



WELLESLEY INSTITUTE
advancing urban health

Health Equity Roadmap

Health Equity Into Action: Planning and Other Resources for LHINs

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1 Introduction

Ontario continues to undertake a massive transformation of its health system: the 2010 *Excellent Care for All* act enshrines quality and performance management; provincial priorities such as reducing wait times for key procedures, chronic disease prevention and management, mental health, e health and other system-wide issues are driving change across the system; the expansion of Community Health Centres, Family Health Teams and other new models have enhanced primary care; and reforms in funding models, e health and other foundations of the system are proceeding. LHINs are at the leading edge of these broad transformations and are dealing with a range of complex issues and priorities.

One of these issues is equity – the fundamental principle that all should have equitable access to the highest quality care when they need it regardless of their income or social position, race, gender or where they came from, and that health care should contribute to reducing overall inequalities in health among the population. Equity and population health are among the fundamental attributes of an effective health system included in the new Act.

This workbook provides tools and resources for LHINs to be able to effectively implement health equity strategies and initiatives.

Why Health Equity?

Health inequalities are pervasive and damaging in Ontario. There is a clear gradient in health in which people with lower income, education or other indicators of social inequality and exclusion tend to have poorer health.¹

Self-reported health is seen as a reliable measure of overall health status:

- the % who report their health as poor or only fair increases as income decreases
- about 1/4 of low income = 3 X as many as high report health to be only fair or poor

The same pattern exists for mental health, chronic conditions, etc.:

- 3 X as many low-income as high report mental health to be only fair or poor
- incidence of diabetes in TC LHIN is over 2 X in low income neighbourhoods as high

This can have a devastating impact on people's lives:

- daily -- activities of ¼ of low income people are limited by pain = 2X than high income

¹ The following data is from the POWER reports: Project for an Ontario Women's Health Evidence-Based Report at <http://www.powerstudy.ca> .

- premature mortality – deaths before 75 – increases with lower income = about 50% worse in low income neighbourhoods

The difference between the life expectancy of the top and bottom income decile in Canada is 7.4 years for men and 4.5 for women. Taking account of the pronounced gradient in morbidity and quality of life, health adjusted life expectancy reveals even higher disparities between the top and bottom of 11.4 years for men and 9.7 for women.²

Another way to look at this – if all Ontarians had the same health as high income people:

- an estimated 318,000 fewer people would report their health as only fair or poor
- there would be 231,000 fewer people who are disabled
- an estimated 3,373 fewer deaths each year.

These systemic and damaging disparities are the problem that health equity strategies are designed to solve.

Context

Recognizing this, the province has prioritized equity in its expectations to LHINs for some time. Some LHINs have developed comprehensive health equity strategies; many have developed a range of programs and initiatives addressing barriers to equitable access or the needs of health disadvantaged populations. Some LHINs have made equity an explicit priority within their Integrated Health Service Plans; other see equity as a theme that underlies all of their priority directions. All have identified equity issues to some degree within their IHSPs and other programs.

More generally, it is clear that the Ministry of Health and Long-Term Care will be driving its priorities through performance management means – through adjusting allocations to programs and providers, tying some funding to meeting deliverables, including meeting deliverables in CEO/senior management performance management and compensation processes, etc. The *Excellent Care for All* Act includes equity and population health among its key principles. While clear directions from the Ministry on how to interpret the new Act and related expectations may not be available for some time, LHINs could be vulnerable if their fiscal and priority decisions do not take all the principles enshrined in the new legislation into account.

Put more proactively, LHINs should realize that equity is part of the overall context of delivering quality enshrined in the *Excellent Care for All* Act and get out ahead of these coming pressures by prioritizing equity within their overall strategies and initiatives.

² Cameron N. McIntosh, Philippe Finès, Russell Wilkins & Michael C. Wolfson. “Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001.” *Health Reports*. December 2009. Statistics Canada.

What This Resource Provides

This resource is about moving from strategy to practice – operationalizing equity. It provides a range of tools, techniques, briefing notes, research findings and other resources LHINs, and the providers and stakeholders they partner with, can use to implement health equity strategies and initiatives in the most effective ways for their regions and needs.

The basic format is essentially:

To operationalize equity, LHINs may need to be able to	This resource provides tools, techniques and experience on ...
build equity into planning	a series of planning tools are outlined which can be matched to the planning purposes and needs; Health Equity Impact Assessment is proving practical and popular – the resource provides training and implementation tips and links to workshops
require or enable hospitals, Community Health Centres and other providers to develop equity plans for their organizations	several LHINs have done so –and their experience can be drawn upon; templates are available; analyses have been done of the impact and implication of provider equity plans
build equity into ongoing performance management	advice on how to develop equity targets; links to promising work underway on equity data and indicators
etc....	etc....

These tools and directions are all evidence-based; well-supported in international research, professional practice and health policy and management literature. Just as importantly, they are all experience-based: all have been deployed for many years and in many settings in jurisdictions across the country and around the world, and many of these tools and initiatives have been adapted and implemented within Ontario LHINs.

One great potential of the LHINs is that they all face a similar broad range of challenges, within significantly varied local circumstances; have developed a wide range of initiatives and programs; and could build on each other's experience and insight by effectively sharing lessons learned. The fact that many of these tools and resources have been adapted or tried in various LHINs means that others can learn from that – at the simplest, there is enough experience with tools ranging from Health Equity Impact Assessment through providers developing health equity plans to not 're-invent the wheel'.

This is not so much a blueprint – as conditions and requirements in individual LHINs will vary – but a repertoire or menu of proven tools and resources from which LHINs can draw and adapt to put equity into practice.

This series of tools and techniques can be implemented individually or – better still – as part of integrated and comprehensive equity strategies.

2 The Problem to Solve: Health Inequalities in Ontario and Canada

This provides basic data and links to further evidence on the nature of existing health disparities in Ontario. A great deal of data from the excellent [POWER reports](#) is broken down by individual LHIN.

How To Analyze the Social Determinants of Health Inequality

The roots of health disparities lie in wider structures of social and economic inequality – in the underlying social determinants of health. Understanding this wider context is vital to grounding action within the health care system. Wellesley has published a range of [policy papers](#) and [research reports](#) on this.

These social determinants do not operate in isolation but are very much inter-connected in individuals' lives and in their system impacts. Similarly, they interact with each other and with wider social, economic and cultural forces in a constantly changing and dynamic way.

Nowhere is this inter-dependence – sometimes called inter-sectionality -- clearer than for gender. While women face systemic differences in the underlying determinants of health, access to services and overall health status, all women are not the same. Low-income and/or racialized women face specific additional cumulative and interdependent inequalities. The women's' health movement, researchers and public agencies have developed gender-based analysis and other essential tools to help address these disparities. [ECHO: Improving Women's' Health In Ontario](#) is a key starting point.

3 Thinking About/Acting on Equity

Definitions

There are tremendous advantages if all LHINs were to work within a similar understanding of health equity – at best, a clear definition from the Province. This links to a consensus definition of health equity that has proven practical and actionable.

Equity and Population Health

It also links to further material on the social determinants of health that underlie health disparities to set the wider context. Material is also provided on systemic barriers and inequities within health care and why it is so important to build equity into health system planning and delivery.

Building From Solid Evidence

To make progress on health equity we need to embed equity into ongoing service planning and system performance management. And to do that we need solid actionable data. The [POWER](#) project provides this crucial data on health conditions, outcomes and service utilization by gender, socio-economic variables, region, language, ethno-cultural background, etc. – it's an essential tool to operationalizing health equity and social determinants of health.

Bob Gardner [spoke](#) at a panel launching the chapter on access to services.

Making a Case for Equity

One critical challenge is boiling complex issues like health equity and social determinants down into plain language and inspiring ideas. Here is one attempt at an [‘elevator speech’](#) on health equity, and a [speech](#) outlining the need for social and provider mobilization to drive equity.

We have also developed workshops on related issues; for example on developing [health promotion strategies and arguments with policy impact](#).

4 Developing Health Equity Strategy

Jurisdictions around the world have developed comprehensive multi-level strategies to address health inequalities and their underlying social determinants:

- The World Health Organization’s [Special Commission on Social Determinants of Health](#) has attracted a great deal of attention. Not only did it publish a massive [report](#), but it

created various knowledge networks on various aspects of social determinants and policy to address.

- WHO Europe, the European Union and other bodies have developed strategies, undertaken extensive research and created clearinghouses where promising practices address health inequalities are assessed and shared.
- Many European, Australian and other jurisdictions have created national or state level strategies. Several of these have been well established for years and have undertaken evaluations of their impact and lessons learned.
- A number of leading cities such as London and New York have created city-level strategies to address health inequalities and population health.

Closer to home, Toronto Central LHIN has developed the most comprehensive health equity strategy – Wellesley developed a [strategic framework](#) the LHIN built on. Local conditions and priorities will vary and strategies developed for particular contexts – such as this for Toronto Central – will not be applicable in other LHINs. Nor does every LHIN need such a comprehensive strategy. But there is also [no need to totally 'reinvent the wheel'](#) and this strategy could be a useful starting point for others.

These notes provide an overview to build from.

5 Starting From a Clear Strategic Commitment

Key to consistent and comprehensive action on health equity is starting from clear Board and organizational commitments and a powerful shared vision.

These resources set out some starting points.

Planning and Delivering Equity in Tough Times

A pressing immediate challenge is how LHINs can maintain and drive their equity agendas in the context of budget restraints, increasing pressure from providers for limited resources, and a conservative fiscal climate. Wellesley has prepared a [policy briefing](#) on meeting this challenge.

6 Building Equity Into Planning

Almost all LHINs have identified the need to map their local population health. Part of this needs to be identifying key barriers to equitable access, those population facing the greatest health disparities and gaps in services.

The Right Tools for the Right Purposes

There is no single ‘magic bullet’ tool that can be used for all purposes. Gender-based analysis is essential for ensuring organizational priorities and program plans take women’s’ needs into account and Health Equity Impact Assessment can effectively build equity into service planning. But neither are designed to drive needs assessments or equity-focused evaluation; different tools are needed for these purposes.

Health Equity Impact Assessment

An HEIA tool and accompanying resources has been developed by the Ministry of Health and Long-Term Care and piloted and implemented in a number of LHINs.

Wellesley has a [page](#) with links to workshops, tips and other resources to realize the potential of HEIA for equity-focused planning. These notes provide starting points.

7 Effectively Using Levers to Hand

LHINs do have considerable powers and they have the potential to develop effective partnerships with providers to operationalize equity. One [lever](#) that has proven effective in several LHINs is having hospitals or community service providers develop health equity plans to guide their organizations. For an analysis of the plans developed by hospitals in Toronto Central see the extremely useful [analysis](#) led by Sanjeev Sridharan of the Centre for Research in Inner-City health.

Bob Gardner conducted a [workshop](#) on health equity for community providers in Central LHIN who were developing equity plans.

An interesting variant came up in recent conversations with another LHIN: enabling provider coordinating or planning networks or committees to do equity plans for the cluster of services or sector as a whole.

8 Building Equity Into Performance Management

A common lesson from jurisdictions around the world and Regional Health Authorities across the country is the need to identify clear equity targets, develop data and indicators to assess progress against the targets, create incentives and requirements to build meeting equity targets into ongoing accountability structures and ensure equity is build into overall performance management systems.

Moving forward, a key objective can be building equity into balanced scorecards and other planning mechanisms used by LHINs and their provider partners.

This links to notes on how to begin to build equity into performance management.

9 Aligning Equity With LHIN Priorities and System Drivers

A number of key priorities – such as those for wait times, diabetes and chronic disease prevention and management, and mental health -- have been identified by MOHLTC that all LHINs must deliver on, and vital reform initiatives are underway across the province.

Wellesley participated in a [workshop](#) on how to apply a specific equity planning tool – the urban health framework developed by GTA Community Health Centres – to diabetes planning.

This provides resources on how equity can be built into plans and initiatives to achieve these priorities.

Diabetes and Chronic Disease Prevention and Management

Put more proactively, [diabetes](#) and other chronic conditions, mental health and other key issues are greatly influenced by the wider social determinants of health and these priorities cannot be achieved without taking equity into account.

This links to how.

10 Targeting For Equity Impact

While equity needs to be built into all planning and service delivery, it is also critical to direct some investment and initiatives to specific equity challenges. Services may be targeted at particular access barriers or disadvantaged and vulnerable population.

These notes set out starting points.

11 Building Equity-Focused Evaluation

In an era of limited resources and quality-driven reform, it is crucial to know how policies and service interventions are working. This is just as important to equity, and an important part of

equity strategy must be evaluating what initiatives are most effective in reducing barriers and enhancing services for the most vulnerable.

Wellesley partnered with the Paloma Foundation to develop [resources for participatory evaluation](#).

These notes set out a framework to ground equity-focused evaluation.

12 Building Equity-Focused Innovation

When successful policies and interventions are identified and assessed, we need forums and infrastructure to share information and experience on what is working and the means to scale up the most promising interventions.

These notes highlight this potential.

13 Partnerships and Community Engagement Towards Equity

All LHINs have prioritized community engagement. In equity terms, it is especially important to ensure the voices of the most health disadvantaged communities are heard and that their needs and perspectives are built into equity planning and interventions. Similarly, it is vital that these populations are involved in defining the terms for equity-focused evaluation. Wellesley did some [earlier work](#) on these issues as LHINs were developing their community engagement strategies.

Given that the roots of health inequalities lie far outside the health system, LHINs and their partners need to be able to incorporate the wider social determinants of health into their planning and actions. Cross-sectoral partnerships and collaboration are seen to be critical ways in which the underlying social determinants of health inequalities can be addressed on the ground.

Among Wellesley papers, a [brief](#) to the Senate Sub-Committee on Population Health, a [policy paper](#), an [article](#) on the potential of local mobilization, a [seminar](#) for the Ontario Agency for Health Protection and Promotion, and a series of [speeches](#) have addressed how this can be done.

These notes set out some starting points on both community engagement and building collaborations and partnerships to address the social determinants of health.