Health in all policies

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WHEREAS, research shows that the primary factors that influence the health of Canadians are not medical treatments or lifestyle choices but instead are the living conditions of people, which are shaped by the social determinants of health including income, education, job security, working conditions, food security, housing, etc.; and

WHEREAS, public policy has the power to influence people's everyday choices by providing people with opportunities for health or limiting such opportunities, through policy decisions made in most sectors (i.e. housing, education, economic, transportation, health, etc.); and

WHEREAS, health in all policies is a health policy approach that considers the impacts that policies in all government levels and sectors have on health; it is founded on the recognition that health is largely determined by factors outside health care. RNAO has done powerful work on various social determinants of health, such as minimum wage, social assistance, housing and others, but has not explicitly advocated for health in all policies;

THEREFORE BE IT RESOLVED that RNAO advocate for a health in all policies approach to be implemented within Ontario to promote population health and ameliorate growing health inequalities.

Background Information

The prevalence of chronic diseases in Canada such as diabetes (1) and high blood pressure (2) continue to increase, along with associated risk factors such as obesity (3), and mental illnesses continue to remain highly prevalent, affecting 20% of the population (4). Health outcomes in Canada have not been moving in the right direction, despite notable improvements in medical treatments, technologies, and investments in health (5). In addition to the rise in chronic disease rates, the existence of health inequalities in Canada is firmly established with recent evidence indicating that over the past decade, there has been minimal or no progress made in reducing health inequalities related to income (6). It is unjust and unfair that those of the lowest socioeconomic position live in worse health and die earlier than those of the highest socioeconomic position (7). Contrary to popular belief, the primary factors that influence the health of Canadians are not medical treatments or lifestyle choices but rather living conditions (8). Research indicates that 50% of population health is determined by our social and economic environments (5) - the conditions in which we are born, grow, live, work and age, known as the social determinants of health (SDH), and formed by the distribution of money, power, and resources at global, national, and local levels (9). The unequal distribution of health, whereby it follows a socioeconomic gradient, is not a natural occurrence but rather the result of a combination of poor social policies and programs, unfair economic arrangements, and bad politics (10). The World Health Organization's Commission on the Social Determinants of Health invites us to look upstream at the root causes, in our analysis of health inequalities (7).

As SDH are the primary factors influencing population health and health equity, health policy must shift its focus from the illness-oriented health care sector toward sectors whose policies affect the social and economic environments of daily living. The potential of public policy to influence people's everyday choices is considerable as public policy has the power to provide people with opportunities for health, as well as to deny them such opportunities (11). Public policies from various sectors can create environments that make the healthy choice the easy one. The Canadian Medical Association (5) recently

urged the Canadian government to adopt a clear mandate to focus on the health of the population and to have all legislation subject to a health lens to determine potential health implications. Inasmuch as public policies from all sectors have a bearing on health, health should be considered in all policies.
Health in all policies (HiAP) is a health policy approach that considers the impacts that policies in all government sectors have on health; it is founded on the recognition that health is largely determined by factors outside healthcare, such as the SDH. "HiAP can be seen as crucial in highlighting accountability, implications and priorities of health policies in the broader policy-making process and in placing health higher on the political agenda" (12). HiAP is coordinated by formal structures and mechanisms of governments, and it is explicitly linked to structural or long-term governmental policies or agendas (as opposed to being ad hoc) (13). HiAP is a viable option for governments wishing to ameliorate health inequalities and rising chronic diseases, and promote population health and health equity. Successful implementation of HiAP must occur at the national, regional, and local government levels. The authors of the Helsinki Statement on Health in all policies make many calls to action to governments, the third being to strengthen the capacity of Ministries of Health to engage other sectors of government through leadership, partnership, advocacy and mediation to achieve improved health outcome (14). It is through this call to action that it becomes clear that the RNAO is well placed to advocate for HiAP at the provincial level.

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