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Health Equity Now: Community-Based Proposals for Action

Briefing Notes: MOHLTC

The Wellesley Institute

June 2008

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The Health Equity Roundtables (hosted by The Wellesley Institute, 2007 ongoing)

- consensus from 35+ participants at the 2007-2008 Health Equity Roundtables and follow-up working sessions hosted by the Wellesley Institute, representing established and emerging institutional and community-based service providers, researchers, policymakers, and advocates from the health, social service, and community development sectors
- what is unique about these observations?
  - based on long and solid experience of delivering services and working with most disadvantaged populations
  - grow out of front-line experience and expertise addressing health disparities on the ground
  - driven by a commitment to reducing disparities and supporting most disadvantaged – i.e. values driven
  - reflects considerable experience in services and system-wide innovations
- community-based experience and innovation can make a major contribution to developing responsive and effective health equity policy

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Key Messages

- there is tremendous interest in health equity among community-based service providers, researchers, policymakers, and advocates ► important support for current policy agendas
- plus a broad willingness and enthusiasm for contributing community–based experience and insight to health policy and reform debates ► potential for community engagement and partnerships
- there are a huge number of innovative and effective front-line service initiatives addressing health disparities on the ground across the Province ► potential to build on them to operationalize health equity and support most health disadvantaged populations
- some of these innovations are ‘quick wins’ and some can be ‘catalysts’ for wider system change ► potential to build momentum for reform through an equity lens

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Why Health Equity Now?

Across Ontario…

- evidence of health disparities is real and adversely affects people's quality of life across a broad range of social and economic determinants of health
- health disparities have a differential and negative impact on people depending on key structural and individual variables, e.g., race, ethnicity, gender, age, citizenship status, culture, language, socio-economic status, educational attainment, ability, sexual orientation
- tremendous interest from diverse service providers, policymakers, sectors, and communities
- broad willingness and enthusiasm to contribute community perspectives
- vibrant conversation and practice in innovative, front-line service delivery that address health disparities

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Why Health Equity Now?

Across Ontario…

- key infrastructure enablers in place: e.g. Community Health Centres (CHCs), Local Health Integration Networks (LHINs), public health, community advisory panels, core funding
- multiple policy windows: e.g., Poverty Reduction Strategy, Health Strategy
- emphasis on equity within MOHLTC strategy and LHINs
- Second Stage of Medicare
- changing demographics of Ontario's population, e.g., ethnocultural, ethnoracial
- age, gender, urban/rural, income/wealth distribution
- links with social justice, civil society, human rights movements
- multi-sector business case to invest in good health for all

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Starting Points: Health and Health Disparities

What is health?

– "a state of compete physical, mental and social well being, and not merely the absence of disease or infirmity. It is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." (WHO, Alma Ata, 1978)

What are health disparities?

– differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage
– roots lie in broader social and economic inequality and exclusion
– most effective conceptual framework for health disparities grounded in determinants of health, e.g., income/wealth distribution and poverty, early child development, education, employment and working conditions, housing, gender, race and ethnicity, citizenship and immigration status, language, ability, sexual orientation, age, racism and discrimination, social exclusion, and natural and built environments

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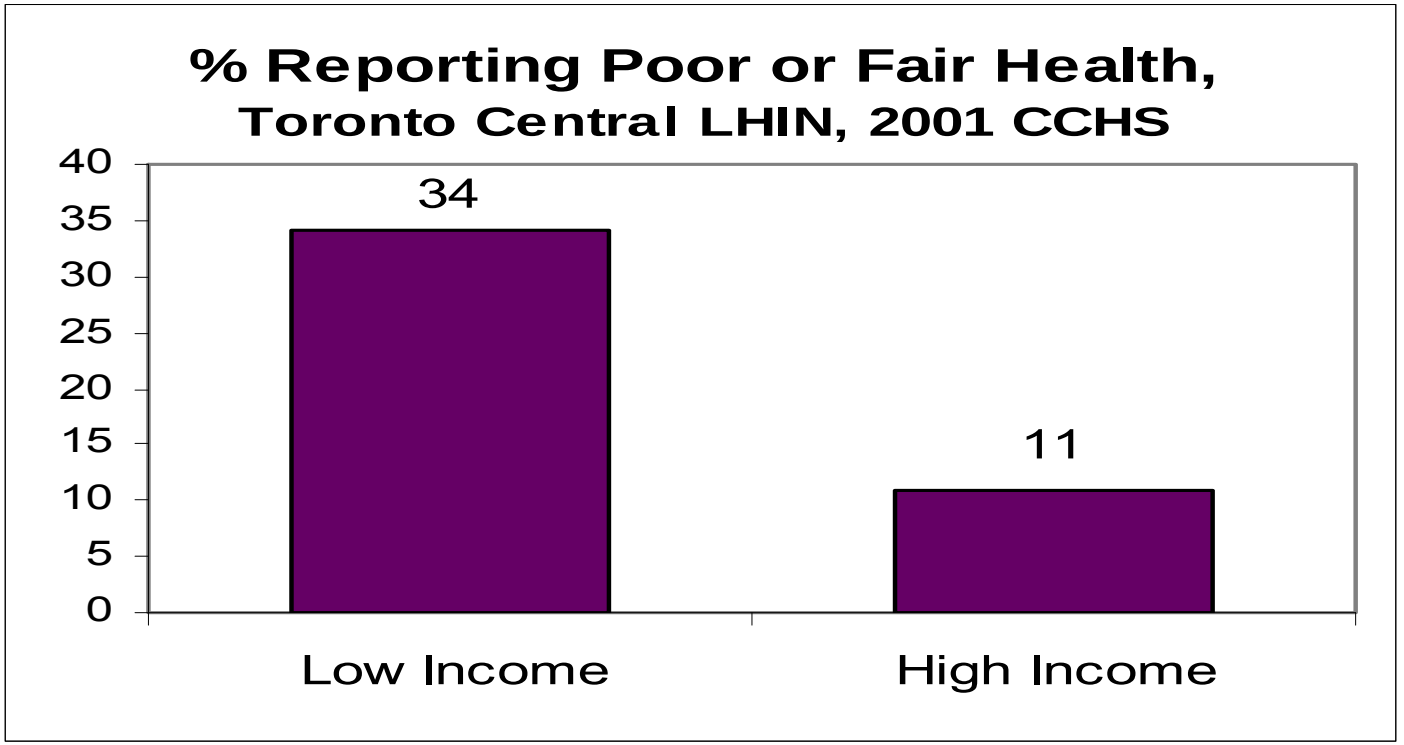
Lower Income: Poorer Self-rated Health



Three fold difference in self-rated health among lowest and highest income neighbourhoods.

Canadian Community Health Survey 2001, Respondents
Glazier et al. Primary Care among Disadvantaged Populations. Primary Care.
ICES Atlas, 2006. www.ices.on.ca/intool

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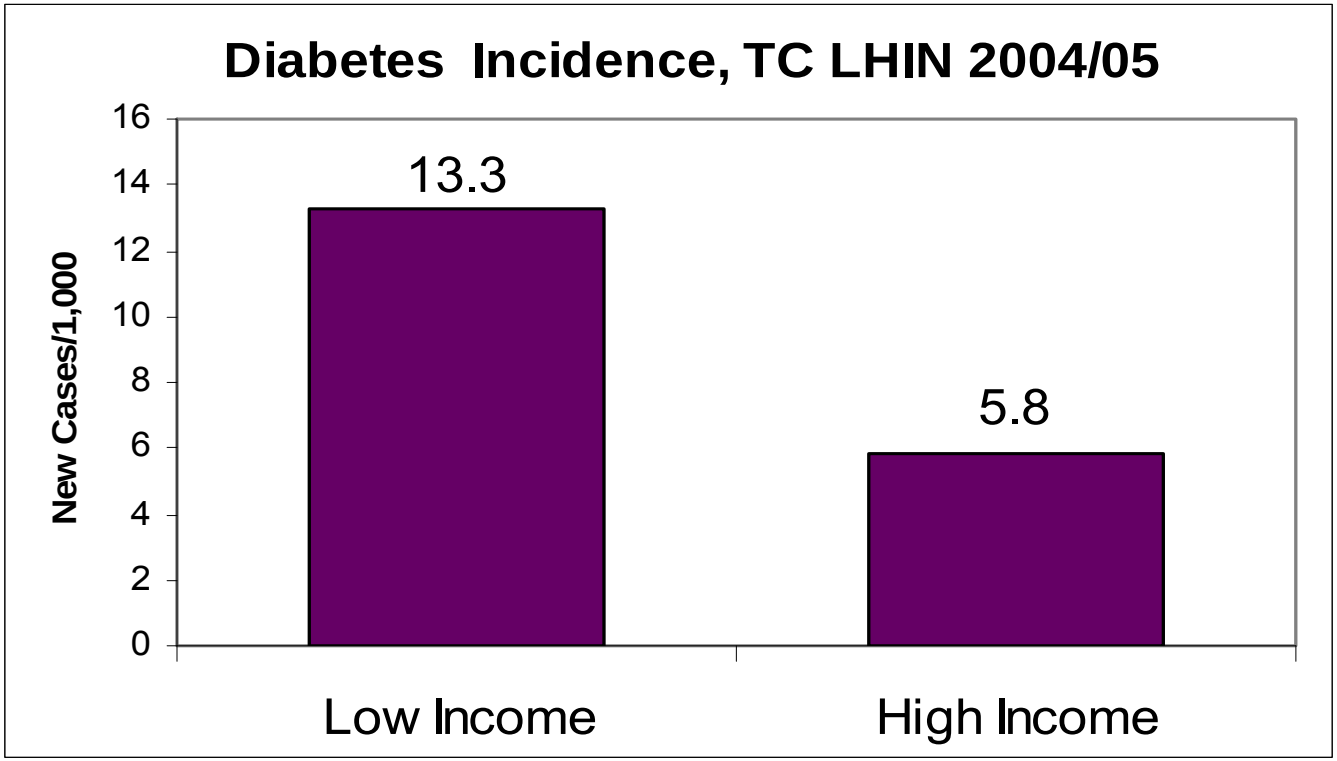
Lower Income: Higher Diabetes Rate



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

Age Standardized Rates. Data Source: Ontario Diabetes Database, 2004/05
www.ices.on.ca/intool

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Starting Points: Health Equity

What is health equity?

- reducing or eliminating socially structured inequalities and differential outcomes
- ensuring equal opportunities for good health for all
- linked with broader ideas about fairness, social justice, civil society, human rights
- much of the solution lies in macro social and economic policy – and in policy collaboration and coordination across governments, sectors, "policy silos"
- but there is a great deal that can be done within the health system to reduce the adverse impact of health disparities
- and we know a lot: across Ontario, there's tremendous potential to build on current and promising community-based initiatives that address health equity now through underlying determinants of health

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Acting 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 disease prevention and management – plan and deliver through an equity lens

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Starting Points: Health Equity in Ontario

- "improving the accessibility of the health system through outreach, location, physical design, opening hours, and other policies; improving the patient-centredness of the system by providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care; and cooperating with other sectors to improve population health." (Ontario Health Quality Council, 2007)

- "Fair and equitable health outcomes across diverse communities will result from utilizing an inclusive health framework for publicly funded and other universally accessible health services…. We further recognize the intersecting and compounding impact of various forms of marginalization, including, but not limited to, race, national or ethnic origin, class, spirituality or faith, sex, gender, sexual orientation, age, mental or physical disability (visible and invisible), immigration or family status, and identified arising from these, on individuals' and communities' state of health and well being." (Health Equity Council, 2005)

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Ontario's Current Health Equity Landscape

Provincial government

- Ministry of Health and Long-Term Care (MOHLTC): ten-year strategic vision/plan for Ontario's health care system with equity as a prominent direction (new unit to coordinate policy activities on health equity); and Health Based Allocation Model (HBAM) to fund province's Local Health Integration Networks (LHINs)
- cross-ministry/sector/policy field collaboration: key Ministries and central agencies engaged in comprehensive policy research on health equity
- political commitment: Poverty Reduction Strategy (The Cabinet Committee on Poverty Reduction)

Local service enablers: LHINs

- must operationalize health equity as part of mandate, have identified diversity, equity and health disparities as critical problems and moving to develop local health planning and delivery solutions

Community-based groups, networks

- representing hospitals, health promotion organizations, community health centres, community-based agencies, educational/engagement organizations, service providers, policymakers, researchers, e.g., Health Equity Council, GTA Community Health Centres Urban Health Framework, Working Group on Health Equity, The Wellesley Institute

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Ontario's Best First Steps: The Health Equity Roundtables (hosted by The Wellesley Institute, 2007 ongoing)

Key enablers identified to bring innovation to action…

- We need sustainable funding for core services/operations and flexible funding for innovation to ensure community-based change
- We see value in public health models based on population health approach
- Real community consultation matters, e.g., advisory panels, community-based research

Key gaps identified…

- We know a lot but not enough in depth ⇒ need scoping research on range, nature, effectiveness, value, potential impact of community-based innovation
- We don't have one forum or infrastructure for systematically searching for on-the-ground innovation, identifying what's promising, sharing information/lessons learned, assessing effectiveness/potential, scaling up ⇒ need scoping research and resources to create infrastructure to make innovation knowledge accessible
- Communities are concerned about HBAM and related funding formulae, i.e., that health disparities and diversity aren't reflected in modeling, that funding for key community-based agencies such as CHCs will create disincentives to continue health equity work

Key message…"Think big, but get going"

- while evidence gaps exist for relationships among specific health outcomes, determinants and/or communities/populations, we have enough credible evidence to raise health disparities as critical emerging public policy issue

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Ontario's Best First Steps: The Health Equity Roundtables (hosted by The Wellesley Institute, 2007 ongoing)

Group 1 initiatives, "Ready To Go"

- lots of equity-based, community-based, innovative, front-line service delivery and enablers already exist - ready to go - across Ontario; they are time-sensitive, based on current models/evaluations, have broad consensus that they work

Group 2 and 3 initiatives, Promising Directions and Catalysts

- more emerging, high-potential ideas and practices from community-based advocates, service providers, and researchers; they show real potential but may need further assessment or mid-term evaluation, or they open the door to broader, more system-level changes

Despite the complex roots of health disparities, the health care system can do a lot:

- identify and reduce barriers to access
- target investments and interventions in the most health disadvantaged communities and populations
- build equity and diversity into all service delivery and planning
- enhance equity-focussed primary and preventive care

Emerging consensus among community and sector-based stakeholders

- for example, Ontario Health Quality Council (OHQC) identifed accessibility, patient-centredness and population health approach as part of high-performing health system (*2007 Report on Ontario's Health Care System,"* OHQC, 2007)

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Ready to Go

Initiatives that are time-sensitive, based on current models/evaluations, have broad consensus that they work

Some examples…see Appendix A for the full proposal menu

- Primary Care Follow-Up Protocol for post-discharge cardiac patients for community-based follow-up primary care
- community-based research projects funded by the MOHLTC Health Equity Unit that respond to specific gaps in outcome research to support building of inventory of best practices/promising approaches and knowledge dissemination within and outside Ontario Government
- MOHLTC/LHINs resourcing to support hospitals to work collectively across their institutions to build equity processes into Hospital Equity Plans through planning process and promote common principles, mechanisms and outcomes among individual plans in advance of October 2008 deadline

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Promising Directions

Initiatives that show real potential but may need further assessment or mid-term evaluation

Some examples…see Appendix A for the full proposal menu

- community-based research (CBR) projects that compare quality and cost outcomes based on community funding assessments vs.. funding models
- CBR projects that collect differentiated data around determinants of health such as income and race/ethnicity that could be used to adjust HBAM funding allocations after the formula has been applied (public health and settlement services are good data sources)

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Catalysts

Initiatives that open the door to broader, more system-level changes

Some examples…see Appendix A for the full proposal menu

- implement advanced access in primary health care and shared care models for medical specialists
- recognize role and responsibility that CHCs have assumed for non-insured clients and fund CHCs to provide health care to them
- replicate current best practices in peer-based research and service delivery by developing community-based research projects that recruit, train and involve peer inclusion researchers from communities specifically affected by health disparities as partners in the conception, development, creation, and dissemination of their stories and show the people and places that contribute to health and social disparities; and/or as community-based peer workers in front-line outreach and service system navigation services, e.g., public health, nutrition (models: Street Health, Access Alliance, Ontario Women's Health Network (OWHN))

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Appendix A

Best Advice: Community Voices

- consensus from 35 participants at the 2007-2008 Health Equity Roundtables and follow-up Working Session hosted by The Wellesley Institute, representing established and emerging institutional and community-based service providers, researchers, policymakers, and advocates from the health, social service, and community development sectors
- prioritized from about 60 initiatives discussed
- reflects lived experience of GTA communities most affected by health disparities – both providing and receiving health care as community members and as members of the public
- broken into three groups: "Ready To Go" initiatives that are early wins; "Promising Directions" that show real potential but may need further assessment or mid-term evaluation; and "Catalysts" that open the door to broader, more system-level changes
- further identified by whether main thrust is towards direct service delivery, community-based research, or community engagement
- foundation for communities and policymakers to create a collaborative strategy/plan by mixing initiatives from all three groups for short-, medium- and long-term delivery

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Ready To Go

Initiatives that are time-sensitive, based on current models/evaluations, have broad consensus that they work

Direct service delivery

- Primary Care Follow-Up Protocol for post-discharge cardiac patients for community-based follow-up primary care
- no three-month waiting period for OHIP eligibility
- vulnerable populations that may not have been reached during recent LHINs' consultations are represented before guidelines and other implementation decisions are finalized, ongoing participation of diverse communities into program monitoring and evaluation, recognize that homeless seniors need parallel forms of support
- track new provincial commitment to dental services for low-income Ontarians, ensure increased access to dental/oral health care for people with no OHIP or private supplementary health insurance coverage who are aged 19-64 years

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Ready To Go

Initiatives that are time-sensitive, based on current models/evaluations, have broad consensus that they work

Community-based research

- community-based research projects funded by the MOHLTC Health Equity Unit that respond to specific gaps in outcome research to support building of inventory of best practices/promising approaches and knowledge dissemination within and outside Ontario Government

Community engagement

- work with LHINs on collection and disaggregation of data along key demographics and determinants of health, and on implications of the HBAM funding formula (particularly for prevention initiatives) at the local level (goal: scale local experiments up to develop standardized diversity and equity-relevant data to be collected Ontario-wide)
- MOHLTC/LHINs resourcing to support hospitals to work collectively across their institutions to build equity processes into Hospital Equity Plans through planning process and promote common principles, mechanisms and outcomes among individual plans
- support continuation of Aboriginal Healing and Wellness Strategy (AHWS) as model of holistic primary care and prevention that recognizes and respects diversity within and among communities

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Promising Directions

Initiatives that show real potential but may need further assessment or mid-term evaluation

Community-based Research Partnerships

- CBR projects that show alternate funding scenarios for key postal-code level GTA communities based on allocations that control for specific social and economic determinants of health, as opposed to only historical utilization rates that create disincentives for health prevention/promotion, control for costs that are specific to health equity but also demonstrate cost efficiency (e.g., translation costs and asthma management) and highlight emerging HBAM conceptual and implementation issues
- CBR projects that compare quality and cost outcomes based on community funding assessments vs.. funding models
- CBR projects that collect differentiated data around determinants of health such as income and race/ethnicity that could be used to adjust HBAM funding allocations after the formula has been applied (public health and settlement services are good data sources)

Community engagement

- track commitment and highlight evidence-based correlations between a poverty reduction agenda, health disparities, and health equity

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Catalysts

Initiatives that open the door to broader, more system-level changes

Direct service delivery

- implement advanced access in primary health care and shared care models for medical specialists
- recognize role and responsibility that CHCs have assumed for non-insured clients and fund CHCs to provide health care to them
- replicate current best practices in peer-based research and service delivery by developing community-based research projects that recruit, train and involve peer inclusion researchers from communities specifically affected by health disparities as partners in the conception, development, creation, and dissemination of their stories and show the people and places that contribute to health and social disparities; and/or as community-based peer workers in front-line outreach and service system navigation services, e.g., public health, nutrition (models: Street Health, Access Alliance, Ontario Women's Health Network (OWHN))

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Catalysts

Initiatives that open the door to broader, more system-level changes

Community-based research

- working from existing definitions as representing current context and experience, craft consensus on a working core definition of health equity to inform the development and implementation of programs, services and projects by both government and communities, as well as community engagement strategies

Community engagement

- work with LHINs to rebalance focus “upstream” on prevention approaches and resourcing that work from a determinants of health perspective
- create series of “Anatomy of Disparity” case studies and key messages for different population health groups, e.g., diabetes, and/or different determinants, e.g., poverty, through participatory media (film, print, visual) that involve people with lived experience in conception, development, creation, and dissemination of their stories and show the people and places that contribute to health and social disparities
- create parallel series of “Anatomy of Poverty” case studies and key messages to make conceptual, actual, and interministerial link between poverty reduction and health equity that is interdisciplinary, multi-sectoral, and action-focused and can be used as model for comment and analysis of other determinants of health and lead to policy/program/funding changes

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Catalysts

Initiatives that open the door to broader, more system-level changes

Community engagement, cont.

- profile link between chronic disease and health disparities at upcoming 2008 events
- build relationships with new partners such as public health, addictions and mental health, CHCs, settlement services, and labour around their specific experiences with health disparities; and develop parallel engagement strategies both for internal sector/profession/sector audiences and external audiences of policymakers and decision makers

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- further resources on health equity, health reform and the social determinants of health are available on our site at http://wellesleyinstitute.com
- specific backgrounders and dialogue highlights from the roundtables are at http://www.wellesleyinstitute.com/health-equity-roundtables
- the roundtables were facilitated by Dr Michael Rachlis and Margot Lettner, Wasabi Consulting; and this deck was drafted by Margot and Bob

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Wellesley Institute and Health Equity

Wellesley Institute

funds and supports 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

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