

## Advocacy Tool Kit

St. Michael's Hospital Academic Family Health Team

### Background and Purpose

The St. Michael's Hospital Department of Family and Community Medicine (SMH DFCM)'s 2017-2018 Strategic Plan commits to:

Collaborating with St. Michael's and community partners to advance systems of care for disadvantaged patients including positively impacting the social determinants of health.

The SMH DFCM recognizes that health is largely determined by socioeconomic factors and these social determinants of health (SDOH) are rooted in historic, cultural, and political power relations such as colonization, systemic racism, ableism, and gender inequality.

Health care providers can tackle negative health outcomes, not only through health promotion at the individual patient level, but by addressing the SDOH through social justice advocacy at the meso<sup>i</sup> or macro-level<sup>ii</sup>.<sup>1</sup>

We have adopted the following definition of social justice advocacy:

“Social justice advocacy works for structural and enduring changes that increase the power of those who are most disadvantaged politically, economically, and socially. It tackles the root and avoidable causes of inequities for those who are systematically and institutionally disadvantaged by their race, ethnicity, economic status, nationality, gender, gender expression, age, sexual orientation, or religion.”<sup>2</sup>

Further, advocacy by health care providers includes actions that promote these changes to “ameliorate suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise”.<sup>3</sup>

Health care providers' responsibility to engage in advocacy has been emphasized by the [College of Family Physicians of Canada](#)<sup>4</sup>, [College of Nurses of Ontario](#)<sup>5</sup>, and the [Canadian Association of Social Workers](#)<sup>6</sup>.

Several frameworks exist to guide health advocacy and education<sup>7,8</sup>, however it can be daunting for individual providers to take action.

**This tool kit seeks to support SMH DFCM staff members to participate in social justice advocacy and to provide a brief overview on practical steps for taking action.**

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<sup>i</sup> Meso-level advocacy occurs within the local community

<sup>ii</sup> Macro-level advocacy occurs within the greater system and targets political structures at the provincial or federal level

## Recognizing Our Privilege As Health Care Providers

Health care providers have varying degrees of privilege and power, which can both determine our career trajectories, and result from our professional positions.

If we understand the social determinants of health as arising from an unequal distribution of resources and power, then reflecting on our own position in society can help us to understand the complex factors contributing to our patients' health.

Reflecting on our own experience is a step toward identifying our privilege, which might include our access to housing, food security, and employment; and less obvious opportunities such as the ability to obtain a credit card, to borrow a book from the library, to walk the streets safely, or to be greeted with respect at service agencies or stores.

Engaging in these reflections and listening to those with different experiences, allows us to be more effective advocates, and allies in advocacy.

## Identifying a Policy Window or Opportunity for Change

Campaigns are most likely to succeed when there is an opportunity for policy change or there is strong public interest in a certain issue. **Timing is everything.**

Examples of advocacy opportunities include;

- Upcoming elections
- Government consultations
- Proposed legislation changes
- Legal action and landmark court decisions
- Issues of current public interest

There are several theories from the social sciences disciplines to explain how and why advocacy efforts lead to policy changes.<sup>11</sup> Key themes among the factors described by these theories are summarized here:

1. Media: public attention on an issue provides an opportunity, media has agenda setting potential
2. Support: presence of a coalition, coordination between individuals with similar core beliefs, allies in positions of power, and a sympathetic administration in office may contribute to change
3. Policy Windows: arise when the definition of the problem, proposed solutions, and/or political climate converge at a critical moment and issues receive increased attention
4. Including People Affected: priorities should be driven by those affected - strategies including training, capacity-building, community mobilization, awareness building and action research

### Helpful Resource:

[http://orsimpact.com/wp-content/uploads/2013/11/Center\\_Pathways\\_FINAL.pdf](http://orsimpact.com/wp-content/uploads/2013/11/Center_Pathways_FINAL.pdf)

## Launching Into a Campaign

<p><b>Step 1:</b> <b>Identify the Issue</b></p>	<ul style="list-style-type: none"> <li>• Research the issue and explore the political climate</li> <li>• How does it relate to SMH DFCM activities or mandate?</li> <li>• <b>Is there a window of opportunity for policy change?</b></li> </ul>
<p><b>Step 2:</b> <b>Connect with Allies – Join a Coalition or Build Your Own</b></p> <p>See Appendix E</p>	<ul style="list-style-type: none"> <li>• Identify peer partners; learn from those with lived experience</li> <li>• Are other SMH DFCM members working on similar issues? Visit the internal website advocacy repository (page 4)</li> <li>• Who else might be interested in the issue?             <ul style="list-style-type: none"> <li>- Community organizations, unions</li> <li>- Academic institutions, professional organizations</li> <li>- Media contacts</li> </ul> </li> <li>• Involve the SMH DFCM Community Engagement Specialist</li> </ul>
<p><b>Step 3:</b> <b>Set an Objective &amp; Target</b></p>	<ul style="list-style-type: none"> <li>• Set SMART objectives <sup>9</sup> (specific, measurable, achievable, relevant, time-bound)</li> <li>• Who can effect change?             <ul style="list-style-type: none"> <li>- Organization</li> <li>- Municipal, provincial, or federal government</li> </ul> </li> <li>• What resources are available to support your efforts?</li> </ul>
<p><b>Step 4:</b> <b>Choose Your Strategy &amp; Tools</b></p> <p>See Appendix A-D</p>	<ul style="list-style-type: none"> <li>• Scope of your activities: individual actions vs. group actions vs. a larger campaign</li> <li>• Determine specific messaging</li> <li>• Choose a strategy and use advocacy tools based on your SMART objectives             <ul style="list-style-type: none"> <li>- Opinion editorials and blogs (Appendix A)</li> <li>- Media releases, press conferences (Appendix B)</li> <li>- Deputations, submissions to government (Appendix C)</li> <li>- Direct action: i.e. rally, demonstration (Appendix D)</li> <li>- Online or paper petitions: i.e. Change.org</li> <li>- Public education or town halls</li> <li>- Lobbying institutions and politicians</li> <li>- Legal action: i.e. human rights tribunal</li> <li>- Social media blitzes or campaigns</li> <li>- Clinical tools and education</li> <li>- Research: i.e. participatory action research</li> <li>- Academic or clinical education</li> </ul> </li> </ul>
<p><b>Step 5:</b> <b>Determine How You Will Identify Yourself</b></p>	<ul style="list-style-type: none"> <li>• Determine how you will identify yourself             <ul style="list-style-type: none"> <li>- Toronto-based health care providers, or</li> <li>- University of Toronto affiliate, or</li> <li>- St. Michael's Hospital staff</li> </ul> </li> </ul>
<p><b>Step 6:</b> <b>Implement and Evaluate</b> (key to future success &amp; support!)</p>	<ul style="list-style-type: none"> <li>• How will you measure success?</li> <li>• What are your intended outputs?</li> <li>• Evaluate strategies, messaging, partnerships</li> </ul>

## Identifying Yourself and Using Institutional Affiliations Within Campaigns

Use professional judgement when identifying as part of a campaign. Physicians are not employees of the hospital and have greater autonomy in how they allocate their work time and how they represent themselves. Non-physician employees may be restricted in their activities during work hours and should speak to their manager if engaging in advocacy during work hours or if planning to identify as affiliated with the SMH DFCM or SMH in the course of that advocacy.

Individuals with a University affiliation are generally permitted to disclose this affiliation if *speaking truthfully* and if they identify that they are *not speaking on behalf of* the University on an issue.

St. Michael's Hospital is a Catholic institution. Staff must carefully consider the acceptability of advocating on certain issues on which the Catholic Church takes a strong position (i.e. medical assistance in dying).

### Tips for Advocacy <sup>10</sup>

- Maintain a high standard of your clinical skills to ensure you are a credible health provider expert
- Reflect on your own privilege and how this influences your role as an advocate and ally
- Form relationships with the communities you are advocating with and for, and follow their guidance
- Identify windows of opportunity for policy change related to a particular issue
- Remain informed – know the policies and evidence on both sides of every argument
- Be truthful and avoid embellishment

### Resources

#### **SMH DFCM AFHT Internal Website Advocacy Repository:**

If you are engaged in advocacy within the department or community, please consider listing this on the internal website by e-mailing [SwartzSA@smh.ca](mailto:SwartzSA@smh.ca). This is a great place to identify ideas or allies!

#### **Advocacy Mentors:**

There are many staff engaged in SDOH advocacy within the department. If you would like to brainstorm or seek guidance on advocating for a specific issue, consider contacting an experienced colleague in the department. Check out the Internal Website Advocacy Repository for names and contacts. If you are willing to be added to this list, please email [SwartzSA@smh.ca](mailto:SwartzSA@smh.ca).

#### **Other Tool Kits**

[RNAO, 2015: Taking Action: A Toolkit for Becoming Politically Active](#)  
[University of Kansas, 2016: Advocating For Change](#)

#### **Books**

[How to Save the World In Your Free Time, Elizabeth May, 2006](#)  
[The End of Protest: A New Playbook for Revolution, Micah White, 2016](#)

## Acknowledgements

This tool kit was developed by the SDOH Advocacy Sub-Committee with contributions from the following individuals: Philip Berger, Gary Bloch, Katie Dorman, Ritika Goel, Samantha Green, Johanna MacDonald, Rami Shoucri, Alyssa Swartz, Lauren Welsh

The approach outlined builds on models developed by the RNAO, Physicians for Human Rights, and Toronto-based physicians engaged in advocacy.

## References

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## Appendix A: Letters and Editorials

### Opinion Pieces / Editorials

Opinion pieces are articles published in the press or online blogs, which generally deliver 1-2 key points supported by evidence and anecdotal experience. These often include a call to action. In some newspapers, authorship is limited to two names. It is helpful to include a one-sentence biography for authors and/or groups involved in writing an article since this provides context, credibility, and publicity for the campaign. The print version of op-eds do not usually include references, however it is common for those published online to use hyperlinks to support key points. Most op-eds average around 700 words.

### Letters to the Editor

Letters to the editor are shorter pieces, typically under 300 words, that respond to a current issue or recently published article.

### Open Letters

Open letters address an individual or organization, such as an elected government official, and include specific action items or “demands”. Publishing an open letter in a newspaper can increase its circulation and draw the attention of other organizations and policy makers.

### General Tips

- Focus on 1-2 key points that the reader will remember
- Draw on professional experience and share stories
- Ensure your writing is factual and accurate
- Timeliness is important - link the article to a related event or current news
- Review submission guidelines for the target outlet, including word count
- Submit to one source at a time, follow-up by telephone or e-mail within 1-2 days
- Once published, share the story widely on social media (i.e. Facebook, Twitter, etc.)

### Examples of Media Outlets

Members of the SMH DFCM have successfully published articles in the following outlets.

<p><b>Print and Online</b> Toronto Star Globe and Mail Hamilton Spectator</p>	<p><i>Letter to the Editor:</i> <a href="mailto:lettertoed@thestar.ca">lettertoed@thestar.ca</a> <i>General:</i> <a href="mailto:Newsroom@globeandmail.com">Newsroom@globeandmail.com</a> <i>General:</i> <a href="mailto:news@thespec.com">news@thespec.com</a></p>
<p><b>Online</b> Healthy Debate Huffington Post</p>	<p>General: <a href="mailto:healthydebate@smh.ca">healthydebate@smh.ca</a> General: <a href="mailto:scoop@huffingtonpost.com">scoop@huffingtonpost.com</a> Pitch a Blog: <a href="http://www.huffingtonpost.com/contact/">http://www.huffingtonpost.com/contact/</a></p>

## EXAMPLE: OPINION EDITORIALS

### **An Essential Medicines List Could Ensure All Canadians Have Access to the Drugs They Need**

Nav Persaud, CBC News, 17 Mar 2017-06-29

<http://www.cbc.ca/news/opinion/essential-medicines-1.4028517>

### **Better Medicare the Prescription for Ontario**

Danyaal Raza and Joel Lexchin, The Toronto Star, 23 Feb 2017

<https://www.thestar.com/opinion/commentary/2017/02/23/better-medicare-the-prescription-for-ontario-opinion.html>

### **Gentrification's Toll on the Health of Long-Term Residents**

Anne Rucchetto and Cian Knights, Healthy Debate, 1 Feb 2017

### **Poverty Has a Dramatic Impact on Health, Especially in Northern Ontario**

Katie Dorman, The Toronto Star, 8 Aug 2016

<https://www.thestar.com/opinion/commentary/2016/08/08/poverty-has-drastic-impact-on-health-especially-in-rural-ontari.html>

### **Worker's Should Be Able to Stay Home Sick**

Andrew Pinto and Mike Benusic, The Toronto Star, 14 Dec 2015

<https://www.thespec.com/opinion-story/6180609-workers-should-be-able-to-stay-home-if-sick/>

### **As a Doctor, Here's Why I'm Prescribing Tax Returns**

Gary Bloch, The Globe and Mail, 20 Mar 2013

<http://www.theglobeandmail.com/opinion/as-a-doctor-heres-why-im-prescribing-tax-returns-seriously/article9981613/>

## EXAMPLE: LETTER TO THE EDITOR

### **That's not so**

Stephen Harper's misrepresentation of refugee health care during The Globe and Mail's leaders' debate was breathtaking.

He stated: "The only time we've removed it [health care] is when we have clearly bogus refugee claimants who have been refused and turned down" and that "We do not offer them a better health care plan than the ordinary Canadian can receive." Mr. Harper's declaration is simply untrue.

Under the Conservative cuts to refugee health care, refugee claimants from Designated Countries of Origin or so-called safe countries (for example the Roma in Hungary) were denied all usual health coverage before they even had their refugee determination hearing. All refugee claimants lost coverage for medication, vision and dental care, and for prostheses necessary for amputated limbs. No refugee claimant ever received more health care coverage than Canadians receiving social assistance. This was all confirmed in the July, 2014, ruling of the Federal Court, which found the cuts unconstitutional and "cruel and unusual" treatment. The federal government still has not fully complied.

Mr. Harper's conclusion that that policy is something both new and "existing and old-stock Canadians agree with" is unbecoming of any political leader and has no place in the national discourse about refugees.

*Philip B. Berger, medical director, Inner City Health Program, St. Michael's Hospital, Toronto*



EXAMPLE: OPEN LETTER



Opinion · Commentary

# Pharmacare should be at the top of Trudeau's agenda

'Pharmacare is the unfinished business of the Canadian healthcare system,' 300 health professionals and academics tell the new prime minister.

By **DANYAAL RAZA**  
**STEVE MORGAN**  
Tues., Nov. 17, 2015



*The following open letter to Prime Minister Justin Trudeau has been signed by more than 300 health professionals and academics:*

Full Letter:

<https://www.thestar.com/opinion/commentary/2015/11/17/pharmacare-should-be-at-the-top-of-trudeaus-agenda.html>

## Appendix B: Press Releases and Media Advisories (Alerts)

The goal of Press Releases and Media Advisories (Alerts) is to inform the media of events or of a group's position on a particular issue (generally in response to a current event).

<b>Press Release</b>	<b>Media Advisory (Alert)</b>
<ul style="list-style-type: none"><li>• Reports on an organization's position, reaction, or initiative</li><li>• Includes background information and quotes from designated spokesperson(s)</li><li>• Should be clear and concise (max 1 page)</li></ul>	<ul style="list-style-type: none"><li>• Informs and invites members of the media to a time-sensitive event or press conference</li><li>• Outlines the schedule or agenda</li><li>• Should be clear and concise (max 1 page)</li></ul>

Press releases and media advisories related to or on behalf of St. Michael's Hospital, must be coordinated and approved by the Communications Department (see Appendix X).

### Tips for Writing Press Releases and Media Advisories

- Include the date and city from which it will be released
- Write clearly and concisely, keep paragraphs short
- Maximum length of approximately 1 page
- Timing and relevance is critical, best to correlate with current event (ideally within 24 hours)
- Provide names, titles, affiliations, and contact information for designated spokesperson(s)
- Use one or two quotes from spokespersons to illustrate and punctuate the point being made
- May include "For Immediate Release" at the top and -30- at the bottom
- Post online, share on social media, send to media contacts

### More Information

#### [How to write an effective press release](#)

Janet Murray, The Guardian, 16 June 2015

## EXAMPLE: PRESS RELEASE

### **St. Michael's Hospital and Toronto Public Library launch Reach Out and Read program to promote childhood literacy; Jan. 27 Family Literacy Day**

[Toronto, January 27, 2015](#)

*By Leslie Shepherd*

In addition to flu shots and vitamins, family doctors at St. Michael's Hospital are now prescribing books to their youngest patients.

The hospital's Department of Family and Community Medicine and the Toronto Public Library have launched one of the first Reach Out and Read programs in Canada, and the first connected with a Canadian hospital.

Reach Out and Read is a three-part literacy promotion program developed by pediatricians and early childhood learners in Boston, with a special emphasis on low-income families.

During regular well-child checkups for children ages 6 months to 5 years, Reach Out and Read physicians and nurse practitioners talk to parents about the importance of reading aloud to their children. They give each child a developmentally appropriate book and they maintain a well-stocked library in their waiting rooms. By the time a child in the Reach Out and Read program at St. Michael's Hospital enters kindergarten, he or she should have a home library of at least five books.

In addition, at their first visit, families will be given a Ready for Reading kit from the Toronto Public Library so that they can bring early literacy tools and resources into their homes to create a literacy-rich environment. The Ready for Reading kit includes the library's award-winning resource guide, "Let's Get Ready for Reading: A fun and easy guide to help kids become readers," filled with research-based tips, activities and recommended reading, developed by expert children's librarians.

The program builds on the unique relationship between families and their health-care teams at one of the most critical developmental periods in a child's life.

"Ninety per cent of brain development occurs in the first five years of life, making this a critical time for learning," said Dr. Laurie Green, a family physician who spearheaded the project with Dr. Kathryn Dorman, a resident in family medicine.

"Many children, especially those from low-income families, experience barriers to reading at home and miss the opportunity to acquire fundamental reading and language skills. This has a negative impact on their language development and can lead to challenges throughout their educational years and beyond," said Dr. Green.

The Public Health Agency of Canada lists education as one of the social determinants of health, the social and economic factors that influence people's health.

"Toronto Public Library is so excited to be partnering with St. Michael's on such an important and innovative literacy initiative," said Cheryl Skovronek, Ready for Reading Manager at Toronto Public Library. "We know that literacy – especially early literacy – is the foundation of learning and life success. By pairing programs like *Reach Out and Read* and *Ready for Reading*, together we expand our reach and provide easy access for parents and caregivers to tools, resources and simple, everyday activities that help them build early literacy skills in their children."

Independent research has found that children who participate in Reach Out and Read in their preschool years score three to six months ahead of non-ROAR children on vocabulary tests, and that kids who start school on track are more likely to reach their full educational and social potential.

The new literacy program was funded by the St. Michael's Hospital Foundation, which contributed \$14,000 to buy books for the pilot project, to run from January to June 2015. First Book Canada helped obtain books at a reduced cost. St. Michael's family physicians are also providing funds for the project and the Children's Book bank in Regent Park is donating gently used books and literacy information for waiting rooms.

The library is providing 4,000 kits for distribution, each one including a *Ready for Reading* bag, a brochure that encourages library card registration and a copy of the [Let's Get Ready for Reading resource guide](#). Funding for the children's kits has been provided by the Toronto Public Library Foundation. Also added to each waiting room library is a set of Toronto Public Library's [First and Best books](#), an annual list of the top ten Canadian books to help kids birth to five get ready for reading, donated by the publishers.

The Reach Out and Read program is one of many that St. Michael's Department of Family and Community Medicine has undertaken in an effort to influence the social determinants of health. The Family Health Team site at 80 Bond St. has a full-time "health promoter" whose job is to help patients improve their financial situation by helping them to navigate the government's social services system, reduce expenses, complete their taxes, set up bank accounts, access free programs, budget and save for emergencies. Clinicians can also refer patients to a lawyer who works for a community legal clinic and has an office on site.

### **About St. Michael's Hospital**

St. Michael's Hospital provides compassionate care to all who enter its doors. The hospital also provides outstanding medical education to future health care professionals in 27 academic disciplines. Critical care and trauma, heart disease, neurosurgery, diabetes, cancer care, care of the homeless and global health are among the hospital's recognized areas of expertise. Through the Keenan Research Centre and the Li Ka Shing International Healthcare Education Centre, which make up the Li Ka Shing Knowledge Institute, research and education at St. Michael's Hospital are recognized and make an impact around the world. Founded in 1892, the hospital is fully affiliated with the University of Toronto.

### **About Toronto Public Library**

Toronto Public Library is one of the world's busiest urban public library systems. Every year, 19 million people visit our branches in neighbourhoods across the city and borrow 32 million items. To learn more about Toronto Public Library, visit [torontopubliclibrary.ca](http://torontopubliclibrary.ca) or call Answerline at 416-393-7131. To get the most current updates on what's happening at the library, follow us on Twitter @torontolibrary.

### **Media contacts**

For more information, or to arrange an interview, please contact:

Leslie Shepherd  
Manager, Media Strategy, St. Michael's Hospital  
416-864-6094  
[shepherdl@smh.ca](mailto:shepherdl@smh.ca)

Sharanja Thangalingam  
Communications Officer, Toronto Public Library  
416-397-5971  
[shthangalingam@torontopubliclibrary.ca](mailto:shthangalingam@torontopubliclibrary.ca)

## EXAMPLE: MEDIA ADVISORY

FOR IMMEDIATE RELEASE

### Health Care Providers Join Growing Calls To Raise Ontario's Minimum Wage

**TORONTO – January 13, 2014** – As the Ontario government gears up for the next provincial budget Health Providers Against Poverty will hold a press conference.

- **Where:** Queens Park Media Studio, Ontario Legislature.
- **When:** Tuesday January 14<sup>th</sup> at 10.30 a.m.

The news conference will be the latest in a number of public comments by health providers on the impact of low income on health.

The [Ontario Medical Review](#) recently published a series of articles detailing why poverty is a medical problem. This followed a report last year by the Canadian Medical Association, which concluded poverty is the biggest barrier to good health for Canadians. Almost half a million people, representing 9% of the Ontario's work force, earn minimum wage that has been frozen at \$10.25 for four years.

Health service providers will speak about the impact they see of poverty and low wages on people's health. Speakers include:

- **Dr. Gary Bloch**, Health Providers Against Poverty; Physician, St Michael's Hospital, Toronto
- **Axelle Janczur**, Executive Director, Access Alliance Community Health Centre
- **Lorraine Telford**; Registered Nurse, Manager of Clinical Programs at LAMP Community Health Centre

These are two of Ontario's 75 Community Health Centres, which are mandated to serve vulnerable populations.

During the press conference Axelle Janczur will spotlight new research, which reveals the damaging health impacts on immigrant communities of low wage work.

**Photo Opportunity:** The speakers will unveil their prescription to the Ontario government for a healthier Ontario.

[Health Providers Against Poverty](#) is a province wide alliance of physicians, nurses, nurse practitioners, and other health providers committed to addressing poverty as a health issue. On January 14<sup>th</sup> community groups across Ontario will be calling Premier Wynne and MPPs asking for a \$14 minimum wage for a healthy Ontario.

See <http://raisethemimumwage.ca/> for further details on the campaign.

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**For further information contact:**

Jacque Maund  
Association of Ontario Health Centres  
[jacque@aohc.org](mailto:jacque@aohc.org)  
Tel 647-294-5724

## Appendix C: Government Submissions, Consultations, and Deputations

Governments sometimes formally seek input from people with lived experience, front line workers, and experts on new policies or legislative initiatives.

This occurs at the municipal, provincial, or federal level, depending on the issue.

Healthcare providers can contribute to the dialogue and decision-making on certain policies by preparing submissions, participating in consultations and making deputations.

These opportunities may be invited or may be identified by health care providers by following the media, Government news releases, and communications from community organizations on a certain issue.

### Examples of Participation by SMH SMH DFCM Members

<b>Municipal</b>	<ul style="list-style-type: none"> <li>• Deputation on housing and homelessness, Toronto Budget Committee Meeting (2017)</li> <li>• Submission on Interim Poverty Reduction Strategy, Toronto City Council (2015)</li> </ul>
<b>Provincial</b>	<ul style="list-style-type: none"> <li>• Invited Membership, Ontario Income Security Advisor Group (2016)</li> <li>• Deputation on employment standards, Ontario Changing Workplaces Review (2016)</li> <li>• Submission on inequality, Ontario Poverty Reduction Strategy Consultation (2013)</li> </ul>
<b>Federal</b>	<ul style="list-style-type: none"> <li>• Submission on drug coverage, NIHB Drug &amp; Therapeutics Advisory Committee (2016)</li> </ul>

### Written Submissions – Sample Structure

- Summary, Overview, or Key Messages \* highlight your key recommendation(s)
- Introduction, Background, Issues
- Recommendations – with supporting evidence
- Signature(s) with title, degree, affiliation
- References

### Tips for Deputations

- Practice your deputation in advance, seek input from colleagues
- Keep it under five minutes unless otherwise specified
- Introduce yourself and your context for providing recommendations
- Provide clinical examples without revealing patient identifiers
- Include “evidence” from the medical or social sciences literature
- Be prepared to book off a half or full day, rarely given a specific time slot

### Find Government Consultations

Government of Canada: <https://www1.canada.ca/consultingcanadians/>

Government of Ontario: <http://www.fin.gov.on.ca/en/consultations/>

## EXAMPLE: WRITTEN SUBMISSION #1

### Improving legislation that governs employment and working conditions in Ontario can positively impact important social determinants of health

Submission to the Changing Workplaces Review

Submitted: September 18, 2015

Read full referenced submission [here](#).

#### **Authors:**

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##### **Gary Bloch, MD CCFP**

Physician, Department of Family and Community Medicine, St. Michael's Hospital; Assistant Professor, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto; Member, Health Providers Against Poverty; Co-Chair, Poverty and Health Committee, Ontario College of Family Physicians

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##### **Tim O'Shea, MD FRCPC MPH**

Associate Professor Department of Medicine, Division of Infectious Diseases McMaster University; Associate Medical Director Hamilton Shelter Health Network

#### **I. Employment, working conditions and the social determinants of health**

The health of individuals and communities is determined by a large number of factors. Canadian health professionals and policy makers have traditionally focused on ensuring patients have adequate access to health services. Increasingly, there is broad interest in addressing the social factors that relate to health outcomes.<sup>1-3</sup> These have been called the social determinants of health (SDOH), "the conditions in which people are born, grow, live, work and age".<sup>4</sup> For example, the Canadian Medical Association conducted a series of town hall meetings in 2013 across the country, entitled "What makes us sick?" Key recommendations that emerged focused on SDOH, including the need for governments to take action on poverty, on the lack of affordable housing and on food insecurity in order to improve the health of Canadians.<sup>5</sup> Employment and working conditions are key social determinants of health. As noted in the Final Report of the World Health Organization Commission on the SDOH, "Employment and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations and self esteem, and protection from physical and psychosocial hazards – each important for health"<sup>1</sup> (p.72) Employment is related to important health outcomes, including mortality. A study of over 90,000 men and

women in Finland who were followed for over a decade found that mortality is significantly higher among temporary workers compared to permanent workers. Moving from temporary to permanent employment was associated with a lower risk of death.<sup>6</sup>

Employment and working conditions influence health through several mechanisms. First, employment determines a person's income, through the wage rate and the number of hours of work a person is given.<sup>7</sup> Living on low income means being unable to afford basic necessities that are important for healthy living, including food, stable housing, clothing and medications to treat acute and chronic conditions.<sup>8</sup> In a study of 331 families in Toronto, among those who were living in market-rent households, families with adults who gained full-time employment experienced a significant decrease in food insecurity.<sup>9</sup> Second, working conditions can determine a person's exposure to physical injury. Certain workers in Ontario are at particularly high risk of injury, such as migrant workers in the agricultural sector.<sup>10-12</sup> One study of temporary workers showed a rate ratio of 2.94 for non-fatal occupational injuries (95% CI 2.40 to 3.61) and 2.54 for fatal occupational injuries (95% CI 1.88 to 3.42).<sup>13</sup> Third, working conditions also determine exposure to stress and mental strain.<sup>14</sup> There is robust evidence that perceived job insecurity is closely linked to psychological morbidity and likely follows a dose response relationship.<sup>15</sup> A study of 5,679 temporary and permanent workers in Spain found a strong gradient association between the degree of employment precariousness and poor mental health, even after adjusting for age, immigrant status, socioeconomic position and previous unemployment.<sup>16</sup> Fourth, the cumulative stress associated with precarious work likely exacerbates chronic diseases, such as heart disease.<sup>17</sup> Access Alliance conducted in-depth interviews with ten families dealing with precarious work, finding that bad jobs were reported as the cause of physical illness, musculoskeletal pain, gastrointestinal complications, mental illness and worsening of chronic conditions.<sup>18</sup>

Health professionals frequently witness the negative impact of poor working conditions in their clinical encounters.

- *A newcomer who has struggled to have her credentials recognized in Canada and can only find work at a chain restaurant. With four children, her minimum wage salary means she can never earn enough to make ends meet. The stress of this situation takes a toll on her mental health.*
- *A man in his 50s who experienced a heart attack and was subsequently laid off from his non-unionized job that had few protections. He has struggled to re-enter the workforce and has gone on welfare.*
- *A man in his mid-40s, working in the hospitality industry. Only obtaining temporary positions, he has worked for several employers over the past five years. He struggles with inconsistent hours, irregular shifts and is required to be on-call for work almost all the time. He has developed tendonitis and lower back from repetitive motions but is worried about taking any time off to address these health issues, let alone raise them with his current employer.*

Motivated by such patient stories, front-line health professionals have become engaged in working toward decent work for all. Building on the definition used by the International Labour Organization, by "decent work" we mean work that is productive, delivers an income that provides social protection, ensures security in the workplace, leads to personal development and social integration, allows people to express their concerns, organize, participate in decision making that affects their work, and provides equality of opportunity across gender, race/ethnicity, age and sexual orientation.<sup>19</sup>

Engaging in advocacy on decent work fits with other initiatives to address SDOH, including actions at the individual patient-provider level, the development of clinical tools focused on alleviating poverty, and education sessions on social determinant interventions for all levels of medical trainees and practicing physicians. The Ontario Medical Association<sup>8</sup> and the Canadian Medical Association<sup>20</sup> have called on members to address SDOH and improving access to decent work is a natural extension of these efforts.



**Recommendation 1.** The Changing Workplaces Review should be guided by the principle of decency and ensuring decent work for all Ontarians.

**Recommendation 2.** The Changing Workplaces Review should also be guided by the concept of the SDOH.

## II. Precarious work in Ontario

Precarious employment has been increasing in Ontario since the early 1990s.<sup>21</sup> However, this trend has accelerated following the 2008 recession, with many Ontarians remaining shut out of the job market.<sup>22-24</sup> Most of the new jobs created during the process of economic recovery are considered precarious.<sup>25</sup> An increasing number of Ontarians report living pay cheque to pay cheque<sup>26</sup> and precarious work particularly impacts racialized immigrant families in Ontario. 18 An analysis of Labour Force Survey data for Ontario found that in 2014, 33% of all workers had low wages (1.5x minimum wage), compared to only 22% a decade earlier.<sup>27</sup> As recognized in the documents published by the Changing Workplaces Review, such changes are occurring in a historical context. Globalization and increased automation has lead to fewer and be characterized by “flexibilized employment”.<sup>28</sup> The increase in precarious work has matched a growing power imbalance between workers and employers. Workplaces are less likely to be organized, related to a long-term decline in union membership, and with it a decline in the power of workers. Workers in Ontario are in urgent need of laws that protect and facilitate their right to unionize and to exercise the rights of collective bargaining and collective action. As noted in the World Health Organization Commission on SDOH report, “Unions are powerful vehicles through which protection for workers – nationally and internationally – can be collectively negotiated”.<sup>4</sup> (p.77) Without unions – and the collective agreements that are put in place as a result of unionization – employers in Ontario are highly likely to employ temporary, part-time, contract and casual staff in order to reduce human resource costs. Employers also benefit from hiring such workers as they can fit their labour supply to demand. Such workers, particularly temp agency workers, are unlikely to receive the same wages, benefits, and working conditions as workers doing comparable work that are hired permanently by a company.

**Recommendation 3.** Workers in Ontario require strong legislative protection to be able to engage in meaningful processes when seeking resolution of concerns and labour standard violations.

**Recommendation 4.** There should be no differential treatment in pay, benefits and working conditions for workers who are doing the same work but are classified differently, such as part-time, contract, temporary, or casual.

**Recommendation 5.** In terms of scheduling and work insecurity, employers should be required to post worker's schedules (including when work begins, ends, changes and meal breaks) at least 2 weeks in advance.

## III. Sickness policies governing work in Ontario

The Changing Workplaces Review has noted that concerns have been raised about how to address an employee's need for short-term absences from work, for example for an illness. This is an area that is particularly relevant to health providers. We realize many workers cannot stay home if they are ill if it means losing income and potentially putting their job at risk, even when going to work means the worker may have a longer recovery period and may put others at risk if they have an infectious disease.

A number of studies have identified the benefits of paid sick leave policies. Econometric modelling suggests that sick leave policies are an important predictor of behaviour around episodic illness<sup>29</sup> which fits with clinical experience. In other words, people without protected sick leave tend to work while they are ill, what has been called “presenteeism”.<sup>30</sup> In a Centers for Disease Control study of almost 500 workers in almost 400 restaurants

from across the United States found that almost 60% had worked while ill and a common reason given was fear of job loss, after controlling for other factors. 31 In a study of 171 nursing homes in New York state, the risk of a nosocomial respiratory or gastrointestinal disease outbreak was significantly lower if the nursing home had paid sick leave policies. 32 A study of 38,000 working adults in the United States found that those with access to paid sick leave were 28% less likely to experience nonfatal occupational injuries. 33

Paid sick leave can also mean that workers can attend to preventive care needs and more quickly recover from illness. In a study of almost 12,000 adult workers in the United States, those with paid sick leave were much more likely to have completed important cancer screening (e.g. mammography, Pap tests and endoscopy for colon cancer screening) and visit a physician than those without paid sick leave, even after controlling for social, economic and health-related factors. 34 For those without paid sick leave, attending medical appointments means losing income and may simply be an unaffordable option for many. A study of 289 employed women who experience a heart attack or angina, those with paid sick leave were more likely to return to work than those without paid sick leave. 35 Other economic benefits have been found. Paid sick leave is associated with a reduced probability of job separation, both involuntary (e.g. laid off, job ended or business dissolved) and voluntary (e.g. retired, illness or injury and quit) 36 International comparative research has found no significant relationship between the duration and generosity of sick leave and national economic indicators, including GDP, unemployment rates and national competitiveness. 37

Finally, as called for by the Ontario Medical Association, requiring sick workers to obtain physician notes as proof of their illness is a practice that should end. 38 First, it presupposes that workers will lie about illness and does not foster a sense of trust between employee and employer. Second, it places the burden of regulating workers on physicians and other health providers. Frequently, the only reason for a visit to a health centre is to obtain a sick note, not to obtain medical advice. This takes up appointment slots and may mean that other patients cannot see their health providers. Third, the cost of obtaining these notes falls on the health care system, when physicians bill for such visits, or on the patient, if their physicians charges for doctor's notes. There are often additional costs born by the patient when seeking health care, including parking, paying for transit and obtaining child care if required. Fourth, there is a risk that by attending a health care facility, a worker may either transmit an infectious disease to others or be exposed to infection. 39

**Recommendation 6.** All workers, regardless of the size of the business, should have the right to emergency leave. The ESA be amended to repeal the exemption for employers of 49 or less workers from providing emergency leave.

**Recommendation 7.** All employees in Ontario should be entitled to a minimum of one hour of paid sick time for every 35 hours worked. For a full-time 35 hour per week employee, this works out to approximately seven paid sick days per year.

**Recommendation 8.** The ESA be amended to prohibit employers from requiring evidence from a worker to entitle them to personal emergency leave or paid sick days.

#### IV. Work, poverty and health

People living at low income in Ontario live shorter lives, with more disability. Their work is more precarious, and they tend to have worse working conditions, that place them at higher risk of illness and injury. People living at the bottom end of the wage scale are suffering, and the ability to protect their health is in the hands of our legislators.

That patients have to live in this way with a full-time job, in a wealthy country, is a tragedy. That we set our minimum wage to benefit, first, companies' bottom lines, and not to ensure low wage workers are able to stay healthy, and to afford the basics of food, shelter, clothing and other necessities, is both a tragedy and a public health travesty.

This is why call for a \$15/hour minimum wage. \$15/hour will not make low wage workers rich, but it will help establish the basic foundation for health we should expect for every working person in Ontario, and for the families that depend on them.

As health providers, we see this as an essential step towards reducing poverty in Ontario, and towards improving the health of our most vulnerable neighbours. If we don't pay for it upfront, we will pay for it and much much more – recent studies have shown that poverty costs us \$3 billion per year in Ontario, and \$7 billion per year in Canada. The lost productivity and increased health dollars are avoidable, through key health interventions such as a living minimum wage of \$15 an hour.

**Recommendation 9.** We call for the minimum wage to be raised immediately to \$15 per hour in 2015.

**Recommendation 10.** We support the recommendations contained in the Workers' Action Centre report, "Still Working On The Edge: Building Decent Work From The Ground Up". 40

## V. Conclusion

The health of our patients, their families and the communities that they live, work and play in are in your hands as you advise on how this legislation should be updated and amended. Thank you for your efforts and dedication to ensure that all Ontarians have access to decent work.

## EXAMPLE: WRITTEN SUBMISSION #2

### Submission from the Inner City Advisory Committee to the Enhancing Equity Task Force and SEAC

June 2, 2017

Committee Including Dr. Laurie Green

The Inner City Advisory Committee would like to submit the following TDSB Research Department reports to the Enhancing Equity Task Force for consideration prior to making final recommendations and to SEAC to inform their ongoing advocacy. The following reports chronicle the Research Department's excellent work in capturing equity concerns within the assessment process and delivery of special education services and in school programming/programs of choice in the TDSB.

The evidence demonstrates that student socioeconomic status and self-reported race as well as other variables (including parental level of education) are strongly associated with Special Education designation, placement in Special Education programs, Grade 9 programs of study, high school graduation rates, acceptance to post-secondary education and experience of acceptance/exclusion in school. These same factors are also strongly associated with programs of choice such as French Immersion, International Baccalaureate program, Advanced Placement program, the Elite Athlete program and the congregated Gifted program as well as Specialty Arts, Alternative, Special Education, Limited Academic Programming schools.

The committee recognizes TDSB Special Education Department's intent to eliminate HSP programs and generally move towards inclusive education and would like to lend strong support to this decision. We recognize the challenges that system change presents but the striking inequity of the current structuring must be addressed.

The Inner City Advisory Committee recommends the following:

- Continue to move ahead with the integration of MID, LD and behaviour students as well as those students/families who chose this option into regular classes with in-class support
- End HSP program and shift to in-class support
- Examine the evidence-based rationale for congregated programs including gifted
- Re-evaluate the use of the IEP re: tool for categorization or goal-directed, strategy-informed document that will be re-evaluated and updated each reporting period
- Improve communication to parents regarding child's progress – eg. Grade level of work being done and not modified grades, the difference between transfer and promotion
- Engaging Teaching and Learning Department in the implementation of special education service delivery
- Study the use of psychoeducational, speech language and occupational therapy assessments (by SES, self-reported race and exceptionality) to determine the use of this service
- Investigate the social determinant barriers to achievement and address these with appropriate resources (ie. Not special education where these concerns may not exist)
- Investigate and present options for dealing with the inequities of Programs of Choice and specialized schools
- Continue to develop cultural/socio-demographically sensitive approaches to student learning
- Consider learning coaches model for special education vs difficult to access specialty teams eg. Behaviour/autism
- Routinely consider medical assessment particularly vision and hearing screening

### Summary of Research

To summarize, this research demonstrates the following (all race designations are self-declared from the Student Census):

#### Special Education: Structural Overview and Student Demographics Dec 2010 (data from 2009 -2010)

- Gifted programs: students are more likely to be White, East Asian, come from disproportionately higher income neighbourhoods, living with both parents who are more likely to have had a university education
- Behaviour programs: students are more likely to come from lower income neighbourhoods, more likely to be Black (35.5% vs 13.5%) or White (40.5% vs 31.9%), less likely to come from two parent households and less likely to have parents who had a university education
- Language Impairment, Developmental Disability, Mild Intellectual Delay programs: lower SES
- Congregated classes generally: students are more likely to live in lower income neighbourhoods
- "Low achievement especially apparent for students taught within congregated settings"

#### Programs of Study: Pathways through Secondary School Dec 2013

- Academic programs: students are more likely to be East Asian, South Asian and White, and much less likely to be Black (8.8%), Indigenous (0.1%);
- Applied Programs: 22.7% Black students, more than doubly represented Indigenous students
- Essential Programs: 29.3% Black students, quadrupled representation by Indigenous students
- Academic level POS was directly related to graduating on time (81.6%) and passing the OSSLT (88%) vs applied level courses (39.2% and 37.4% respectively)
- Students with special education needs: board wide (16%), academic program (6%), applied (33%), essential (68%)
- Family Income: students in academic programs more likely to come from higher income neighbourhoods than applied/essential programs; students in the lowest income decile in essential (18.2%) > applied (13.2%) > academic (7.2%)

#### In-School Programs: Pathways through Secondary School Dec 2013 (Congregated gifted and Special Education Programming, International Baccalaureate (IB), French Immersion (FI), Advanced Placement (AP), Elite Athlete, Specialist High Skills Major (SHSMP), Ontario Youth Apprenticeship program (OYAP)

- Academic program: Gifted/IB/FI/AP/Elite athlete all > 95%, SHSMP 54%, OYAP 40% and congregated Special Education 2.5%
- Self-reported race: White (over-represented in Gifted, FI, Elite Athlete, OYAP and congregated Special Education; under-represented in IB, AP, SHSMP); S. Asian (over-represented in IB, SHSMP; under-represented in Gifted, FI, Elite Athlete, congregated Special Education, AP and OYAP); E. Asian (over-represented in congregated Gifted, AP, IB; under-represented in FI, Elite Athlete, SHSMP, OYAP, congregated Special Education); Black (over-represented in congregated Special Education, SHSMP, OYAP; notably under-represented in Gifted, IB, AP, Elite Athlete and slightly under-represented in FI)
- Family Income: Highest 3 income deciles: FI/gifted/Elite Athlete (over 50%), OYAP (25%), congregated Special Education (19%), SHSMP (18%)
- LOI: mean across secondary panel (0.45); FI (0.135), Gifted (0.186), AP/Elite Athlete/IB/OYAP (0.4- 0.5), SHSMP (0.629), congregated Special Education (0.678)

**School-Wide Structures: Pathways through Secondary School Dec 2013** (Specialty Arts, Alternative, Special Education, Limited Academic Programming: 2011 – 2012 school year)

- Arts Schools: proportion of White students is triply represented; students much more like to come from higher income household; highest student report of sense of belonging (72%)
- Alternative schools: proportion of White students is doubly represented; much more equitable income stratification; student sense of belonging high (71%)
- Special Education Schools: Black students are the largest racial category (30%) > White students (25%) > S. Asian (16%); student more likely to come from lower income households; have the highest suspension rates of specialty schools (three times the TDSB average); have low student sense of belonging (56%)
- “schools that offer more marketable programs, such as Specialty Arts schools (mean LOI=0.058), have substantially lower LOI scores than schools that offer Limited Academic opportunities (mean LOI = 0.8)” and Special Education schools (mean LOI = 0.776) (LOI of 0.001 represents the school with the least external challenges and 0.956 represents the school with the most external challenges).

**The TDSB Grade 9 Cohort 2006 – 2011: Special Education** (data from 2004- 2011; Gr 7 – Gr 12 cohort)

- Gr 6 EQAO at Level 3/4 reading: gifted (93%), no special needs (68%), LD congregated (14%), LD integrated (30%), IEP only congregated (9%), IEP only integrated (30%)
- Similar pattern for EQAO math scores, Gr 9 academic courses, graduation, confirmation post-secondary program (exception is confirming college program where LD congregated/IEP only congregated were higher than integrated)
- Self-reported race and representation in Special Education programs: Gifted: White (52%), E. Asian (29%), S. Asian (7%), Mixed (6.3%), Black 5%
- LD: White (53%), Black (17%), Mixed = S. Asian (8%), E. Asian (7%) MID: Black (31.5%), White (24.2%), S. Asian (20%), Middle Eastern (10%), Mixed (6%)
- IEP only: White (29%), Black (27%), S. Asian (15%), E.Asian (10%), Mixed=Middle Easter (7%)  
Students without Special Needs: White (33%), S. Asian (21%), E. Asian (20%), Black (11%), Mixed (6%), Middle Eastern = S.E. Asian (4%), Latin (2%)
- Socio-economic status: gifted more likely to come from backgrounds of greater privilege > students without special education needs > students with special education needs in integrated settings > students with special education needs in congregated settings
- Congregated classes and academic program in Gr 9: Gifted (99%), no special education needs (82%), special education integrated (40%), special education congregated (11%)
- Losing IEP only status between Gr 7 and 12 (37%) resulted in no difference in achievement between the two groups

**Programs of Study and the Dangerous Discourses around (Dis)Ability: Lessons from a Project in De-streaming** (data from 2000 – 2014)

- Most TDSB students taking Applied and Locally Developed programs in Gr 9 will not go to post-secondary education and are students with Special Education Needs
- HSP is the single largest Special Education program in the TDSB (n = 5000)
- 60% of students in HSP are there without a formal identification
- Study examined 1) the relationship between placement and academic streaming in Grade 9 when achievement was controlled (from Gr 6 cohort of 2010-2011 followed to 2013- 2014); 2) the relationships of key Special Education programming to socio-economic and demographic variables
- Strong relationship between special education identification and placement in elementary school to secondary streaming

- Access to academic programming in Grade 9 is severely restricted and streamed towards non-academic programming regardless of student achievement (as measured by EQAO data)
- Student in the lowest income tertile, students self-identified as Black and students whose parents have not gone to university are disproportionately over-represented in the HSP program and are at greatest risk for encountering academic restrictions in secondary and post-secondary access

“The presence of strong socio-economic factors (and self-reported race) and their close relation to specific exceptionalities may complicate impressions of student ability.”

**References:**

Special Education: Structural Overview and Student Demographics, Dec 2010

<http://www.tdsb.on.ca/Portals/0/Community/Community%20Advisory%20committees/ICAC/research/SpecEdStructuralOverviewStudentDemo.pdf>

Structured Pathways Fact Sheets:

<http://www.tdsb.on.ca/Portals/research/docs/reports/ProgramsOfStudyAnOverview%20FS-%20FINAL.pdf>

[http://www.tdsb.on.ca/Portals/research/docs/reports/In-SchoolProgramsAnOverview%20FS\\_%20FINAL.pdf](http://www.tdsb.on.ca/Portals/research/docs/reports/In-SchoolProgramsAnOverview%20FS_%20FINAL.pdf)

<http://www.tdsb.on.ca/Portals/research/docs/reports/School-WideStructuresAnOverview%20FS-FINAL.pdf>

Grade 9 Cohort Fact Sheet:

<http://www.tdsb.on.ca/Portals/research/docs/reports/Gr9CohortFactSheet4SpecialEducation13May13.pdf>

HSP study:

<https://gatewaycities.mcmaster.ca/conferences-and-workshops/conference-and-workshop-documents/congress-pos-and-hsp-final-may-30.pdf>

## EXAMPLE: DEPUTATION

### Changing Workplaces Review: Speaking Notes for HPAP, EMMER, and Health Justice Initiative (Gary Bloch, Alyssa Lane, Johanna Macdonald)

**Event:** Changing Workplaces Review

**Special Advisors:** Mr. C Michael Mitchell and Judge Murray

**Location:** Queen's Park Conference Room, Trent Room, 900 Bay Street, Toronto

**Date and Time:** Friday, September 18, 2015, 9:00-9:10 am

Read the full referenced version [here](#)

GARY - Good morning Mr. Mitchell, Judge Murray, Ministry of Labour staff and other guests. Thank you for the opportunity to speak today. My name is Gary Bloch. I am a family physician with St. Michael's Hospital and an Assistant Professor in the Faculty of Medicine at the University of Toronto. I am also Chair of the Ontario College of Family Physicians' Committee on Poverty and Health. I am here representing Health Providers Against Poverty. Health Providers Against Poverty is an advocacy organization made up of physicians, nurses, nurse practitioners, occupational therapists and other professionals who work on the frontlines of health care. We believe that poverty represents a serious, reversible threat to the health of people living in Ontario. We work from the well-accepted understanding that poverty is the most powerful known risk factor for ill health. I am here presenting today also with Johanna Macdonald and Alyssa Lane from the Health Justice Initiative.

Today, we focus our submissions on three key areas as they related to your review of the Employment Standards Act ["ESA"]:

- 1) Utilizing a social determinant of health and disability rights lens to guide your review and form the backbone of your recommendations;
- 2) Recommending essential changes to leave provisions for all workers; and
- 3) Recommending a call to action on workplace bullying and harassment.

Together, we will highlight the opportunities that you have to maximize the ability of Ontario's workers to live healthy, productive lives by making meaningful changes to the ESA that recognize employment standards as a major determinant of workers' health.

JO – Good morning. My name is Johanna Macdonald and I am speaking with you today in my capacity as the onsite lawyer at St. Michael's Hospital Academic Family Health Team and the Health Justice Initiative. Our Initiative is novel in Canada, partnering a primary care health team and four community legal clinics, taking a disability rights lens with the goal of improving our communities' social determinants of health and access to justice. Working closely together to provide legal services, our Initiative provides a unique opportunity to see the intimate link between employment standards, health consequences and the disproportionate impact of such standards on persons with disabilities. It is with this unique view that we discuss today our experiences and our suggestions for reform that you may include in your recommendations.

First, we would like to endorse in their entirety the recommendations presented in the following submissions:

- The Workers' Action Centre's written submission and report "Still Working on the Edge: Building Decent Jobs from the Ground Up"; and



- The Income Security Advocacy Centre's submission "Making Work Work for All".

ALYSSA - Good morning, my name is Alyssa Lane and I am a student with the Disability Law Intensive Program at the ARCH Disability Law Centre, working with the Health Justice Initiative. Through the Initiative, we have observed that lack of sufficient safeguards in our Employment Standards Act has resulted in a number of patients being referred to our Initiative in desperate circumstances. Jamal, an employee for three years at his minimum wage cleaning job, was terminated after having the flu and being absent for one week. Martina, a trans-gendered woman who faced ongoing bullying and harassment at her telemarketing job, and Farah, a delivery driver who was hospitalized for a mental health condition for 2 weeks and upon returning to work, was told that her contract was 'up' and 'no further pay was coming'.

GARY - As Johanna and Alyssa work with our patients to provide relevant legal assistance, my role is to treat the health conditions all too often exacerbated by poor working conditions. Jamal reported feeling high levels of stress. His heart condition worsened after he was terminated. Martina developed anxiety and depression. Farah's mental health condition worsened, and she required investigations for new shortness of breath and chest pain.

JO - And though Jamal, Martina, and Farah may be able to seek legal redress, the fact that these issues arise at all is deeply concerning and points to a lack of baseline preventative protection in our ESA. I all-too-often provide advice to individuals like Jamal or Martina who are unable, due to their social location and exacerbated health conditions, to take on legal action or make any grievances. As Gary has illustrated, health consequences persist, even if they do take action. Health care practitioners and patients alike are desperate to avoid workplace conflict, poor treatment, and discrimination at work because they see and experience the clear and direct immediate effect on their health.

GARY - Our experiences and research have demonstrated the link between healthy work and healthy individuals, and we urge you that it is timely and imperative for you to take the opportunity to analyze and make recommendations for workplace reforms using a social determinants of health lens. Social determinants of health research informs us that the health of individuals and our communities is driven by the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems".<sup>1</sup>

Employment conditions clearly have a big impact on health.

- As noted in the Final Report of the World Health Organization's Commission on the Social Determinants of Health: "Employment and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards – each important for health".<sup>2</sup>
- Poor mental health outcomes are associated with precarious employment (e.g. informal work, non-fixed term temporary contracts, and part-time work)<sup>3</sup>
- Workers who perceive work insecurity experience significant adverse effects on their mental and physical health.<sup>4</sup>
- Temporary workers showed a 3 times higher rate of non-fatal occupational injuries (95% CI 2.40 to 3.61) and a two and a half times higher rate of fatal occupational injuries (95% CI 1.88 to 3.42)

Given this powerful body of evidence, we recommend you consider the health impacts of changes to the ESA, as one framework of analysis in your review. One way to operationalize this is to utilize Health Equity Impact Assessments as endorsed by the Income Security Advocacy Centre to evaluate the impact of changes to the ESA on the health of our most vulnerable individuals and communities. We feel it is a mistake to consider social regulations separately from health outcomes, as negative consequences of such regulations for workers are

intimately felt in higher demand on, and expenditures through, the health system.

JO – We further urge in your review, to resist engaging in a balancing approach to efficiency, equity and voice, and instead retain an approach that infuses all three. We suggest that you can do so by adopting social determinants of health and disability rights lens to your analysis. We support the Income Security Advocacy Centre's suggesting that you use the tools outlined in the Law Commission of Ontario's report "A Framework for the Law as It Affects Persons with Disabilities"<sup>6</sup> as you build your recommendations for law and policy change. We know that over 10% of our labour force identifies as having a disability,<sup>7</sup> and that persons with disabilities face unacceptably high rates of discrimination in the workplace. Currently, 30-50% of human rights claims made to our Human Rights Tribunal cite the ground of disability, most of which are in the area of employment.<sup>8</sup> As a result of discriminatory practices, people with disabilities are much less likely to be employed than those without disabilities, and are particularly impacted by the lack of accommodations in the workplace and poor enforcement of the duty of employers to accommodate.<sup>9</sup>

The Guide calls upon businesses to provide greater integration of historically under-represented groups, including persons with disabilities. The Ontario Human Rights Code provides an overarching, quasi-constitutional overlay for the right of workers to have equal treatment in workplaces, and the Accessibility for Ontarians with Disabilities Act<sup>10</sup> has a number of requirements for employers to remove barriers for persons with disabilities. But the ESA, our most basic foundation of employee rights, holds no provisions that recognize the overarching intent and compliance with these fundamental laws. We suggest that you recommend the creation of a preamble to the ESA that give recognition to the need for healthy workplaces as rooted in our social determinants of health and recognition of our overarching Constitutional and human rights laws that protect persons with disabilities and other protected grounds against discrimination. The preamble should feature goals of increasing social inclusion by reducing poverty and discrimination through our basic employment standards.

GARY - In the context of taking a social determinants of health and disability rights approach to reform recommendations, we would like to specifically highlight our support of the Workers' Action Centre's submission on leave provisions within the ESA. The recommendations are to:

- Repeal the exemption for employers of 49 or less workers from providing personal emergency leave
- Allow all employees to accrue a minimum of one hour of paid sick time for every 35 hours worked.

Repeal Section 50(7) and amend the ESA to prohibit employers from requiring evidence to entitle workers to personal emergency leave or paid sick days.<sup>11</sup>

The benefits of paid emergency or sick leave are backed by evidence: an article in the International Labour Review<sup>12</sup> identified many studies that showed that providing paid sick-leave reduces duration of illness,<sup>13</sup> reduces risk of worsening minor conditions,<sup>14</sup> is correlated with a higher return to work rate following heart attacks,<sup>15</sup> and an overall lower burden on health care resources.<sup>16</sup> Research involving long-term care facilities showed a significant reduction in the frequency of outbreaks<sup>17</sup> when comparing sites with and without paid sick leave policies. A recent study in the American Journal of Public Health found workers with access to paid sick leave are 28 per cent less likely to be injured on the job than workers without such a benefit, and reduction of productivity losses associated with 'presenteeism' – when sick workers continue to show up at work despite their illness.<sup>18</sup>

Often, workers who are sick end up in family medicine clinics or emergency rooms: not for medical care but merely to obtain proof they are ill. In delegating physicians into a policing role, clinical hours get chewed up by administrative tasks. When these illnesses are due to larger outbreaks, physicians are doubly burdened – by the workers who need treatment and the workers who need notes. The Ontario Medical Association discourages requiring sick notes for this reason,<sup>19</sup> and also because of the real risk of transmission to others in the health care environment.<sup>20</sup>

These simple amendments would likely have had a significant impact on our clients Jamal and Farah, who were both absent from work for short periods of time, would likely have not lost their jobs, and would not have had to avail themselves of the health system and legal actions to enforce their rights.

ALYSSA – Finally, we are concerned about the specific discriminations experienced by our patients and clients with mental health disabilities. Disclosure of a mental health problem in the workplace can also lead to discriminatory behaviours from managers and colleagues such as micro-management, lack of opportunities for advancement, overinferring of mistakes to illness, gossip and social exclusion.<sup>21</sup> Employees may find themselves isolated and marginalized in the workplace – impacts that may be made worse by other human rights-related barriers such as racism, sexism, ageism or homophobia.<sup>22</sup> Research has shown and we have seen the health effects of these circumstances,<sup>23</sup> and strongly recommend taking measures to hold employers accountable to maintaining a healthy workplace for all employees. For this, we would like to highlight our endorsement of the Workers' Action Centre recommendations calling for action to address and prevent workplace bullying and providing remedies for psychological harassment.<sup>24</sup>

We thank you for the opportunity to speak with you today. We strongly advocate that you take a new approach to employment standards that adopt social determinants of health and disability rights lens. We are excited about the potential for positive change this approach holds to protect the health and rights of workers and the communities we live in, meaning the health and rights of all of us.

## Appendix D: Direct Action

There are many peaceful forms of direct action that can be used alone or in combination to capture media attention and politician interest on an issue.

It is helpful to plan campaigns in collaboration with health professional or community-based organizations, who often have access to large contact lists.

Press releases and media advisories are a helpful tool for increasing public awareness of an action.

### Examples of Direct Action

- Public rally or march
- Creative actions, i.e. public clinic
- Sit in or disruption
- Banner hanging
- Strike – employment, rent
- Public petition drive

### Considerations

- Choose a convenient time to allow as many people as possible to attend – lunch hour, evening, weekend
- If planning an event that might cause road blockade, notify the police in advance
- Prepare signs, banners, leaflets, and/or coordinated props in advance

### More Ideas

#### Beautiful Trouble: A Toolbox For Revolution

<http://beautifultrouble.org/all-modules/>

**EXAMPLES: DIRECT ACTION**

**Occupation of Federal MP Office**

Physicians occupied MP Joe Oliver's office in 2012 in opposition to cuts to the Interim Federal Health Program, which provides health care for refugees in Canada.



90 Canadian Physicians protest dangerous cuts to Refugee Health Care at MP Joe Oliver's office

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Health Rate My Hospital

## Doctors stage sit-in over refugee health care cuts

Government plan would cut services to refugee claimants

By Maureen Brosnahan, CBC News Posted: May 11, 2012 8:48 PM ET | Last Updated: May 11, 2012 8:46 PM ET

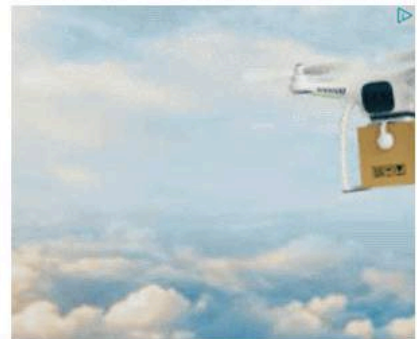


Dr. Paul Caulford, a family physician from Scarborough, speaks on a megaphone to protest proposed changes to health care for refugees and refugee claimants. (Maureen Brosnahan/CBC)

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### Petition Presented to Provincial Minister

Health care providers and allies delivered a petition to Minister Eric Hoskins in 2016, supporting mandatory paid sick days for workers in Ontario.



**Protest at Federal Government Announcement**

Physicians interrupted a public Federal announcement in 2012 to bring attention to the harmful impact of cuts to the Interim Federal Health Benefit.

**Demonstration at Queen's Park**

Mass Hunger Clinic held at Queen's Park in 2005, where health care providers completed Special Diet Allowance forms to help people living in poverty access funds



## Appendix E: Examples of Organizations Engaged in SDOH Advocacy

<b>Health Professional Organizations and Clinical Groups</b>	
<b>GTA</b>	
Access Alliance	<a href="http://accessalliance.ca">http://accessalliance.ca</a>
Inner City Health Associates	<a href="http://icha-toronto.ca">http://icha-toronto.ca</a>
Street Health	<a href="http://streethealth.ca">http://streethealth.ca</a>
<b>PROVINCIAL</b>	
Rainbow Health Ontario	<a href="http://www.rainbowhealthontario.ca">http://www.rainbowhealthontario.ca</a>
Registered Nurses Association of Ontario	<a href="http://rnao.ca">http://rnao.ca</a>
<b>FEDERAL</b>	
Canadian Medical Association	<a href="https://www.cma.ca">https://www.cma.ca</a>
Canadian Association of Nurses in HIV/AIDS Care	<a href="http://canac.org/">http://canac.org/</a>
<b>Community Organizations – Health Focused</b>	
<b>PROVINCIAL</b>	
Decent Work and Health Network	<a href="http://decentworkandhealth.org">http://decentworkandhealth.org</a>
Justica For Migrant Workers	<a href="http://www.justicia4migrantworkers.org">http://www.justicia4migrantworkers.org</a>
Health Providers Against Poverty	<a href="https://healthprovidersagainstopoverty.ca">https://healthprovidersagainstopoverty.ca</a>
Health For All	<a href="http://www.health4all.ca">http://www.health4all.ca</a>
OHIP For All	<a href="http://ohipforall.ca">http://ohipforall.ca</a>
<b>FEDERAL</b>	
Canadian Doctors for Medicare	<a href="http://canadiandoctorsformedicare.ca">http://canadiandoctorsformedicare.ca</a>
Indigenous Physicians Association of Canada	<a href="http://ipac-amic.org">http://ipac-amic.org</a>
Upstream	<a href="http://www.thinkupstream.net">http://www.thinkupstream.net</a>
<b>Community Organizations - Broader Social Determinants</b>	
<b>GTA</b>	
Social Planning Toronto	<a href="http://www.socialplanningtoronto.org">http://www.socialplanningtoronto.org</a>
Toronto Alliance to End Homelessness	<a href="http://taeh.ca">http://taeh.ca</a>



Wellesley Institute

<http://www.wellesleyinstitute.com>

**PROVINCIAL**

ARCH Disability Law Centre

<http://www.archdisabilitylaw.ca>

HIV & AIDS Legal Clinic of Ontario (HALCO)

<http://www.halco.org>

Income Security Advocacy Centre

<http://incomesecurity.org>

Ontario Coalition Against Poverty

<https://ocaptoronto.wordpress.com>

Worker's Action Centre

<http://www.workersactioncentre.org>

**FEDERAL**

First Nations Child & Family Caring Society

<https://fncaringsociety.com>