efficacy and empowerment, socially supportive communities, and access to educational and occupational opportunities. [iii] Acute health care alone, cannot be relied on to provide a sufficient response to these challenges. Fostering stronger linkages among community agencies may be one strategy of addressing these determinants in a practical meaningful way. Public health units may be a more natural venue to facilitate such a coordinated response. This paper documents the attempt to do so in a health unit in southeastern Ontario.

Public Health and the Challenge of Addressing the Broad Determinants of Health

It is a challenge for the boards of health that govern health units in Ontario to fulfill their broad mandate. They must simultaneously meet the requirements of the provincial Health Protection and Promotion Act, the Mandatory Health Programs and Services Guidelines (the Mandatory Programs) and, at the same time, act in ways that meet local population health needs. Although the Mandatory Programs are officially viewed as minimum standards, in practice it is difficult for the boards of health to meet all the requirements of the Mandatory Programs while also addressing the emerging public health issues of recent years such as West Nile virus and SARS. Thus, it is very difficult for local boards of health to justify expending resources on activities outside of the Mandatory Programs. Compounding this difficulty is the fact that boards of health are accountable both to provincial governments as well as to their local municipalities, as the costs are shared by both levels of government.

The Mandatory Programs address socioeconomic issues only to a very limited degree. This can be a significant barrier to the initiation of local public health programming to address issues such as poverty, economic and educational opportunities, food or housing insecurity. In addition the question of the appropriateness of developing such programming would need to be addressed by any local boards of health that may be considering such initiatives. In such deliberations it would be reasonable to apply following criteria taken from the guiding principles of the Mandatory Programs. [iv]

1. **Need**: How big is the problem?
2. **Impact**: How much can we fix?

3. **Appropriateness**: Are we the best people to do it?
4. **Capacity**: Are we able to do it?

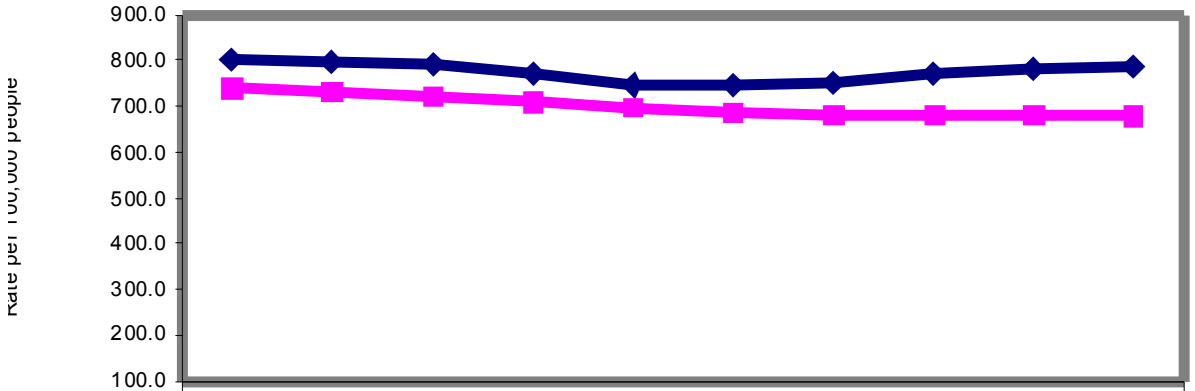
Research indicates that socioeconomic issues meet the first of these criteria.[v] What is unclear is the answer to the other three questions, in particular the potential effectiveness of programs offered by local boards of health to address such issues. Were a board of health to attempt to seriously address socioeconomic issues such as poverty, how might it proceed? The questions of appropriateness and capacity to effect the required changes also remain as daunting challenges for a local public health unit acting alone. The scope and complexity of socioeconomic issues suggests that a collaborative broad approach involving many agencies within communities would be desirable because no single agency can address all these issues effectively. The strengths of one agency can be combined with the expertise and knowledge base provided by another creating valuable synergies.

Rationale for the Health Improvement Strategy of the Lanark Leeds and Grenville Health Forum

In the early spring of 2000,a number of directors for health care and social services agencies within the counties of Leeds, Grenville and Lanark, (LGL) a rural district within southeastern Ontario, identified a collective need to convene on a regular basis for communication, collaboration and planning. Communication between this group of directors and the Southeastern Ontario District Health Council led to the initiation of the Lanark, Leeds and Grenville Health Forum (the Health Forum) with an inaugural meeting of representatives from some 80 members agencies in the spring of 2000.

The convening of this forum was timely; the Leeds, Grenville and Lanark (LGL) District Health Unit had produced a comprehensive community health status report entitled "Health Status 2000" [vi] that noted a rise in mortality rate by 5% in Leeds, Grenville and Lanark between 1991-1995. These figures sharply contrasted to the declining age-adjusted mortality rate for the province. The same pattern of increasing mortality in this district was noted for the two major categories of disease, specifically cardiovascular disease and cancer. The Health Information Partnership of Eastern Ontario independently reproduced the same findings.

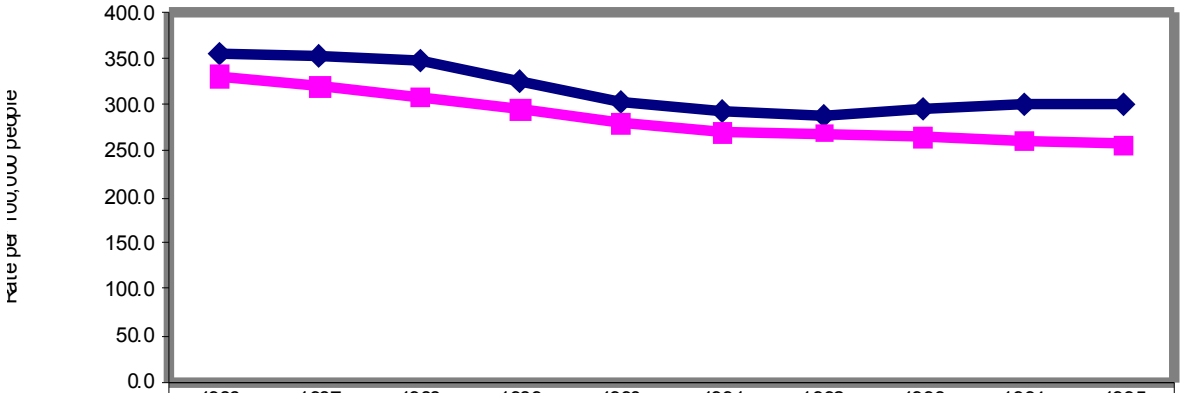
Age standardized mortality rates for all causes of death in LGL and Ontario for both sexes (Using 3 year moving averages) between 1985-1996



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
LGL	800.1	796.7	790.5	767.9	746.1	746.1	748.1	773.2	783.9	786.5
Ontario	740.1	732.4	721.3	710.2	696.7	685.2	684.0	682.7	683.0	677.6

Sources: Ontario Ministry of Health: HELPS1 Y2K June 1999 release. Population Estimates Database & Mortality Database
The standard population was the population of Canada in 1991.
A three year moving average means that each standardized mortality rate is based on data from three years. For example the rates for 1994 data from 1993,1994 and 1995.
Three year averages were used to improve the stability of the age specific rates used in this calculation

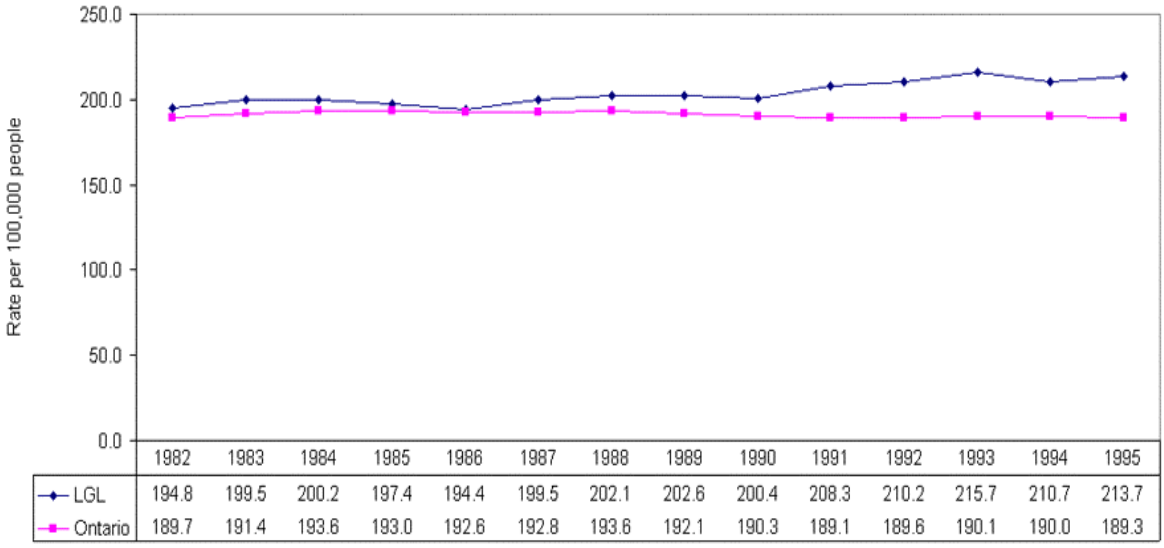
Age standardized mortality rates for all circulatory disease deaths in LGL and Ontario for both sexes (Using 3 year moving averages) between 1985-1996



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
LGL	355.5	352.8	346.7	326.2	303.4	292.5	288.3	294.3	301.6	300.2
Ontario	330.0	319.8	307.9	294.3	280.3	270.5	268.6	265.7	261.3	256.4

Sources: Ontario Ministry of Health: HELPS1 Y2K June 1999 release. Population Estimates Database & Mortality Database
The standard population was the population of Canada in 1991.
A three year moving average means that each standardized mortality rate is based on data from three years. For example the rates for 1994 data from 1993,1994 and 1995.
Three year averages were used to improve the stability of the age specific rates used in this calculation

Age standardized mortality rates for all cancer deaths in LGL and Ontario for both sexes (Using 3 year moving averages) between 1981-1996



	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
LGL	194.8	199.5	200.2	197.4	194.4	199.5	202.1	202.6	200.4	208.3	210.2	215.7	210.7	213.7
Ontario	189.7	191.4	193.6	193.0	192.6	192.8	193.6	192.1	190.3	189.1	189.6	190.1	190.0	189.3

Sources: Ontario Ministry of Health: HELPS1 Y2K June 1999 release. Population Estimates Database & Mortality Database
The standard population was the population of Canada in 1991.
A three year moving average means that each standardized mortality rate is based on data from three years. For example the rates for 1994 are based on data from 1993,1994 and 1995.
Three year averages were used to improve the stability of the age specific rates used in this calculation

Note: It should be noted that although the elevations noted in these graphs were the prime concern that led to the health strategy of the Health Forum, mortality data on later years that became available by 2004 demonstrated a reversal of the increasing mortality trend in Leeds, Grenville and Lanark. Neither the increased mortality trend nor its reversal have been completely explained.

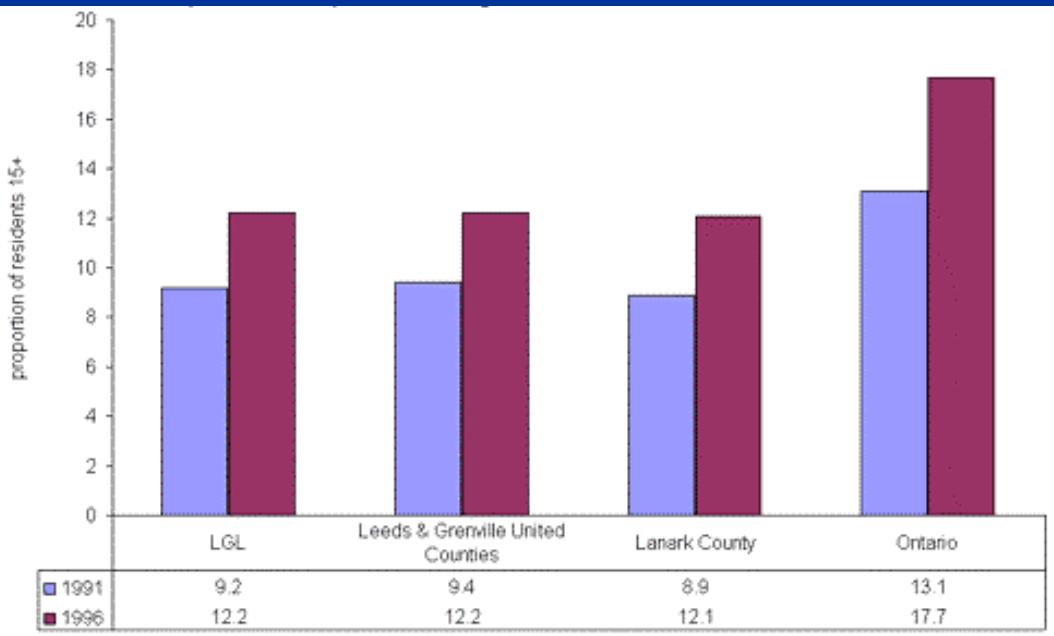
A review of the district's statistics (grouped under three of the four broad categories of health determinants from the Lalonde Report [vii]) revealed that during the same period in question the contributing explanations might be found in the following three categories.

Socioeconomic indicators: Between 1991 and 1996 there was an increase in the percent of the population in LGL and in Ontario that had an income level below the low income cutoff as well as a proportional increase in single parent residences. LGL fell below the provincial mean for income and education levels.

Behavioural indicators: Tobacco use in southeastern Ontario was approximately 10 percentage points greater than the provincial average. The LGL population is also at greater risk from other risk behaviours such as high fat consumption, obesity, and physical activity.

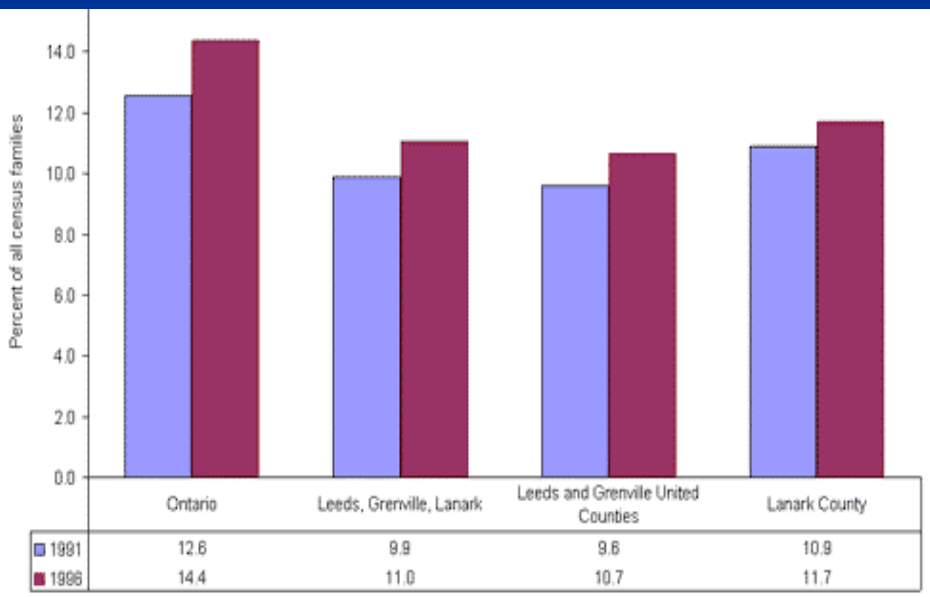
Access to Health Care: The Brockville area has been officially designated as medically underserviced, although there was limited available data about adequacy of access to health care in LGL as a whole.

Proportion of Population Living Below the Low-income Cut-off Point



Source: Statistics Canada, Census of the Population, 1996 & 1991

Proportion of Single-parent Families
Leeds, Grenville and Lanark and Ontario



	Ontario	Leeds, Grenville, Lanark	Leeds and Grenville United Counties	Lanark County
1991	12.6	9.9	9.6	10.9
1996	14.4	11.0	10.7	11.7

Source: Statistics Canada, Census of the Population, 1996 & 1991

Highest Level of Education Attained, in 1991 & 1996								
Highest level of education attained	Ontario		Leeds, Grenville and Lanark		Lanark County		Leeds and Grenville, United Counties	
	1991	1996	1991	1996	1991	1996	1991	1996
Less than grade 9	11.5	10.0	10.0	8.1	10.7	8.4	9.6	7.9
Grade 9-13	40.4	37.6	44.8	41.8	44.2	40.9	45.2	42.3
Trade certificate	3.4	3.5	4.2	4.1	3.9	4.3	4.4	3.9
Other non-university education	22.5	24.5	25.2	29.9	24.9	29.2	25.4	30.3
University	22.2	24.3	15.7	16.2	16.3	17.1	15.4	15.7

Overall, the elevation in mortality may be due to adverse changes in health-related behaviours, socioeconomic conditions and possibly relative access to health care in LGL between 1991 and 1996.

It was determined that a broad, coordinated community strategy would be required through the newly constituted Health Forum. A vision paper provided an operational framework coordinating action on the broad determinants of health in the district and recommended the formation of a steering committee supported by two sub-committees to address Socio-economic Issues and Access to Health Care respectively. The Steering Committee would also maintain communication and provide some support for the already established, multi-agency Trihealth Team (the heart health coalition for LGL) that promotes health through public education on the topics of diet, physical activity and tobacco use. The objectives of the Health Forum included , over a five year period, monitoring the broad determinants of health within Leeds, Grenville and Lanark, identifying activities within an overall strategic plan to address the findings of population needs assessment, pursuing ongoing resources to support these activities, conducting the activities, evaluating their effectiveness and impact on health, and modifying plans and activities accordingly.

The Experience of the Health Forum

By the end of 2001, discussions with the Southeastern Ontario District Health Council (DHC), and the Eastern Regional Office of the Ministry of Health and Long-Term Care led to the allocation of a budget of $80,000 to support the Health Forum's strategic plan for its first year. It was hoped that funding would be secured for future years. By April 2002, the Health Forum recruited and hired a Health Planner on contract to work with its members and to coordinate and support the activities of the strategic plan.

Both the Access to Health Care Subcommittee and the Socioeconomic Subcommittee obtained, reviewed, and presented data on LGL with regard to their respective mandates and presented their findings to the general Health Forum membership at its meeting in April 2003. The general membership of the Health Forum provided discussion, feedback and direction to the subcommittees on their findings and made recommendations to them on the next steps to be taken to address the findings. Thus in April 2003 the subcommittees were well positioned to develop further plans of action if resources had allowed.

The Socioeconomic Subcommittee identified the following issues within its mandate for advocacy which it took to the general membership for endorsement in both the fall of 2002 and at the April 2003 meeting recommended positions of opposition to the following government initiatives:

- the federal government introduction of legislation to render disability pensions more difficult to access,
- the provincial government's "clawback" of the National Child Benefit Allowance.

The Health Forum also supported motions from the Trihealth Team to develop municipal bylaws throughout LGL prohibiting smoking in all indoor public places and workplaces. In keeping with these motions, letters of advocacy were drafted and sent by the Steering Committee to the appropriate levels of government. The Steering Committee included correspondence to its member agencies as well as to the Southeastern Ontario District Health Council (DHC), inviting each agency to communicate its support for the respective motions to the appropriate levels of government

General membership meetings of the Health Forum were held in the fall of 2002 and in April 2003. In addition to discussing the activities of the subcommittees, these meetings were used to allow the membership to engage decision makers regarding health care. Members and staff from the neighbouring District Health Councils (Southeastern Ontario; and Champlain District) attended and presented on their initiatives and plans. Presentations were also made on the negative impact of poverty on heart health

(presented by Dr. Dennis Raphael of York University), as well as on other health care topics such as the Romano and Kirby Commissions and mental health care reform.

A very healthy and powerful set of self-reinforcing dynamics took place between the three basic components of the Health Forum, namely its general membership, its committee structure and the Health Planner staff member. The general membership provided the committees with legitimacy and direction for their tasks, as well as for the motions brought forward to the general membership by the subcommittees. In this way the work of the subcommittees was greatly strengthened. In turn the general membership communicated via meeting evaluations a high degree of satisfaction with the work of the Health Forum and with the quality of its general membership meetings.

The Health Planner was able to work full time to ensure that the tasks of the committees were conducted. This was absolutely essential for the successful dynamics of the Health Forum. Before the funds were obtained for this position, Health Forum Steering Committee meetings were often poorly attended. Participation within the committees of the Health Forum immediately and dramatically increased (from below quorum to near full attendance) with the arrival of the Health Planner who coordinated meetings and worked to ensure that action items were completed.

Unfortunately further funding for the project was not continued in the spring of 2003. With this change attendance quickly fell below quorum levels rendering successful activity impossible. The lack of funds also precluded ongoing general membership meetings. This pattern of participation and attendance demonstrates that funding for the Health Planner position was critical to stimulating believe by partner agencies in the viability of the project, and thus supporting it with their staff-time. To date no replacement funding has been found to allow this health improvement initiative to continue.

Recommendations

The Health Forum was not able to sustain its activities to improve population health by systematically addressing the board determinants of health without ongoing financial support. Based on this experience the following three recommendations are made:

- The Mandatory Programs for boards of health should include socioeconomic issues such as poverty,
- provincial policies are needed to encourage collaborative partnerships in the district on such issues,

- and a local agency such as the local public health unit, must be empowered to act as a facilitator of the initiative and adequately funded and supported.

Conclusion

Addressing the board determinants of health and in particular socioeconomic issues within a district is very challenging. The experience of the Lanark Leeds and Grenville Health Forum demonstrates that it is possible to bring multiple agencies together to work in a systematic way on these topics, provided that a modest amount of funding is provided for the task of coordination. The cost of the LLG Health Forum was minimal particularly when considering burgeoning health care costs and the enhancement of population health that could be achieved.

[i] Declaration of Alma-Ata International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978.
[ii] Ottawa Charter for Health Promotion First International Conference for Health Promotion Ottawa, 21, November 1986-WHO/HPR/HEP/95.1.
[iii] Improving the Health of Canadians. Canadian Population Health Initiative. Canadian Institute for Health Information. 2004. www.cihi.ca
[iv] Mandatory Health Programs and Services Guidelines. Ontario Ministry of Health, December 1997.
[v] Improving the Health of Canadians. Canadian Population Health Initiative. Canadian Institute for Health Information. 2004. www.cihi.ca
[vi] Posted at http://www.healthunit.org/chsr/index.htm
[vii] New Perspective on the Health of Canadians, Lalonde M, 1974. http://www.hc-sc.gc.ca/hppb/phdd/pdf/perspective.pdf