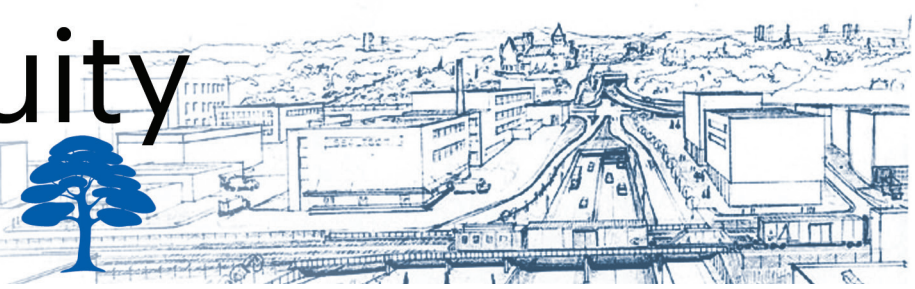
Health Equity Road Map



OVERVIEW

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THE PROBLEM TO SOLVE: SYSTEMIC HEALTH INEQUITIES

Pervasive and damaging health inequities are one of the most important problems facing Canadian and Ontario society — 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 gradient in which people with higher income, more education, living in better housing and more advantaged 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[1], twice as high as for the high income group. 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.[2]

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 elements of social and economic inequality and exclusion.[3] These determinants of health interact and intersect with each other, producing reinforcing and cumulative impacts over people's lives and on the health of populations or communities.

WHY EQUITY MATTERS IN THE HEALTH CARE SYSTEM

Even though the roots of health disparities lie in far

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 Socioeconomic Inequalities.* Berkshire, England: Open University Press.

wider social and economic inequality, equity also needs to be addressed within the health care system. First of all, it is in the health system that the most disadvantaged end up sicker and needing more care. Systemic health inequities are one driver of demand for health services; reducing these inequities would reduce pressure on resources and sustainability. Put more positively, 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.

Secondly, there are inequitable differences 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 care could make overall disparities even worse.

DRIVING EQUITY INTO HEALTH SYSTEM ACTION

To ensure equitable access to high quality health care regardless of social or economic position, we need a multi-pronged strategy. Here is a seven point roadmap for building equity into health care to improve access and quality for all.[4]

1: BUILDING HEALTH EQUITY INTO ALL HEALTH CARE PLANNING AND DELIVERY

This doesn't mean that all health care programs are only about equity, but all must take equity into account in planning their services and outreach. For example, health promotion programs in any Ontario city can only be effective if they address the diversity of its population. Similarly, 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.

This needs to start from high-level strategic commitment. Ontario has the *Excellent Care for All Act*, which enshrines equity and population health among its key principles of an effective and high-quality health system. However, legislation will not work on its own. For example, the Ministry of Health and Long-Term Care recently set out an Action Plan to transform the health system in which equity was not identified and prioritized in its specific reforms.[5]

Many Local Health Integration Networks (LHINs) have played a leading role in driving equity within their regions, but commitment and action has been less consistent in others. The Ministry of Health and Long-Term Care should set out a powerful framework of cascading expectations: clarifying its *Excellent Care for All* principle of equity, stating how equity will be interwoven into specific provincial priorities and policies, and making it clear that every LHIN is expected to make an explicit strategic commitment to reduce health inequities within its area.

Moreover, these strategic commitments need to be built into practice. For example, when the Ministry of Health and Long-Term Care is planning major initiatives — such as elaborating mental health, diabetes, or seniors' strategies — it should apply its already-developed Health Equity Impact Assessment tool to ensure that it meets the needs of all.[6]

2: ALIGNING EQUITY WITH SYSTEM DRIVERS AND PRIORITIES

Preventing and reducing the impact of chronic conditions such as diabetes is a major provincial priority. But lower income people, Aboriginal communities, some recent immigrant communities, and others facing social inequality and exclusion face far higher risks and burdens of preventable chronic conditions. Programs need to be specifically designed to address these greater needs. Overall levels of conditions like diabetes will not be successfully reduced unless the higher incidence within particular health disadvantaged populations is addressed.

As LHINs develop comprehensive and coordinated strategies for these issues, they may need to shift primary care, chronic disease prevention and management, and other resources to where need is greatest. In addition to considering effectiveness and quality, such allocation decisions must take equity into account — e.g. focussing expanded services on those neighbourhoods and populations who have the greatest risk and

4 Because this is meant to be a high-level overview, this paper does not fill out the evidence for particular directions or include extensive references. A range of analyses of more specific reform issues is available at http://www.wellesleyinstitute.com/our-work/healthcare/ and a more comprehensive health equity roadmap is being developed.

5 We set out how this could be done in a separate policy briefing at http://www.wellesleyinstitute.com/wp-content/uploads/2012/03/Building-Equity-into-Ontarios-New-Health-Care-Action-Plan.pdf.

6 We have previously analyzed how equity can be built into provincial mental health strategy http://www.wellesleyinstitute.com/news/every_door_is_the_right_door__mental_health_disparities_in_ontario/

burden of ill health, and have traditionally had less equitable access to services.

3: IDENTIFYING THE LEVERS OR PATHWAYS THAT WILL HAVE THE GREATEST IMPACT ON REDUCING HEALTH INEQUITIES AND DRIVING SYSTEM CHANGE

In reforming the health care system, some opportunities offer immediate progress, while others must be pursued over the longer-term. The challenge is to find levers or pathways where enhancing particularly effective programs, improving quality service delivery or investing in new innovations will have the greatest impact in transforming the health system — and enhancing its equity.

One such lever has already been identified in Ontario. A major provincial priority is improving primary care, and 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.

Improved chronic disease prevention and management is a further provincial priority that could have major transformative effects, and this priority has significant health equity implications. There is a consistent gradient in the incidence of diabetes, mental health and other chronic conditions that needs to drive service and program planning. Plus, people in less advantaged health situations also have less access to or ability to afford the good nutrition, recreation and fitness programs necessary to manage chronic conditions.

Another lever that is increasingly important in a diverse society is interpretation — improving access could have far-reaching system impact. 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, overprescription and avoidable complications due to poor communication.

4: EMBEDDING EQUITY IN PROVIDER ORGANIZATIONS' DELIVERABLES, INCENTIVES AND PERFORMANCE MANAGEMENT

Within health care, what gets measured, matters. Equity needs to be explicitly built into program targets and deliverables. To carry forward examples from above, LHINs and providers' objectives should not just be reducing the overall prevalence of diabetes, but reducing the inequitable differences that exist between neighbourhoods and populations. Similarly, targets for primary care should include ensuring access and use does not vary inequitably by income level, immigration status, neigbourhoods, gender, race, etc.

Under the *Excellent Care for All Act*, hospitals are required to develop Quality Improvement Plans. Equity needs to be embedded in these key levers for organizational and system change, and the plans should be required to include equity indicators.

Reducing hospital readmissions is another provincial priority that could drive significant improvements in quality and effectiveness of acute care. But hospitals also need to monitor if there are differences in avoidable admissions or readmissions by income, neighbourhood or region, immigration status, etc., and they should be expected to reduce any inequitable differences.

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. For example, the Ministry of Health and Long-Term Care Action Plan highlights the more comprehensive and integrated primary care that can be provided by Family Health Teams (FHTs). But this kind of care may not be available equitably — data indicates that FHTs tend to serve people who are better off and healthier. One factor is that FHTs and other practice models are funded by capitation or on a per patient basis. This schema creates 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.

This demonstrates that considering existing incentives — and their intended and unintended consequences — is essential to achieving equitable health care reform. It is crucial that any new patient-based funding does not have unintended and inequitable consequences and that funding models take account of the greater burden and risk of ill health in disadvantaged populations.

5: TARGETING SOME RESOURCES OR PROGRAMS SPECIFICALLY TO ADDRESSING DISADVANTAGED POPULATIONS OR KEY ACCESS BARRIERS

The challenge is to identify investments and interventions that will have the greatest impact on reducing health disparities or enhancing the opportunities for good health of the most vulnerable. In particular contexts, this can mean reducing language, accessibility and other barriers to access. For example, rates of cancer and other preventative screening have been found to be lower in particular immigrant communities, especially among women, and peer-led and other innovative programs have been developed to reach out to these communities.

This can also involve focusing on particular health disadvantaged populations. For example, several LHINs, public health departments and municipalities have developed coordinated health care and related programs to support homeless people and all LHINs are required to prioritize Aboriginal health. A critical part of public health units' formal mandates and practice standards is to identify and develop programs for priority populations — groups facing especially disadvantaged health situations or the most inequitable risks and burdens of ill health.

6: ENABLING EQUITY-FOCUSED INNOVATION

A huge range of promising and innovative programs have been developed by Community Health Centres, hospitals, community-based networks and organizations, and other providers to address the needs of disadvantaged communities. Unfortunately, there are no systematic ways in which these programs are shared, lessons learned, and promising equity practices evaluated. We need to build on the enormous amount of local imagination and innovation going on among front-line service providers and communities across the province and country by:

- Creating effective knowledge forums and infrastructures to share lessons learned and promising practices;
- Creating incentives and allocating resources to support equity-driven service innovation;
    - One mechanism could be to require a small defined percentage of provincial and LHIN research and innovation funding to explicitly focus on equity, disadvantaged populations or access barriers;
    - Another could be to ensure that equity is considered in all program and innovation planning. One LHIN has already required organizations shortlisted for funding opportunities to have applied Health Equity Impact Assessment to their proposal;
- Undertaking comprehensive and community-orientated evaluations to identify what interventions have the greatest potential to improve equity, for which populations, and in what contexts;
- Building on the best outcomes to gradually transform equity-driven service delivery and resource allocation; and
- Drawing on the lessons learned — both successes and failures — to pull innovation, experience and learning together into a continually evolving repertoire of effective program and policy instruments, and into a coherent and coordinated overall strategy for health equity.

7: THINKING UPSTREAM TO HEALTH PROMOTION AND ADDRESSING THE UNDERLYING DETERMINANTS OF HEALTH

PROMOTING HEALTH FOR ALL

Building on the above examples: diabetes and other chronic conditions are concentrated in poor neighbourhoods and marginalized communities. Universal programs will not be enough to redress this inequity – or may worsen it — as better educated and more advantaged people are more likely to take up health promotion messages and programs. This means that health promotion and preventative programs need to be concentrated in those communities that need them the most. It also means that health promotion programs need to be specifically adapted to particular populations; for example, translated into the culture of the particular community and delivered in their languages.[7] This has been termed "targeted" or "proportionate" universalism; meaning that within systems in which all have universal access to services, the particular mix of care and support is not the same for all, but geared to what particular people and communities need.

Focusing on chronic disease prevention and treatment also highlights a further underlying point: if we don't improve access to good housing, adequate food, safe neighbourhoods and other determinants of the inequitable gradient of health, we will not be able to reduce these preventable diseases.

7 See Wendy Rice, *Health Promotion Through an Equity Lens*, Wellesley Institute: 2010.

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 childcare, 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 well-being.

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.

Ontario has a number of opportunities on the immediate horizon to start to address these fundamental determinants of health in a coordinated way. For example, the Commission for the Review of Social Assistance in Ontario will be releasing its report in the fall. The Wellesley Institute, health practitioners, and other health policy leaders set out a series of concrete recommendations on how 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. The Ministry of Health and Long-Term Care also developed a Health in All Policies approach: the basic idea, being pursued in many leading jurisdictions, is that the population health implications of all legislation, policy and programs — including from non-health ministries and departments — are considered as they are designed. The Ministry of Health and Long-Term Care has a Health Equity Impact Assessment tool to facilitate this analysis.[8]

8 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.