

# Diabetes Planning Through an Equity Lens

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Workshop Notes  
Working Together to Prevent and Manage Chronic Disease  
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# Chronic Conditions and Health Disparities

- understanding how to control and prevent chronic conditions is going to be one of the crucial challenges for health reform over coming decades
  - meeting this challenge will be critical to quality, efficiency and sustainability of system
  - but like all key aspects of health reform – need to analyze equity implications
- chronic conditions clearly reflect wider health inequities:
  - more disadvantaged populations have higher incidences of key chronic conditions
  - at the same time, they have less access to specialized health promotion and preventive services and to chronic care management support
  - similarly, cost of drugs, exercise, alternative therapies and other means to manage chronic conditions are a huge barrier for poorer

# Health Equity = Reducing Unfair Differences

- there are pervasive and consistent health disparities across the Province and City:
  - people with lower income or education or from racialized or marginalized populations tend to have poorer health
  - the gap between the health status of the best off and most disadvantaged can be huge – and damaging
- the most common definition of health equity is the absence of socially structured inequalities and differential outcomes
- so the goal is to reduce those differences in health outcomes that are **avoidable, unfair and systematically** related to social inequality and disadvantage
- this concept is:
  - 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

# A Forward Looking Vision of Health Equity

- not just an absence of disparities but equal opportunities for good health
- nested in a society in which poverty, inequality and social exclusion – and their impacts on ill health – have been reduced
- consumer/patient driven care and delivery, with individual and community needs at the heart of planning
- culturally appropriate care – crucial in diverse society
- equitable access to a full and seamless continuum of health and social services
- health and human services systems that focus on the most disadvantaged to reduce the gap
- investing ‘up-stream’ in preventive and health promotion

# Chronic Disease Prevention and Management Through an Equity Lens

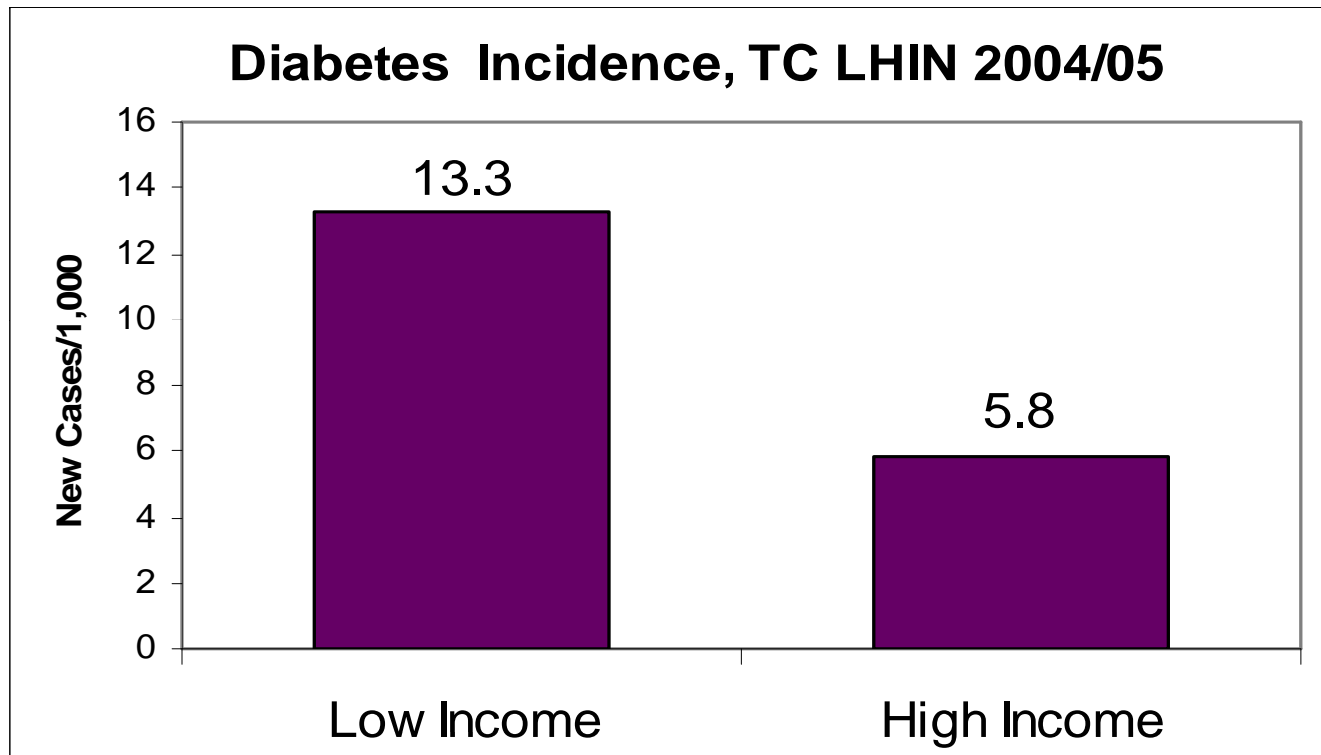
- need to take equity and diversity into account in service planning and delivery:
  - targeting prevention and support services to the most disadvantaged communities
  - and delivering services in ways that work best for the particular community – e.g. in specific culture, within appropriate languages
  - and adjusting service mix and approach to the greater and more complex needs of disadvantaged communities
- a tremendous example is a framework developed by the Ontario Women’s Health Network and others for stroke prevention among marginalized women:
  - based upon principles of inclusion research in which women from marginalized communities are directly involved in all aspects of research, development and delivery
  - in this case, focus groups and educational material led by peers

# Diabetes: The Challenge

- over-concentrated in less advantaged communities and populations = equity issue
- a major driver of ill health and expenditure = worse for worse off
- we know a lot about what to do to medically manage treatment
- have good epidemiological data to identify problem areas and monitor results
- good groundwork has been done, both in terms of planning and innovative delivery
- but we need to know more about how to:
  - take account of the wider social determinants of health in planning and delivering chronic care
  - deliver comprehensive and responsive services and support



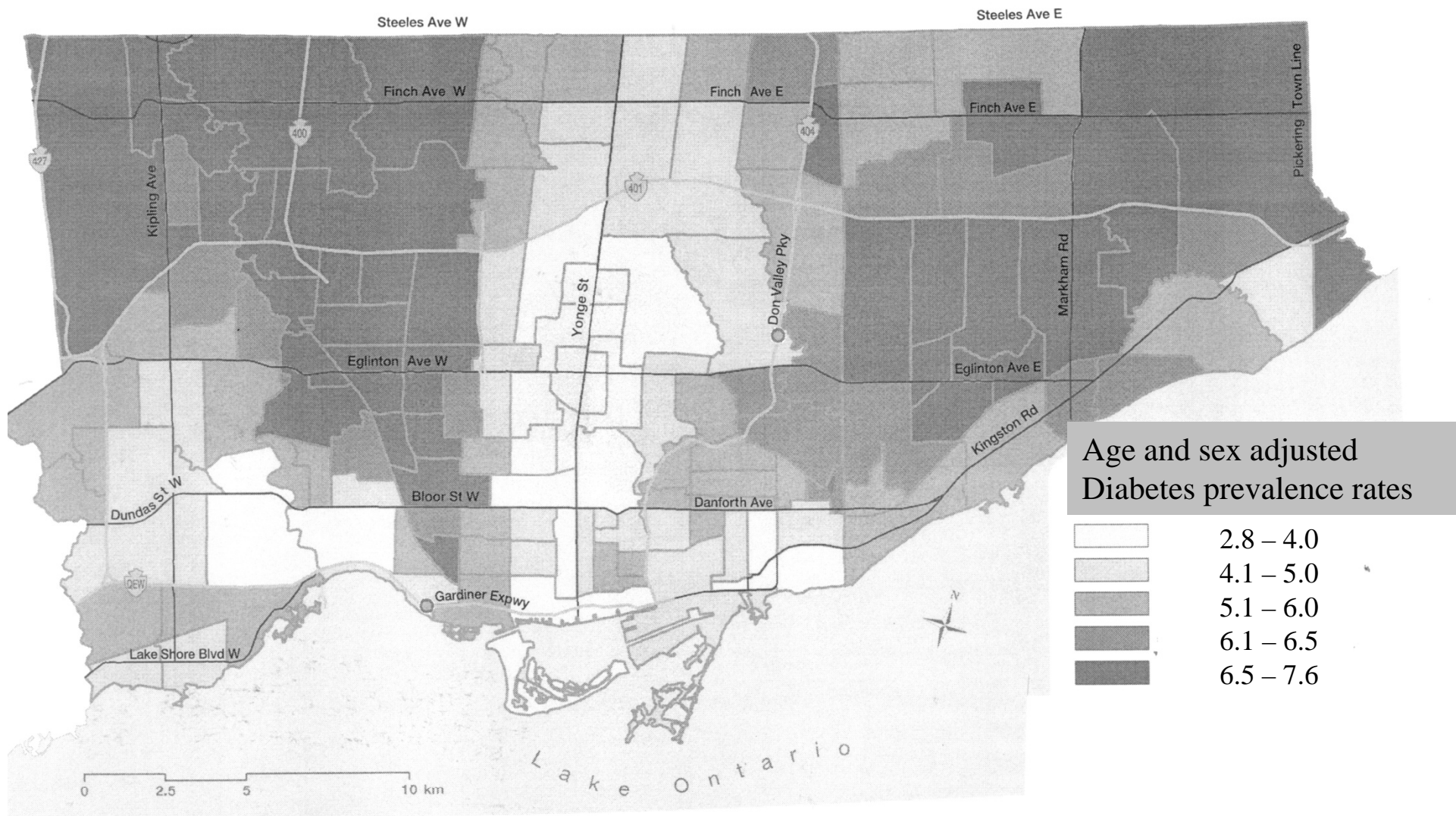
## Lower Income: Higher Diabetes Rate



**Two fold difference in Diabetes Incidence among lowest and highest neighbourhoods.**

# Toronto Diabetes Prevalence Rates by Neighbourhood 2001

From: R Glazier. Neighbourhood environments and resources for healthy living [http://www.ices.on.ca/file/TDA\\_Ch2.pdf](http://www.ices.on.ca/file/TDA_Ch2.pdf)



## What We Know

- clear research and practice evidence consensus:
  - good preventative programmes
  - good treatment to manage conditions
  - kinds of support needed to enable people to live well while managing condition
  - importance of health promotion and addressing social situations in which patients live
- pioneering London Intercommunity Health Centre Latin American Diabetes Program:
  - first arose out of local Hispanic community and CHC
  - now being developed LHIN wide there
  - can explore how to adapt this and other innovative and responsive local initiatives

## What Is Needed

- key features of effective programmes:
  - integrated – multi-disciplinary teams, full range of support
  - comprehensive -- intensive support and long-term follow-up
  - community-based -- providing barrier-free services and support where people are
  - in languages and cultures of people needing services
  - collaborations of many agencies
  - well coordinated – with neighbourhood and area networks
  - addressing social inequalities that shape diabetes – housing conditions, food security and nutrition, access to exercise programs, employment conditions and income
- policy action needed = pilot and adapt comprehensive programs in different neighbourhoods

# Build On What Is Working

- luckily a great deal of ground work has been done already
- the Urban Health Framework developed by GT CHCs has been workshopped on diabetes
  - useful tool to support collaboration and plan comprehensive campaign on coordinated and focused way
  - policy action needed = fund such planning and coordination initiatives
  - revealed solid networks and sophisticated cooperation already underway
  - policy action needed = modest investment in existing networks will enable effective coordination, outreach and expansion

# Windows of Opportunity: Health Equity and Chronic Conditions Are On The Agenda

- Province is developing new overall health strategy and has been driving a comprehensive health transformation
  - indications that equity is among top priorities within strategy
  - cross-Min project on health equity
  - new equity unit within MOHLTC
- Toronto Central LHIN
  - adopting a health equity strategy
  - lots more opportunity to influence ongoing implementation
- that means community-based providers and advocates need a well-articulated and achievable vision of what health equity could be

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- chronic disease prevention and management are a major priority for Province and LHINs
- so also need a clear framework for applying equity and diversity lenses and community-orientated planning frameworks to chronic conditions

# Potential of Equity Driven CDPM Planning

- the urban health framework facilitates planning around key directions:
  - highlighting the ways in which prevalence, impact and access to treatment and support vary dramatically along the health gradient
  - identifying the roots of chronic disease disparities in broader social and economic inequalities
  - determining the kinds of intensive community-based programs that will make the most difference to the most disadvantaged populations
  - surveying the wide range of existing services – and where needs are not being currently met
  - identifying access barriers and gaps in existing services
  - guiding how to build on existing collaborations and networks to ensure more accessible and responsive care for all
- and it builds equity and diversity into the fabric of this planning

## Bigger Picture: Action on Health Equity

- need to recognize that the roots of health disparities lie in broader social and economic inequalities and addressing these foundations must be the core of any equity strategy – nowhere clearer than for diabetes
  - which means we need comprehensive and integrated social and economic strategy to reduce inequality and its health impacts
  - can look to other countries that have developed comprehensive policies to tackle health disparities for ideas and inspiration – and adapt
  - need to act across government departmental silos and sectors – policy collaboration and coordination are key
  - need to encourage and resource cross-sectoral collaboration – for example, between housing, health and social services – on the ground
  - but don't wait for the perfect strategy – get going on what we can

# Action on Equity Within the Health System

- build equity into health system reform – and into the core fabric of the new LHINs:
  - make equity a central priority – every bit as important as efficiency, sustainability and quality
  - 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 health care – that have the most impact on reducing health disparities
- encourage local innovation, initiatives and collaborations addressing access barriers, differential quality or disadvantaged populations
- invest up stream in prevention and health promotion, also targeted to the most disadvantaged
- and, finally, whatever the specific issue – such as better chronic care management and prevention – plan and deliver through an equity lens



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works in diverse collaborations and partnerships for social innovation and progressive social change

supports and funds community-based research on housing, poverty, social exclusion, and other social and economic inequalities as key determinants of health disparities

commissions comprehensive comparative and other policy research

identifies and mobilizes for policy alternatives and solutions to pressing issues of urban health and health equity

