Blueprint for Health Equity

Speaking Notes

Health Equity: Are We There Yet?

Heart Health Resource Centre OPHA Symposium

November 2007

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Starting Points

- the question for the symposium = Health Equity: Are We There Yet?
- nowhere near
- health disparities are pervasive, incredibly damaging and solidly rooted in overall social and economic inequality
- but, action is possible:
  - there are innovative on-the-ground initiatives across the country addressing the impact of health disparities
  - many jurisdictions have developed comprehensive policies and programs to tackle the foundations of health disparities – and there are enough indications of how these policies can be effective
- goal today is to set out a broad blueprint for action
  - and to link these directions to the kinds of front-line work you do

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Outline: A Blueprint for Health Equity

1. health disparities are produced by a wide range of complex factors – the most important of which are far beyond the health care system
2. much of the solution to health disparities lies in macro social and economic policy – and in policy collaboration and coordination across departments and governments
3. but a great deal can be done within the health system
   – identifying and reducing barriers to access
   – targeted investments and interventions in the most health disadvantaged communities and populations
   – local and community-based action to address disparities on the ground
4. and enhancing equity-focussed primary and preventive care, and health promotion can make a significant difference

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Pervasive and Systemic Disparities in Health Outcomes

- men in the lowest income quintile live five years less than men in the highest
- life expectancy at birth, on average, is five to 10 years less for First Nations and Inuit peoples than for all Canadians
- while infant mortality rates have been declining overall, rates in Canada's poorest neighbourhoods remain two-thirds higher than those of the richest neighbourhoods
- disparities exist in all provinces and territories -- in Ontario, data from the Ontario Health Quality Council show that risk-adjusted rates of death in hospital following a stroke were 36% higher in the worst regions than in the best

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Health Equity = Reducing Unfair Differences

- the most common definition of health equity is working to reduce differences in health outcomes that are **avoidable, unfair and systematically** related to social inequality and disadvantage
  - clear, understandable & actionable
  - it identifies the problem that policies will try to solve
  - it's also tied to widely accepted notions of fairness and social justice
- this definition sees health equity as eliminating – or at least drastically reducing -- socially structured inequalities in health outcomes and status
- a more forward-looking and positive vision of health equity = equal opportunities for good health

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1: Look Widely for Ideas and Inspiration

- a number of countries have made lessening health disparities a top national priority and have developed cross-sectoral policy frameworks and/or action plans:
  - UK, New Zealand, some Australian states
  - many European countries
- also increasing international and high-level attention:
  - World Health Organization, especially its Commission on Social Determinants of Health
  - European Union, with its *Closing the Gap* project to tackle health disparities
- look broadly for policy solutions, and adapt flexibly to local/provincial circumstances

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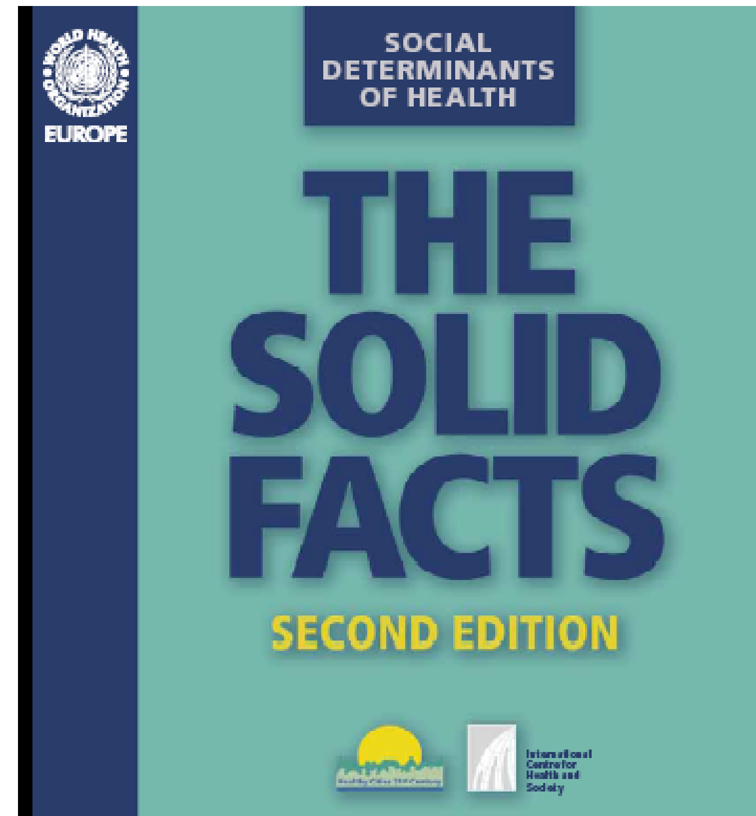
Roots of Disparities Lie in Social Determinants of Health

- clear research consensus that roots of health disparities lie in broader social and economic inequality and exclusion
- impact of key determinants such as early childhood development, education, employment, working conditions, income distribution, racism, social exclusion, housing and deteriorating social safety nets is well established
- real problem is differential access to these determinants – many analysts are talking more specifically about social determinants of health disparities



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2: Think Big: Macro Policy Is Fundamental

- social and structural basis of health disparities means that many of the policy solutions to health disparities lie outside the health system
- reducing overall social and economic inequality may be the most significant single way to reduce health disparities → requires a significant commitment and re-orientation of social and economic policy
- need to build equity into all macro social and economic policy:
  - not just as one factor among many to be balanced, but as core priority
  - some jurisdictions have built equity consideration into their policy processes – e.g. a change in tax policy or new environmental policy would be assessed for its differential and equity impacts
  - Canadian Index of Wellbeing = idea that how well a country is doing cannot be captured by GDP or stock market indexes, but should include social, cultural and other facets of wellbeing

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Commitment to Equity: Sweden

- social welfare policy was seen to be key to reducing health disparities
- coordinated national policy to reduce the number of people at risk of social and economic vulnerability
  - focus on inclusive labour market, anti-discrimination, childcare, affordable housing and other policies
  - equitable access to improved health care was seen to be just one part of this broader package
- emphasized partnerships with community service providers and organizations – in both policy development and service delivery
- its national public health strategy has 12 key objectives – five of which, defined as fundamental to all the others, are about improving social and economic determinants
- similar directions in other Nordic countries – sometimes seen as a distinct model of social policy, one that arose out of a political culture with strong consensus on social solidarity

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3: Think Big, But Get Going

- one problem is that health disparities can seem so overwhelming and the policy solutions so daunting
- everything can't be tackled at once:
  - need to split strategy into actionable components and phase them in
  - but coordinate through a cohesive overall framework
- need to recognize that fundamental policy action on equity takes time – need patience
- pick issues and levers that will show progress and build momentum for action on equity
  - look for collaborations on issues with broad consensus – e.g. child poverty
  - and initiatives that will show results and build momentum – linking schools, local health and social services to enhance early years services for high-need children, families and communities

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4: Act Across Silos

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- significant improvements in health disparities require broad cross-sectoral coordination of public policy
  - a number of countries have solid high-level commitments to reducing disparities,
    - few have implemented comprehensive policies
    - and they vary a great deal
  - but there is a clear consensus that integrated cross-sector policy frameworks are needed
- UK *Tackling Health Inequalities; A Programme for Action* was published in 2003:
  - committed to reducing inequalities in health outcomes by 10% by 2010
  - argued that links across government are essential to sustaining long-term change
  - spelled out specific targets for reduced child poverty, more affordable housing, early childhood development, employment, building healthy communities, and broad national redistributive and social policies that various Departments were responsible for

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5: Set and Monitor Targets

- another clear conclusion from international experience is that a vital part of comprehensive policy on health equity is setting targets:
  - with indicators that build on available reliable data and make the most sense in the particular policy context
  - then closely monitoring progress against the indicators or targets
  - and disseminating the results widely for public scrutiny
- big problem in Ontario is that data on key facets of equity are not collected or analyzed:
  - we know Ontario is an increasingly diverse society, but we don't have the data to understand what that means in terms of health
  - health service utilization and outcomes by specific ethno-cultural background, by sexual orientation, by length of time in the country and country of origin, by neighbourhood, etc. are not readily available
- further lessons:
  - build equity considerations into policy at design stage – not afterthought
  - use tools such as Health Equity Impact Assessments

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Argument So Far

- addressing the roots of health disparities in social and economic inequality requires huge shifts in public policy
- I've set out some examples from other countries and argued we can adapt these directions to Ontario and Canada
- but all of this is a best case scenario:
  - no country has implemented fully comprehensive policy on health equity, and none has dramatically reduced disparities yet
  - will need to be compromises and adjustments along the way
  - but it is crucial to have a clear vision of where we want to go
- because doing nothing is not an option
  - the cost – in terms of avoidable and unfair sickness and death -- is too high

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Act on Equity Within the Health System

- evidence shows that health care system has less impact on health than broader social and economic factors
- but this doesn't mean that how the health system is organized and how services and care are delivered are not crucial to tackling health disparities
- while there was a significant focus on social and economic policy in those countries emphasizing health equity, all also saw transforming the health system as indispensable
- will set out five more lines of action:
  - reducing barriers to equitable access
  - targeted interventions to improve the health of the poorest fastest – generally as part of community/local initiatives
  - building equity into the new LHINs, including enhanced community participation and engagement in health care planning
  - investing in primary care as a key enabler of health equity
  - more emphasis on health promotion, chronic care and preventive programmes

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6: Reduce Access Barriers

- critical part of health equity strategy is to identify and reduce barriers to access:
  - within system architecture: considerable evidence that private provision and payments create critical barriers – e.g. user fees, parallel systems where people can pay for faster access, etc. will restrict poorer people's access to needed care
  - availability of specialist, primary and other care varies by region and neighbourhood → need targeted remedial plans to enhance access in under-served areas
  - language and culture → ensure culturally competent care and build anti-racism/oppression approach into service provision
- one policy direction is to assess what models have best served the most vulnerable communities and invest in them
  - e.g. Community Health Centres, public health and other community-based service providers have explicit mandates to support the most under-served communities

  → expand their coverage and impact

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7: Target Interventions To Most Disadvantaged

- comprehensive and successful health equity strategies target resources and services to specific areas or populations as one direction for action:
  - those communities facing the harshest disparities – to raise the worst off fastest
  - or those most in need of specific services
  - or where interventions will have the most impact
- this requires sophisticated analyses of the bases of disparities:
  - i.e. is the main problem language barriers, lack of coordination among providers, sheer lack of services in particular neighbourhoods, etc.
  - which requires good local research and detailed information – speaks to great potential of community-based research to provide rich local needs assessments and evaluation data
  - involvement of local communities and stakeholders in planning and priority setting is critical to understanding the real local problems

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8: Act Locally

- clear conclusion from leading countries is that action on equity cannot just come from senior governments → many of the most innovative and insightful programmes addressing health disparities have come from local authorities or community providers:
  - emerging evidence that neighbourhood has an independent or reinforcing impact on health disparities
  - lived experience of health problems and opportunity structures always takes place in a local context
  - this requires that equity-driven interventions be locally focussed
- regional health authorities across Canada and in many countries have been an important enabler and lever for planning and promoting local initiatives
- so a vital immediate challenge is building equity into LHIN planning, priorities and operations from the start

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Ideas and Options: Implementing Equity Through LHINs

- identify reducing health disparities as a key priority
  - especially inequitable access, quality of care and other facets that LHINs have the most control over
  - but also committing to collaborating and working beyond health to address the foundations of health disparities
- use planning tools such as diversity lenses and health equity impact assessments
- commit to targets -- all LHINs could make explicit commitments that they will reduce specified health disparities in their region by X% over 5 years:
  - the identified/prioritized disparities would no doubt vary by LHIN, whether by locality, income, ethno-cultural or other factors
  - but all LHINs should adopt clear equity targets, adapted to their local situations and needs

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LHINs II: Building Equity In From the Start

- use the levers to hand – LHINs have significant powers:
  - the LHINs are currently negotiating their initial service agreements with hospitals and will be entering into such agreements with all their funded providers over the coming months and years
  - opportunity to build equity into performance management structures and expectations from the start should be seized
  - e.g. Toronto Central LHIN is requiring all hospitals in its area to develop equity plans
- target investment and programmes in disadvantaged neighbourhoods
- build the voices and interests of the whole community – including marginalized and traditionally excluded – into their governance and planning
- support front-line innovation:
  - fund or pilot new ways of addressing barriers or supporting hard-to-serve communities
  - enable on-the-ground collaborations and partnerships among health care providers that focus on reducing disparities

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LHINs III: Acting Beyond Their Box

- encourage -- and invest in -- collaborations beyond health to address roots of disparities
  - back to British example – Health Action Zones and other models were designed to combine community development with targeted health care access and service improvements
- and in Canada, some RHAs have developed operational and planning links with local social services or emphasized community capacity building:
  - the Winnipeg Regional Health Authority and Manitoba Family Services and Housing have been partnering on a new model to integrate health and social service delivery – one-stop access models in various communities to deliver a broad range of health and social services directly and to refer on to other agencies when services aren't available
  - Saskatoon is developing cross-sectoral action on health equity:
    - began from local research documenting shocking disparities among neighbourhoods
    - focussing interventions in the poorest neighbourhoods – locating services in schools, relying on First Nations elders to guide programming, etc.

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9: Enhance Equity Focused Primary Care

- considerable international evidence that expanding primary care can reduce health disparities
- major reforms are underway across Canada to restructure primary care
  - these system-level reform initiatives are an opportunity to build equity in by concentrating increased primary care in areas with poorest access or health status
  - think of practice innovations as well -- e.g. nurse practitioner and nurse-based clinics have been very effective in delivering primary care and managing chronic conditions
  - in terms of policy levers, it has been easier to establish CHCs and other clinics, than to reform private medical practice
- can also see primary care reform as a catalyst for wider changes – back to issue of collaborative action beyond health:
  - many countries have clinics that provide both health and wider social services in one place
  - new satellite CHCs are being developed in designated high-need areas in Toronto — and some will involve the CHCs delivering primary and preventive care and other agencies providing complementary social services out of the same location

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Pulling All This Together: Second Stage of Medicare

- the Association of Ontario Health Centres and progressive health groups in Ontario and beyond have been discussing a very promising idea
- Tommy Douglas and the original founders of Medicare always saw the crucial goals of universal health insurance and access to hospital and medical care as just the vital first steps to a system that would keep people well, and not just treat them when sick
- the Second Stage of Medicare would:
  - increase the emphasis on preventing illness and promoting good health
  - develop cross-sectoral approaches to addressing the underlying social determinants of health
  - prioritize reducing health disparities
  - reorganize services to provide them in more flexible and integrated ways such as multi-disciplinary teams, comprehensive clinics, better local and regional coordination, and so on
  - through such changes – and through more democratic governance of health care planning -- ensure more timely, equitable and effective care

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10: Up Stream Through an Equity Lens

- health promotion needs to also build equity into its principles and programming:
  - at worst, anti-smoking, exercise and other health promotion programmes can seem to imply that health problems are all a question of individual lifestyle and behaviour
- need to identify the barriers disadvantaged communities face:
  - can hardly urge people to eat better if the nearest decent fresh fruit store is a long bus ride away – or if low income people can't afford to buy the necessary food
  - language, cultural and other barriers can make it hard for disadvantaged communities to get appropriate health promotion information and support
- equity-driven health promotion would ensure preventive, dental care, sexual and reproductive health, immunization and related public health services are provided in disadvantaged communities

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Chronic Care and Prevention Through an Equity Lens

- chronic care is one of most pressing challenges facing health system:
  - at worst, increasing costs will be huge burden
  - thinking more positively and proactively -- investing in better chronic care management, preventive care and health promotion can be vital elements of health reform
- taking equity and diversity into account means:
  - targeting prevention and support services to the most disadvantaged communities – and delivering services in ways that work best for the particular community
  - a tremendous example is a framework developed by the Ontario Women's Health Network for stroke prevention among marginalized women, based upon principles of inclusion research in which women from the marginalized communities are directly involved in all aspects of research, development and delivery

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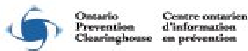
Tools for Action

Primer to Action:
Social Determinants of Health

A resource for health professionals, lay workers, volunteers and activists to explore how the social determinants of health impact chronic disease.



- all kinds of promising initiatives are talking place at front-line – how to support and empower
- a very interesting primer has been developed by the Ontario Prevention Clearinghouse, Ontario Chronic Disease Prevention Alliance and other partners to help incorporate social determinants into chronic care management and support http://www.ocdpa.on.ca/docs/PrimertoAction-EN.pdf

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Summary: Blueprint for Health Equity

- we need an achievable and forward looking vision of what health equity could be
- first of all, Canadian governments need to adapt the best of what other countries are doing to our circumstances
- the roots of health disparities lie in broader social and economic inequalities and addressing these foundations must be the core of any equity strategy
  - which means we need comprehensive and integrated strategy
  - but don't wait for the perfect strategy – get going on what we can
- need to act across government departmental silos and sectors – policy collaboration and coordination are key
- there need to be clear targets and incentives – and ways to hold those responsible up to public scrutiny

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Blueprint for Health Equity: II

- build equity into health system reform:
  - make equity a core objective – every bit as important as efficiency, sustainability and quality – for the Province, LHINs and every provider
  - reduce barriers to equitable access to services and care
  - target interventions and enhanced services to the most disadvantaged communities
  - mobilize key levers – such as enhanced primary care – that have the most impact on reducing health disparities
- encourage local innovation, initiatives and collaborations
- invest up-stream in prevention and health promotion, also targeted to the most disadvantaged
- and, finally, pull all these components together, to learn from on-the-ground innovations and build on what is working well locally, to transform the whole system

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About the Wellesley Institute

- funds community-based research on the relationships between health and health disparities, and housing, poverty and income inequality, social exclusion and other social and economic determinants
- works to identify and advance policy alternatives and solutions to pressing issues of urban health and health equity
- works in diverse collaborations and partnerships for progressive social change
- provides workshops, training and other capacity building support to non-profit community groups
- all of this is geared to addressing the pervasive and inequitable impact of the social determinants of health

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Contact Us

- these speaking notes, background papers and further resources on policy directions to enhance health equity, health reform and the social determinants of health are available on our site at http://wellesleyinstitute.com
- my email is bob@wellesleyinstitute.com
- we are always interested in any comments on the ideas in this presentation and any information or analysis on initiatives or experience that address health equity

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