Health Policy

Health and well-being under one umbrella
Marc-André Maranda & Michel Clermont

This article examines issues raised by Quebec’s combined health and welfare policy, drawn up in 1992. The objectives set and the strategies adopted are discussed. The results will be fully assessed in 2002, when questions relating to such matters as public involvement and the allocation of resources will have to be answered.

Many countries have defined their health policies on the basis of WHO’s health-for-all model, which has been adapted to national situations. The specific features of each country then lead naturally to the formulation of specific objectives.

Canada’s Quebec Province drew up a health and welfare policy in 1992 (1), certain aspects of which merit examination because of their effect on resource allocation and planning. The policy concerns the integrated health and social services, which have been closely linked and interdependent at all levels for almost 30 years. It thus covers health problems that can be assessed with conventional indicators as well as particularly serious social ills affecting young people, families, the disabled and the elderly. Nineteen objectives have been set for achievement by 2002, in the areas of physical and mental health, public health, social adaptation, and rehabilitation. The list encompasses measures against cardiovascular disease, domestic violence, suicide, sexually transmitted diseases, and social barriers affecting the elderly.

Epidemiology provides accurate indicators of major health problems, allowing comparisons between groups or societies that may be quite different in nature. Because information on social ills is not so readily available, drawing up quantifiable objectives in this area is much more complex. It is all the more difficult because very often the extent of the problems is unknown. In some cases, for instance where domestic violence occurs, the values of various groups within society may be quite divergent.

Nevertheless, a single policy for social and health objectives offers advantages. It provides motivation as well as broadening the range of options for constructive action and raising the value of activities that tackle more than one problem at a time.
Objectives for 2002

- To reduce the number of cases of child sexual abuse, violence against children and child neglect, and to reduce the negative impact of these problems.
- To reduce the principal behavioural problems in children and adolescents.
- To lower both the frequency and the seriousness of juvenile delinquency.
- To reduce the number of cases of conjugal violence.
- To prevent homelessness, and, particularly in Montreal and Quebec, to lessen its consequences, and to promote the social reintegration of homeless people.
- To reduce by 15% the consumption of psychotropic medicines by elderly people and by last-resort beneficiaries, and to increase the number of people who will never use illegal drugs.
- To reduce to under 5% the number of premature births and to under 4% the number of low-birth-weight infants, and to reduce the incidence of congenital or genetic defects.
- To bring about a 30% reduction in the mortality rate for cardiovascular diseases.
- To stabilize the mortality rate for lung cancer and reduce the mortality rate for breast cancer by 15%.
- To lower by 20% the mortality and morbidity rates for accidents on the roads, at home, at work and during recreational or sports activities.
- To reduce the prevalence of back problems by 10%, and reduce the duration of disability resulting from arthritis and rheumatism.
- To lower by 10% the mortality rate for respiratory illnesses.
- To reduce the incidence of HIV infection and of sexually transmitted diseases, to lessen their complications, and to stabilize infections resistant to conventional antibiotics.
- To eliminate measles, rubella, diphtheria, tetanus, mumps and polio, and to reduce the number of cases of whooping cough and type B Haemophilus influenzae to 10 and 50 per year respectively.
- To reduce by 50% the average number of dental cavities, missing teeth or fillings among children aged 6–12 years, and by 5% the rate of missing teeth among adults aged 35–44.
- To reduce the number of mental health problems.
- To reduce by 15% the number of cases of suicide and attempted suicide.
- To eliminate obstacles to the social integration of elderly people.
- To reduce the number of situations that cause difficulty to disabled people, irrespective of the nature of their disabilities.
The matching of social and health objectives has made it possible to clarify difficulties requiring special attention because of their prevalence in the population. A full review will be conducted in 2002. Meanwhile, in 1997, favourable trends were evident in cardiovascular illnesses, road accident injuries, sexually transmitted diseases, AIDS, alcohol consumption, birth weight and certain types of cancer. On the other hand the suicide rate had increased, psychological distress had worsened, and there had been a rise in juvenile delinquency (2).

**Strategy definition**

Objectives, on their own, cannot make a policy fully effective: its relevance can be judged by the way it induces change and influences decision-makers. If objectives are to be achieved, work strategies have to be chosen on the basis that they can be proved effective in tackling problems. In resource development the customary response to various social and health challenges has been to increase the institutional and professional resources available. Quebec’s health and welfare policy reversed this approach. Drawing up the policy was a dynamic process exploiting the latest know-how and work strategies in a way that motivated those involved in putting the policy into practice. Strategies were selected by examining each problem in the light of the following questions.

- What is the nature and scale of the problem? What is its distribution among the population, and how does it evolve with the passage of time?
- What are the main factors associated with it which explain variations within the population?
- Which population groups are most affected?
- How is the problem being tackled at present?
- What measures have been most effective in preventing it?

### Strategies

- Encouragement for strengthening human potential.
- Maintenance of proper living environments, and development of healthy and safe environments.
- Improvement of living conditions.
- Working for and with at-risk groups.
- Harmonization of public health and welfare policies and activities.
- Ensuring orientation of the health and social services system towards the most efficient and least costly solutions.
It emerged that the same factors were invariably associated with most of the problems. When a health policy is extended to cover social problems, the influence of the four chief determinants of health, namely biology, lifestyle, environment and the health care system, becomes even clearer. Three elements gain in importance: the quality of the living environment, whether in the family, school or workplace; the social environment, with particular reference to relations between men and women; and living conditions as indicated by income, schooling, housing, work and so on. The more that is learnt about determinants, the clearer it becomes that health problems and social ills stem from common causes.

It also became clear that the living conditions of some groups experiencing numerous social and health problems made them particularly vulnerable. Some groups were affected by a range of conditions and risk factors, including cardiovascular diseases, cancers, behavioural disorders, mental health problems, injury, low birth weight, violence and neglect. Among the groups in question were disadvantaged youths, elderly women living alone in precarious circumstances, people with disabilities, low-income and single-parent families, recent immigrants and communities in poor neighbourhoods.

These observations determined the main thrusts of the health and welfare policy. It was recognized that the solutions to social and health problems often lay outside the system providing care and services. Furthermore, equitable access to health and welfare was necessary, and this required focusing on the most disadvantaged population groups. The policy was thus of importance at government level and merited consideration at the centre of social policy.

Mobilizing for change

The following changes, which are likely to have a lasting effect, have taken place:

- the objectives were adopted for implementation at regional level;
- incentives were provided for research;
- a complete set of health and welfare indicators was developed.

Implementation plans were drawn up by the health and social services board in each of Quebec’s 18 regions, with the aim of defining objectives corresponding to the particular characteristics of each population group. The regional objectives differed somewhat from the central ones but nevertheless reflected the broader priorities and strategies.

The most noticeable feature of the regional objectives is their emphasis on social problems, underscoring the difficulties associated with adverse living conditions and the urgent need to fight poverty. The place occupied by the social services among public bodies is being examined, and increased efforts are being made to provide local coverage of community needs. Regional plans are being based on towns, neighbourhoods, villages and groups of small settlements so as to give access to health and social services at the
local level. Local and regional forums have been provided for discussing health and welfare matters and the practical aspects of intersectoral cooperation. This has led to improved pooling of resources by local government, schools, community groups and others.

The health and welfare policy has encouraged research in some areas that were previously neglected, relating, for instance, to vulnerable groups, the determinants of health and welfare, and intervention in different population groups. It is intended to achieve improved targeting, a multidisciplinary approach, and results that are more tangible and more widely accessible than formerly.

The Fonds de la Recherche en Santé du Québec and the Conseil Québécois de la Recherche Sociale were encouraged to link their research programmes explicitly to the objectives and strategies of the health and welfare policy. The biggest change was in social research, where studies were undertaken on living conditions and the most vulnerable groups. The recent establishment of university social research institutes and a public health institute has further strengthened research on needs and problems requiring concrete solutions. It is intended that these bodies should achieve close links between research and practice.

Periodic social and health surveys conducted both regionally and locally can help to identify the most vulnerable groups and the most harmful living conditions. The Quebec Health Survey (3) has made it possible to gauge differences in health and welfare with increased precision. Certain social matters related to health can be better documented, for instance the impact of socioeconomic status. By placing health and welfare in the social and economic context a move has been made beyond simple indicators that merely quantify the performance of the various components of the health and social services system.

The scope of the indicators (4) has thus been broadened to take account of the determinants, the state of health and welfare, and the consequences of health problems and social ills. The health and welfare policy has also facilitated a comparison of Quebec with other states and countries (5), having made it possible to develop information on the basis of the main indicators recognized globally.

**Economic and social context**

The availability of a tool to improve health and welfare does not necessarily help the system to cope with certain issues, some of which may be particularly important (6). For instance:

- the influence of health and welfare policy on resource allocation;
- the importance attached to health and welfare by the community;
- the manner in which responsibility is shared.

**Influence of policy on resource allocation**

The public financing system is still more or less impervious to ideas about radical decompartmentalization of the political
and administrative apparatus, and there is no indication that resource allocation outside the health and social services system has been affected. Within this system, however, the situation is quite different. While financial resources are not always allocated according to policy objectives or priorities in the regions, there have been some encouraging signs. For example, needs indicators have been introduced for the main risk factors and the identification of vulnerable groups, and they are used to distribute resources among the regions. Although the overriding rule may still be to adopt budgets that match resources, the policy has made it possible to develop the equity principle further among territories and population groups. The ideas of the health and welfare policy are gradually being adopted in respect of resource allocation procedures at all levels.

So far, the fields identified as priorities in the regional boards’ plans have been protected from the major restructuring undertaken in the health and social services system. The public financing crisis has led to many staff cutbacks, but disinvestment has so far spared the fields of mental health and social adaptation and integration. Health and welfare promotion, preventive health programmes and assistance at community level have even seen their budgets grow.

**Importance attached to health and welfare**

Economic globalization and free trade agreements have a considerable bearing on various aspects of social policy. The gap between social progress and economic development is illustrated all too clearly by the difficulties encountered in adopting strict tobacco control legislation, tightening the control of handguns and improving environmental protection. In each case, economic considerations predominate. The Health and Welfare Council has been assigned the task of keeping health and welfare in the picture and ensuring that social progress and economic development go hand in hand.

**Sharing responsibilities**

What will happen if some of the objectives are not achieved? Although the policy was adopted by the government and has a multisectoral dimension, its design and follow-up are limited to one sector. The health and social services system seeks to tackle problems through a vast network of institutions. To what extent can the bodies managing this network be held accountable for results which depend on the way conditions develop in other sectors? On the other hand, how can the system place responsibility for improvement in health and welfare on workers in these sectors? The multisectoral aspect of the policy presents problems that are far from simple, especially at national level.

When the health and welfare policy is reviewed in 2002 the issues discussed above will probably be of key importance and the following questions will have to be answered.
Can a policy provide guidance for the allocation of resources, both within a health and social services system and outside it?

Is a policy enough to maintain public interest in health and welfare?

How can the responsibility for achieving an improvement in the health and welfare of the population be shared?

References

1. The policy on health and well-being. Quebec, Department of Health and Social Services, 1992.


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Health-for-all policy for the 21st century

I. We, the Member States of the World Health Organization (WHO), reaffirm our commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health.

III. We recommit ourselves to strengthening, adapting and reforming, as appropriate, our health systems, including essential public health functions and services, in order to ensure universal access to health services that are based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future. We intend to ensure the availability of the essentials of primary health care as defined in the Declaration of Alma-Ata and developed in the new policy. We will continue to develop health systems to respond to the current and anticipated health conditions, socioeconomic circumstances and needs of the people, communities and countries concerned, through appropriately managed public and private actions and investments for health.

extracted from the World Health Declaration adopted at the Fifty-first World Health Assembly, Geneva, 16 May 1998 (resolution WHA51.7).