

# Building Equity Into Ontario's New Health Care Action Plan

POLICY BRIEF | BOB GARDNER | MARCH 2012

The Minister of Health and Long-Term Care recently released an ambitious plan to transform Ontario's health care system. It identifies key drivers of change to improve access, quality and value; all underlain by improved system coordination and coherence, and by service and quality innovation. These are positive directions, but there is a critical element missing. We need to ensure that this transformation also contributes to reducing pervasive and damaging inequities in health that exist in the province, so we need to build equity into these reforms from the outset.

The Action Plan emphasizes the high proportion of costs attributed to preventable illness. However, the plan should also stress that health inequities are a major cause of avoidable illness and system costs. There is an overwhelming body of evidence demonstrating the impact of wider social determinants of health and of structured social and economic inequality on shaping population health. All of the particular challenges noted on the Action Plan — chronic conditions, emergency room use, navigation — are worse for lower income people, recent immigrants, and others facing social exclusion.

Similarly, the solutions proposed — from increasing access to community-based services, through ensuring seniors can stay in their homes longer, through improved health promotion — can only succeed if people's living conditions and community context are taken into account. Children cannot be expected to exercise more if there are no safe parks in their neighbourhood or if recreation programs with user fees exclude children from poorer families. What if poor housing is the real problem underlying some senior's ill health? How can health information and support be provided in the different languages and cultures of our diverse communities? Addressing challenges in the health system needs to look beyond what happens in hospitals and doctor's offices.

## WHY WORRY ABOUT EQUITY?

Pervasive and damaging health inequities are one of the most important problems facing many people — and the health system as a whole. Whether measured by self-reported health, the burden of diabetes, mental illness and other chronic conditions, or life expectancy, there is a consistent systemic gradient of health. People with higher income, more education, living in better housing and other indicators of socio-economic conditions have better health than

those lower down the scale. The impact of these systemic inequities is significant: in Ontario, pain and discomfort prevent the daily activities of fully one-quarter of people in the lowest income group, twice as high as for the high income group.<sup>1</sup> For Canada as a whole, 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.<sup>2</sup>

A huge body of research demonstrates that health and health inequalities are shaped by income distribution, access to education, availability of affordable adequate housing, child care and early child development, social exclusion, environmental factors and other social determinants of health.<sup>3</sup> These determinants of health interact and intersect with each other, producing reinforcing and cumulative impacts over people's lives and on the health of particular populations or communities.

Even though the roots of health disparities lie in far wider social and economic inequality, equity needs to be addressed within the health care system because it is in the health system that the most disadvantaged end up sicker and needing more care. Equitable access to high quality health care and support can help to mediate the harshest impact of the wider social determinants of health on health disadvantaged populations and communities. In addition, there are systemic disparities in access and quality of health care that need to be addressed: people lower down the social hierarchy can have poorer access to health services, even though they may have more complex needs and require more care. Unless we address inequitable access and quality, health

- 1 Bierman, AS et al. Social Determinants of Health and Populations At Risk in: Bierman, AS, ed. Project for an Ontario Women's Health Evidence-Based Report, Volume 2, 2012, 12B.4, p 65.
- 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.
- 3 These determinants of health have been the focus of sustained high-level policy attention in recent years: from the World Health Organization's Special Commission on Determinants of Health, through European Union and other broad efforts, to comprehensive policies to address the determinants and their impact on health inequalities in many countries. For an excellent survey of the research and policy literature, see Hilary Graham. 2007. *Unequal Lives: Health and Socio-economic Inequalities*. Berkshire, England: Open University Press.

care and community support services could make overall disparities even worse.

## **DRIVING EQUITY INTO ACTION**

To ensure equitable access to high quality health care regardless of social position, we need a multi-pronged strategy:

### **1. Building health equity into all health care planning and delivery:**

- This doesn't mean that all programs are only about equity, but all must take equity into account in planning their services and outreach. Health promotion programs in any Ontario city can only be effective if they address the social diversity of its population. For example, health care planning in Northern Ontario can only work by taking into account the systemic health inequities and multiple access barriers faced by Aboriginal communities.

### **2. Aligning equity with system drivers and priorities:**

- A major provincial priority is improving primary care, and this is highlighted in the Action Plan. This would have positive equity implications: extensive international research shows that improving access to primary care is one of the most effective levers for improving the health of the most disadvantaged populations. Provincial, LHIN and local planning should consider how new and better coordinated primary care can be focused on those populations with the greatest and most complex needs.
- Preventing and reducing the impact of chronic conditions such as diabetes is also a major system priority. But lower income people, some recent immigrant communities, and others facing social inequality and exclusion face far higher risks and burdens of diabetes. Programs need to be specifically designed to address these greater needs.

### **3. Embedding equity in provider organizations' deliverables, incentives and performance management:**

- What gets measured, matters. To carry forward the diabetes example, incentives for LHINs and providers should not just be geared to reducing the overall prevalence of diabetes, but to reducing the inequitable differences that exist between neighbourhoods and populations.
- Similarly, targets for primary care should be reformed to ensure access and use of primary health care does not vary inequitably by income level, immigration status, neighbourhoods, gender, race, etc.
- Many hospitals, Community Health Centres and other programs assess their services through client satisfaction surveys and look for high and improving satisfaction levels. The equity expectation is to reduce any differences in satisfaction by gender, income, ethno-cultural background, etc.
- Payment schemes, budget allocations, and other incentives need to be structured so they encourage and reward achieving these types of equity-orientated expectations.

### **4. Targeting some resources or programs specifically to addressing disadvantaged populations or key access barriers:**

- This is about looking for investments and interventions that will have the highest impact on reducing health disparities or enhancing the opportunities for good health of the most vulnerable.
- For example, improving interpretation services in hospitals and other providers will not only improve quality for those who are uncomfortable in English or French, but can also contribute to reducing misdiagnoses, over-prescription and avoidable complications due to poor communication.

### **5. Thinking upstream to health promotion and addressing the underlying determinants of health:**

- Building on the above examples: diabetes and other chronic conditions are concentrated in poor neighbourhoods and marginalized communities. If we don't improve access to good housing, adequate food, and safe neighbourhoods we will not be able to reduce these preventable diseases.

## **BUILD EQUITY INTO THE PLAN**

Equity must also be built into the specific reforms identified. For example, the comprehensive and integrated care that can be provided by Family Health Teams (FHTs) has great potential, but this potential may not be available equitably — existing data indicates that FHTs have tended to serve the better off and healthier. This also shows how one success condition to this Action Plan is paying attention to incentives: for FHTs and other practice models paid per patient, there is an incentive to take on the healthiest (and easiest) people to serve; to avoid patients with chronic conditions and complex needs; and to locate in wealthier, and consequently healthier, neighbourhoods. Ensuring any new patient-based funding does not have such unintended and inequitable consequences, and that funding models take account of the greater burden and risk of ill health in disadvantaged populations will be crucial.

There are many levers within the Action Plan that can be used to improve health equity:

- Hospital Quality Improvement Plans can be required to include equity indicators;
- Initiatives to reduce hospital readmissions could greatly improve quality and effectiveness. But they also need to collect data to monitor if there are differences by income, neighbourhood, or region, and they should be expected to reduce any inequitable differences they find;
- As LHINs shift primary care, chronic disease prevention and management, and other resources where need is greatest they must take equity into account — focussing on those neighbourhoods and populations who have the greatest burden of ill health and have traditionally had less equitable access to services;
- Every LHIN should make an explicit strategic commitment to reduce health inequities within its area; and
- When the Ministry of Health and Long-Term Care is planning major initiatives — such as elaborating its seniors' strategy — it should apply its already-developed Health Equity Impact Assessment tool to ensure the needs of all

seniors are met.

By building equity into the Action Plan, these reforms can help to provide quality care to all Ontarians, including the most vulnerable, and deliver better value for the health care system.

#### **THE BIG ACTION ON HEALTH IS FAR BEYOND HEALTH CARE**

These health system reforms are only part of the picture of achieving the Ministry's goal of 'Making Healthy Change Happen'. The really healthy changes will come through addressing the underlying social determinants of health. Affordable housing, access to child care, equal opportunities to get a good education and decent living environments are all pre-conditions for good health. And precarious work, racism, poverty and income inequality are the underlying foundations of systemic and damaging inequities in health and wellbeing. Governments need to act in a coherent way across Ministries and program areas to create the foundations of good health for all, including those communities consistently marginalized and left behind.

The province has a number of opportunities on the immediate horizon to start to address these fundamental determinants of health in a coordinated way. First of all, the Commission for the Review of Social Assistance in Ontario has just released its options paper for discussion and will be continuing its work over the coming months. The Wellesley Institute, health practitioners, and other health policy leaders set out a vision and series of concrete recommendations to create a health-enabling social assistance system.

Similar principles of expanding opportunities and ensuring adequate living conditions that support good health should drive the provincial Poverty Reduction Strategy. As the Province is adapting to current fiscal challenges and post-Drummond policy opportunities, it needs to ensure that policy reform does not worsen social, economic, and health inequalities or weaken the resources and infrastructure that underpin healthy communities.

A pre-condition for addressing the social determinants of health within governments is developing more coordinated cross-government action and new ways of developing and implementing policy. Fortunately, a good deal of foundational work has been done within the Ontario government. Several years ago a major cross-Ministry initiative to develop a coordinated policy framework around health equity was undertaken, and was well received at the Deputy Minister's Social Policy Committee. MOHLTC also developed a Health in All Policies approach: the basic idea, being pursued in leading European agencies and jurisdictions, is that the population health implications of all legislation, policy and programs, including from non-health ministries and departments, are considered as policy is designed. The Ministry has a Health Equity Impact Assessment tool to facili-

tate this analysis.

Health equity impact assessment is essential to preventing unintended consequences: this common policy term is a bit of a misnomer — that poor urban planning results in food desserts and inadequate access to safe parks, that restrictive fiscal and monetary policy underlies income inequality, or that inadequate safety regulation will have adverse health effects may not be intentional, but it is certainly predictable — and avoidable.

We need policy across all spheres — from social assistance reform, through employment support and training, to fiscal policy — that contributes to reducing structured social inequality and enhancing the fundamental conditions for good health for all.



**The Wellesley Institute engages in research, policy and community mobilization to advance population health.**

