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Addressing Health Disparities

Best Practices from Regional Health Authorities

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Commissioned Grants

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Prologue

Since this report was completed, recent political decisions in two provinces have had implications for its content and require comment.

In mid-May, the Alberta provincial government dissolved its nine health regions into one provincial authority. The reasons for this sweeping and unexpected reform were not made clear. The Calgary Health Region as described in this report no longer exists, although the impact on its projects is yet to be determined.

At the end of March, the newly elected Saskatchewan provincial government withdrew funding of $8 million dollars committed by the previous government to a Saskatoon community development project, Station 20 West. The Saskatoon Health Region was holding the funds for the project and as noted in this report, had become an important partner in pursuing a strategy to address disparities in the city. The provincial government, however, directed the health region to withdraw its support for the project and reallocate the funds (i.e. to upgrade existing healthcare facilities).

The large change in Alberta and the smaller but indicative change in Saskatchewan speak to the political nature of the health care system and of health care regionalization. The reflections section of this report notes the importance of the provincial context and policy environment within which regional health authorities operate. A clear mandate with support from the province can be an important facilitator for those health regions actively pursuing equity strategies. However, provincial policy can also represent a barrier if that mandate does not include, or de-prioritizes, addressing health disparities.

A. Background

This briefing paper examines equity strategies of regional health authorities (RHAs) across Canada. The research was not intended to be comprehensive, but rather quickly surveyed what is in place and what is being thought about in some of Canada's largest RHAs. The paper is intended to inform the equity strategy being developed by Dr. Bob Gardner of the Wellesley Institute for the Toronto Central Local Health Integration Network (LHIN).

The study sought to identify RHA strategies to address health equity, the policies and programs being implemented and how RHAs interact with other authorities on questions of equity. It looked for resources and levers that enable community-based service providers and other organizations to address health disparities on the ground, and that support hospitals, community health centres, clinics and other providers to build equity into their service delivery and

organization. It also looked for institutional, professional and other barriers to successfully drive equity strategies at the regional level. Finally, the study drew out some implications of key differences in the Ontario situation and that of RHAs in the rest of Canada.

This work is timely in that addressing health disparities is currently on the public agenda. Various commissions, studies and reports are raising awareness on the issue, including the WHO Commission on the Social Determinants of Health and the first report of Canada's Chief Public Health Officer (due in the spring).

A focus on health equity is part of a population health approach to health, which has been official policy in most of Canada since the 1990s, and is part of the move to regionalization, which also began in the early 1990s. There has been an extra boost in the last few years, with the creation of the Public Health Agency of Canada and strengthening of public health in Canada (where public health is understood to include population health). In most provinces, public health and population health programming have become increasingly linked, if not merged altogether, as is the case in Quebec.

The study focused on six RHAs: Vancouver Coastal, Calgary Health Region[1], Saskatoon Health Region, Winnipeg Regional Health Authority, l'Agence de la santé et des services sociaux de Montréal and Capital Health of Nova Scotia, based in Halifax[2]. We selected these RHAs because they are principally urban centres, where the situation is closer to that of Toronto and because they were known to be leaders in addressing issues of equity and diversity. We selected a maximum of one RHA per province.

Sources for the study included documents on the RHA websites and on the websites of relevant organizations (e.g. Canadian Population Health Initiative, Canadian Public Health Association, etc.) and discussions with key informants. Eight key informants were interviewed – six from the four western provinces, one from Quebec and one from Nova Scotia. All were managers, six from RHAs, one from the provincial health ministry, and one from a provincial research organization[3].

Note that for all RHAs in the study, health disparities are experienced within the health region. This is in contrast, for example, to regions in the north of Canadian provinces, where disparity is more an issue of the region as a whole compared to other regions. There are extremes of rich and poor within all these health regions. In Vancouver, Calgary and Montreal, there are highly

[1] In mid-May, the Alberta provincial government dissolved its nine health regions into one provincial authority. The Calgary Health Region as described in this report no longer exists, although the impact on its projects is yet to be determined.

[2] For clarity of expression, we use the generic phrase regional health authority (RHA) when referring to all of these organizations.

[3] We express our appreciation to these key informants for their time and attention to this research.

visible homeless populations. For the four western health regions, the Aboriginal population represents a large segment of those with lower life expectancy and poor living conditions, although they are not the only poor.

Please also note that the study was prepared as an indicative briefing rather than a comprehensive inventory. The tight focus and timeframe did not permit in-depth investigation into specific programs or services. Nevertheless, the paper as a whole provides a good picture of the range and variety of efforts by RHAs in addressing health disparities.

B. Strategies to address health disparities

Strategies to address health disparities can be discussed in different ways. There are at least two dimensions along which we could categorize them. One dimension might be along the pathway to health, from the distal (or structural) determinants, to the proximal (behavioural) ones, and then to the treatment and management of health problems. A second dimension could be according to the structural organization of a typical RHA, i.e. hospital care, clinical care, public health, health promotion, research, etc. After interviewing the key informants, we decided to organize the discussion in the following categories, which are a combination of the two dimensions mentioned.

1. Explicit strategy and policy documents
2. Information for planning and raising awareness
3. Multi-sectoral and multi-organizational strategies for non-medical determinants
4. Health services

Following the presentation of strategies in the four categories, we present some general reflections by the key informants about barriers and facilitators to addressing health disparities.

B.1 Explicit strategy and policy documents

Explicitness by the RHA on the goal of reducing health inequities is an important characteristic. It is a sign of commitment, as well as a way of explaining to the public the importance of the issues and raising awareness and understanding. For example, in Saskatoon Health Region, the current strategic planning document for 2007-2010 makes an explicit commitment to addressing disparities. This is one of the prominent documents on the website that has in general many references to addressing disparities. Vancouver Coastal has a Population Health Framework as one of its core organizational documents, which has a commitment to equity.

There is a section of the RHA website devoted to materials on population health which provides resource materials and tools for dealing with equity. One of the goals of the Calgary Health Region 2006-2009 plan is a focus on reducing health disparities. The region's Community Service Development Strategy has a goal to create an integrated, innovative and sustainable community-based health system to improve overall population health and reduce health disparities. In Winnipeg, the Community Development Framework was adopted by the WRHA board and has guided their strategy.

Commitment to equity strategies at top management levels was noted in Vancouver, Saskatoon and Montreal and interviews spoke to its importance. Addressing disparities required re-allocation of resources (financial, human and otherwise), and required changes in the operations of the organization. In general, the commitment and support of the CEO, the Chief Public Health officer, and a Vice-president or director of population health are key. But the support of the whole management team is important for alignment. The interview from Nova Scotia's Capital Health also noted that the board has a committee for population health.

The strength of the public and population health departments in these RHAs was noteworthy – the department had a willingness to include the social determinants of health as part of the public health equation. Vancouver Coastal's former public health officer, John Blatherwick, is one of the longest-servicing CMOs in Canada and was a strong and vocal supporter of addressing disparities. The current CMO, Patricia Daly, continues the tradition. She was, for example, scheduled to attend a press conference about poverty in Vancouver the morning of the interview. Saskatoon CMO Cory Neudorf is also a vocal advocate for addressing disparities, spearheading various initiatives in the RHA as well as nationally through his work with the Canadian Population Health Initiative (CPHI).

In Montreal, CMO Richard Lessard is also a well-known vocal advocate for addressing health disparities – he has been president of the CPHI board. In Montreal, the regional public health department is large and well-resourced compared to other public health departments in Canada. Since 1998, the public health department has focused on social inequalities as a key determinant of health.

B.2 Information for planning and raising awareness

In general, the mandate of RHAs requires accountability and planning based on the health needs of their population. This mandate is one that reveals disparities and encourages addressing them. In Manitoba, for example, RHAs are mandated by the provincial government to carry out needs assessments every five years. There is a set of core indicators that must be reported on, which includes indicators on disparities.

Further, there is a growing awareness of how to carry out needs assessments in such a way as to better identify disparities, and in ways amenable to strategizing, i.e., measures of health and

social conditions are collected by age group, gender, ethnicity and location, and often by socio-economic group. The interview from the Manitoba Centre for Health Policy noted that they used to age-standardize all their health data, as researchers typically do, but were asked instead to report the data by age group and by sex, to reveal disparities. Reporting data by neighbourhood or their close equivalents also facilitates planning. The Saskatoon interview reported their region starting to make use of an index of deprivation (first developed in Montreal).

The importance of relevant indicators was highlighted by almost all interviews. For example, Capital Health is in the process of developing a set of community health indicators that will identify inequities.

Obtaining local data is key for raising public awareness. Montreal, Calgary and Saskatoon interviews all said explicitly that neighbourhood data showing disparities in life expectancy and related conditions had an effect on public attitude. It aroused a moral sense that people living in the same city should not experience such different health outcomes and life conditions.

Saskatoon CMO Cory Neudorf has spearheaded, with CPHI and Montreal CMO Richard Lessard, a study of disparities in 19 Canadian cities. When the results are published later this year, it will lead to increased knowledge and public awareness.

Calgary and Saskatoon health regions are each establishing population observatories for surveillance. Montreal already has such an observatory (OMISS).

RHAs in Manitoba are linked to the Manitoba Centre for Health Policy for their information and knowledge translation needs. The Need to Know project helps ensure that information is framed and translated to be relevant and useful to decision-makers in the regions. In the context of a mandate to address disparities, this adds an effective information base. Manitoba Annual Rural Day brings together RHA board members from all the regions to learn about trends in the data and to develop shared understanding of the issues. This is considered a strategy to affect future decision-making.

The East Calgary Health Services Initiative was recently launched after the Health of the Region 2005 Report identified specific health disparities between community groups in the Calgary Health Region.

Vancouver Coastal has hosted conferences on various disparities issues, and is planning to host another in 2008. The health region has a research department linked to the Vancouver universities, whose research agenda includes topics of child poverty, homelessness, etc.

Saskatoon Health Region’s research on disparities, in addition to the studies discussed above to document disparities in Saskatoon by neighbourhood, includes surveys about the attitude of residents to the issue. They are using these documents for planning as well as for raising

awareness and changing attitudes among the public. The region has partnered with academics at the University of Saskatchewan in doing community-based research.

Montreal has the benefit of the several universities in the city, as well as the provincial INSPQ, but its most important asset in dealing with disparities is the Centre Lea-Roback (CLR), a research centre dedicated to studying health disparities in Montreal. The Montreal public health department (DSP) was a founding partner for the CLR, and continues to be a principal institutional partner. The CLR is housed within the DSP.

Educating the public about disparities is an important component of RHA strategies. As we mentioned above, the Vancouver interview demonstrated how a member of the upper management is often present at press conferences, not only to show SHR support, but also to explain the point that social inequities lead to health inequities.

The Montreal interview stressed that an important activity for public health is to communicate with the public and with policy makers. This communication is about affecting the values of policy makers and the public – showing that that there are consequences to large gaps in health and in living conditions.

The Saskatoon Health Region CMO has also communicated to the public through the newspapers, making the case that poverty and health are related, and Saskatoon must address its level of poverty.

Community engagement and consultation were also mentioned as strategies to both learn about what disparities exist, and to raise awareness and buy-in about challenging them. The Capital Health interview, for example, stressed the importance of combining information from community consultations, with local surveillance data and research information, and bringing that information to staff, board and community members. The Winnipeg interview described their community engagement strategy as using a variety of approaches, such as Advisory Groups on specific topics (e.g. mental health), local area consultation groups, consultations with community organizations or advocacy groups, and focus groups on specific topics.

B.3 Multi-sectoral and multi-organizational strategies for non-medical determinants

Partnerships and coalitions

As part of their population health mandate, regional health authorities have developed partnerships at the regional level with organizations working on the non-medical determinants of health. Saskatoon Health Region participates, for example, on the Regional Intersectoral Committee for Saskatoon, a grouping that brings together agencies working in health, education, justice and other sectors, to increase collaboration. Vancouver Coastal is a member

of the local Campaign 2000 Poverty coalition, to end child poverty. The Montreal RHA participates in many regional coalitions, including the regional plan on homelessness and the city plan for families. Calgary Health Region has worked with the City of Calgary and with the school board to define common units of service, called social districts, to enable more coordinated multi-sectoral programs and services. The Calgary Health Region also has an Aboriginal Community Health Council, which promotes and advocates culturally appropriate health services for Aboriginal people served by the region. In Winnipeg, there is an Aboriginal Health and Human Resources Advisory Committee to the RHA board. In Winnipeg as well, the Integrated Service Initiative is bringing the health region together with other service departments, such as social services. One of the objectives is to better address the needs of vulnerable clients, who often have multiple needs, which cross department lines. Capital Health's community health boards partner with many organizations to address disparities, such as school boards, for example. The RHA also participated in the development of a recent poverty strategy and an initiative to improve services for the Francophone population.

In seeking to take intersectoral relationships a step further, Saskatoon Health Region CMO, Cory Neudorf, has designed a new study, focused on governance, intended to develop joint leadership between the health region and municipal councils.

Community development

Community development initiatives, which are present in several RHAs, are also part of an intersectoral approach. Community development focuses on strengthening the ability of a community to organize itself effectively. It involves relationships with community-based organizations, promoting participation, deliberation and reflection, and building local leadership. Community development efforts by RHAs are targeted at local areas where poverty is high and civil society is weak, as a strategy to bring about more equitable social conditions, and thereby better health.

The Winnipeg RHA Community Development framework includes promoting organizational development, networking and inter-sectoral collaboration, and supporting and facilitating public participation initiatives and local area development.

In Saskatoon, the Public Health Department has several staff who have community development responsibilities. Saskatoon RHA has recently established a new program call Building Health Equity. It targets the "core", a set of neighbourhoods that experiences very high health disparities. Creating the program required a reallocation of public health resources, with school-assigned public health nurses and animators for community-based relationships with residents and organizations.

Capital Health's community health boards are mandated to foster community development at the local level and are supported by coordinators who have community development

experience. The boards have a community development fund that provides funds for grassroots initiatives many of which deal with disparities.

Specific initiatives and programs

Leading RHAs have many collaborations and partnerships with other sectors and agencies to address the adverse impact of the wider social determinants of health. Saskatoon Health Region participates in Comprehensive School Initiatives, which is a strategy for placing the school as a focal point for improving the quality of life of the community. SHR staff work with educational and other agencies to develop the schools in poorer areas of the city.

Capital Health's public health portfolio is also involved in initiatives that address disparities, such as food security and teen health centres in all public high schools within the region.

Vancouver Coastal has chosen a focus on child poverty; partially because the issue clearly addresses fundamental social inequalities, but it is relatively non controversial and is closely linked to health. There is also a great deal of information available for both planning and advocacy. Montreal RHA also works on an initiative for poor mothers and children, which encompasses various strategies.

Vancouver Coastal has eight local community food action committees, whose purpose is to facilitate food security initiatives. Montreal and Saskatoon RHAs also have food security programs.

In Montreal, the public health department intervenes and advocates with many other agencies, providing information and advice on issues of inequity. For example, their recent submission on transportation in Montreal included a section explaining the important role of transportation in reducing or increasing social exclusion and social inequity. Their input into the family action plan for Montreal urged City Council to address equity concerns in urban management plans, including for example, the need to address the problem of the increasing number of conversions to condos decreasing the number of affordable housing units. Their recent paper for the multi-agency homelessness initiative provides proposals for renewed efforts over the next few years.

B.4 Health services

In general, primary health care is the route indicated by interviews from Vancouver and Saskatoon as having promise for addressing health disparities in health services. It involves locating team-based services in areas of the RHA where vulnerable populations live and co-locating multiple types of services designed to address the medical and social needs of vulnerable populations (i.e. medical and dental clinics with drop-in ability, programs for healthy mother and healthy baby, food security, sexual health, family and psychological support, literacy, housing, etc.)

Some of these initiatives are long-standing. Montreal for example, has CLSCs, community-based centres throughout the city to service local populations, as has had the rest of Quebec since the 1990s. Vancouver also has long-established community health centres throughout the city, as does Winnipeg RHA. In Winnipeg, the primary health care centres, which are funded by the RHA under a performance agreement, but have their own boards, deliver a wide range of non-health services affecting health determinants.

In Saskatoon, the RHA has established a new primary health care site in the poorer area of the city, and a commitment to partner with other groups at another, which will include, as well as clinics, a housing development, library and food store[4]. The Building Health Equity program also provides services to the underserved core area.

Capital Health has developed the North Preston Health Centre – a community-based centre designed to address the needs of the local population with a high percentage of African Nova Scotians.

As we described above, the East Calgary Health Services Initiative was recently launched after the Health of the Region 2005 Report identified specific health disparities between community groups in the Calgary Health Region. The RHA initiated the East Calgary Health Services Initiative to determine and implement strategies that would focus on improving the health status of vulnerable communities living in the East Calgary catchment area.

The Calgary Aboriginal Health Program also has a clinic that specifically serves people of First Nations, Métis and Inuit ancestry. It will soon be linked to the Elbow Healing Lodge. Winnipeg RHA also has an Aboriginal Health Program focusing on enhancing existing health services and employment opportunities, and establishing culturally appropriate services for Aboriginal people in the health system.

We described above the Montreal initiative, focused on mothers and children in poverty. Part of this initiative targets family physicians to assist them in interacting with patients from these vulnerable populations, and to be more effective in addressing factors related to disparity (i.e. poverty, illiteracy, isolation, powerlessness, etc.). A set of questions for physicians to ask is posted on the Internet in both French and English.

Vancouver Coastal is initiating development of an Equity Lens for staff to use. It is based on a tool developed in New Zealand. They will use mechanisms such as hospital rounds to educate staff on its use, as well as holding workshops to work with staff in applying the Equity Lens to

[4]As noted in the prologue, after this report was written, the Saskatchewan provincial government directed the health region to withdraw its support for the project (Station 20 West) and reallocate the funds.

specific programs (e.g. what does an inequity look like for the clients in my nutrition program and what can I do about it within the parameters of my program?)

In Capital Health, the Diversity Initiative is intended to raise awareness among health region staff about the diverse needs of the region clientele, including the four specific target groups of African Nova Scotians, Acadians, MicMaq and immigrants.

On a related note, another interview affirmed that whatever the program, using specific approaches to reach vulnerable and marginalized populations is a key factor in reducing disparities. For programs like smoking prevention, cancer screening, breast feeding, and the like, using strategies that "take the easy way" and do not address the conditions of the marginalized will only serve to increase disparity.

Other programs of note that provide services to extremely vulnerable populations include street health programs and supervised injection sites, examples of which were discussed in the Vancouver, Saskatoon and Montreal interviews. Such programs can be very controversial and require strong commitment by the RHA, as well as good communication to explain the programs to the population.

Housing as a health determinant, and services to the homeless in particular, were discussed in the Montreal, Vancouver and Calgary interviews. In Vancouver, the health region's efforts have focused on dealing with housing for those with mental health and addictions problems. There is a concerted effort to ensure that those receiving treatment through programs or at hospital emergency rooms are not released to a homeless situation. Similarly in Montreal, where there has been a multi-agency initiative against homelessness since the 1990s, one of the hospitals focuses on drug addiction and its social consequences. The health services staff work with organizations for emergency housing. The initiative has also sensitized police, when arresting people, to think about their possible social deficits and work with others to address their basic needs. The issue of discharging patients who have no home is also on the agenda of the Calgary Health Region.

C. General reflections

C.1 Barriers

Almost all interviews stated that one of the barriers to addressing health disparities was an overly medical orientation and prioritization of medical solutions among staff. For example, even when addressing a disparity such as that in women's health outcomes, a proposed solution

might be to have a women's health services program rather than to have programs in the community that support women's autonomy, efficacy and resources.

A related barrier mentioned by most interviews was that public health (and population health) is not sufficiently protected from budget pressures.

One interview also spoke about insufficient capacity of public and population health professionals.

Two interviews talked about the attitude of the city council in their region as a barrier. Councillors see health as health care and not their responsibility. They do not perceive a common purpose with the health region.

C.2 Facilitators

All the strategies presented in section B are certainly facilitators. We now note other facilitators that have a more overarching or contextual nature.

The provincial governments have a facilitating role in setting the context. The explicit mandate of regional health authorities as being responsible for population health is important[5]. Although there continue to exist barriers, as discussed above, to the full implementation of population health strategies, the mandate sets the stage for the strategies discussed in this paper.

The existence of provincial resources and legal frameworks is helpful to RHA efforts. The BC Provincial Health Services Authority is a provincial resource, providing valuable surveillance data. In Manitoba, the mandated community assessments, including disparities indicators, focus attention on population needs. Provincial resources include the Manitoba Centre for Health Policy to provide surveillance data, and the related Need to Know program that supports RHAs and the Centre together in knowledge exchange. In Quebec, the Public Health Act, which integrates population health and mandates use of health impact assessments, is an important provincial policy instrument. Specific to addressing disparities is the Quebec Poverty Law. The interview explained that it is not necessarily the regulations in the Poverty Law that are so valuable, but the framework and commitment expressed in it that provide a lever for the RHA to address disparities. We also know from other studies that initiatives funded at the provincial and federal levels will influence RHA programming, by providing targeted resources, e.g. healthy baby initiatives, primary health care, diabetes prevention programs, etc.

As we were requested to do, we asked the interviews about what the structure of RHAs brings to addressing disparities. Interviews suggested that RHAs can be more aligned and coherent in

[5] The provincial mandate can also represent a barrier if it does not include, or de-prioritizes, addressing health disparities.

their strategies, and the resources of the organization can be allocated to addressing health disparities, once the RHA decides it is a priority. Important information can be accessed more easily (i.e. city-wide emergency room data on services and populations). They also noted that they can engage staff more directly, i.e. staff workshops, and they can use workforce policies to reallocate staff where appropriate.

Interviews stressed the importance of surveillance data of the right kind. It should show where the disparities exist, both to allow for planning and to increase public awareness and support.

Also mentioned was the value of research on determinants of health, such as how education, food security, and income affect health outcomes.

Some interviews spoke of the value of continuing to educate the public and policy makers. And in this line of thought, some interviewees reinforced the traditional advantage of public health informing the population directly and remaining independent of government

D. Summary table

Strategies
Explicit commitment from the organization – official strategy documents
Commitment to equity strategies at top management levels
The strength of the public and population health departments
Needs-based planning at the regional level
Surveillance data that identifies disparities and facilitates targeted programming
Neighbourhood-level data
Raising public awareness and engaging and consulting communities
Research, conferences on disparities issues
Resources for research: RHA-based units, population observatory
Links to universities, provincial research organizations

Regional partnerships and coalitions on multi-sectoral collaboration
Participation in and support to multi-agency initiatives related to specific determinants: e.g. child poverty, food security, young mothers, education
Specific partnerships – i.e. Aboriginal
Community development initiatives and equity programs targeted to underserved and vulnerable populations
Establishing multi-level primary health care services in underserved locations
Establishing target programs for specific vulnerable populations e.g. Aboriginal clinic, street health
Training for staff and related tools such as an Equity Lens to ensure services and planning with equity in mind
Attention to housing needs, especially those with mental health and addictions problems.
Barriers
Prioritization of medical solutions and budgets
Insufficient capacity of public and population health professionals.
City councils not interested in common purpose
Facilitators
Provincial government mandate reinforces RHA role regarding population health and disparities
Provincial resources and other support
Authority to reallocate resources
Ability to work with staff to re-orient services

Public health independence in role of informing and otherwise communicating with the public about disparities