Health Equity

Dr. Kwame McKenzie
CEO, Wellesley Institute

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Toronto Stories
Diversity puts us on the map
Charles Correa & Moriyama / Teshima Architects
• We are greater when we all pull together

Pan Am Games
Harry Jones muscled his way over the goal line for the winning try in Canada's 22-19 win.
What you already know
Social determinants have contributed to a difference in life expectancy of 28 years in Glasgow.

- A difference of 16 km in Scotland can result in a 28 year drop in life expectancy.

- A boy from the poor Glasgow suburb of Calton could expect to live to 54, while a boy born in nearby affluent Lenzie is likely to reach 82.¹

Social Factors Key to Ill Health

BBC Video²
PHO and Cancer Care Ontario’s risk list

<table>
<thead>
<tr>
<th>Socio-demographic Indicator</th>
<th>Category</th>
<th>Current smoker (%)</th>
<th>Alcohol &gt; 2 drinks any day (%)</th>
<th>Inactive (%)</th>
<th>Obese (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal identity (off-reserve)</td>
<td>Aboriginal identity</td>
<td>41.5</td>
<td>31.7</td>
<td>46.6</td>
<td>30.6</td>
</tr>
<tr>
<td></td>
<td>Non-Aboriginal identity*</td>
<td>19.5</td>
<td>23.4</td>
<td>53.0</td>
<td>18.2</td>
</tr>
<tr>
<td>Immigration</td>
<td>&lt;10 years in Canada</td>
<td>11.0</td>
<td>15.1†</td>
<td>66.2</td>
<td>8.5†</td>
</tr>
<tr>
<td></td>
<td>≥10 years in Canada</td>
<td>15.2</td>
<td>15.9</td>
<td>59.3</td>
<td>15.3</td>
</tr>
<tr>
<td></td>
<td>Canadian born*</td>
<td>23.1</td>
<td>26.6</td>
<td>49.0</td>
<td>20.9</td>
</tr>
<tr>
<td>Neighbourhood income quintile</td>
<td>Poorest neighbourhood</td>
<td>25.4</td>
<td>22.7</td>
<td>61.1</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td>Richest neighbourhood*</td>
<td>15.0</td>
<td>25.5</td>
<td>47.5</td>
<td>16.4</td>
</tr>
<tr>
<td>Education</td>
<td>Less than secondary</td>
<td>23.6</td>
<td>20.6</td>
<td>66.3</td>
<td>23.5</td>
</tr>
<tr>
<td></td>
<td>Some post-secondary</td>
<td>25.2</td>
<td>24.6</td>
<td>55.9</td>
<td>20.1</td>
</tr>
<tr>
<td></td>
<td>Post-secondary graduate*</td>
<td>17.3</td>
<td>23.8</td>
<td>48.5</td>
<td>16.8</td>
</tr>
<tr>
<td>Urban/rural residence</td>
<td>Rural</td>
<td>23.6</td>
<td>26.1</td>
<td>50.8</td>
<td>24.0</td>
</tr>
<tr>
<td></td>
<td>Urban*</td>
<td>19.5</td>
<td>23.3</td>
<td>53.4</td>
<td>17.9</td>
</tr>
</tbody>
</table>

* indicates a comparison group that is significantly different from the Aboriginal identity (off-reserve) category.
Keeping immigrants well (Newbold 2005)
Overweight or Obesity

Low rates: East/ South- east Asian
High rates: Black group

Pain or Discomfort

High rates: Black group

High Blood Pressure

High rates: Black, Latin American/Multiple/Other groups
Rates of psychosis for immigrants in Ontario (Anderson et al 2015)
MH services costs 2008 Ontario per person means (McKenzie 2015)
Those at lower income levels are significantly more likely to be hospitalized for depression (Power study)
• Societal trends
MAP 1: CHANGE IN AVERAGE INDIVIDUAL INCOME, CITY OF TORONTO, RELATIVE TO THE TORONTO CMA, 1970-2005

Average individual income from all sources, 15 years and over, census tracts

Change in the Census Tract Average Individual Income as a Percentage of the Toronto CMA Average, 1970-2005

City #1
Increase of 20% or More
100 Census Tracts, 20% of City

City #2
Increase or Decrease is Less than 20%
208 Census Tracts, 40% of City

City #3
Decrease of 20% or More
206 Census Tracts, 40% of City

Note: Census Tract 2001 boundaries shown. Census Tracts with no income data for 1970 or 2005 are excluded from the analysis. There were 527 total census tracts in 2001.

The Three Cities Within Toronto
How it connects locally: Age-Sex-Adjusted Diabetes Rates, Toronto

How it connects locally: Concentration of Visible Minority Populations, Toronto

How it connects locally: Age-Sex-Adjusted Diabetes Rates, Toronto


16/09/2015
Map 1: Age-Standardized All-Cause Mortality by Neighbourhood, Toronto, 2007-2009 Combined

Age-Standardized Rate per 100,000 population

- 214.9 - 355.3 Highway
- 355.4 - 433.0 Major Streets
- 433.1 - 503.3 Neighbourhoods
- 503.4 - 592.7
- 592.8 - 921.9

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Prepared by: Toronto Public Health
Contact: publichealth@toronto.ca

Note:
1. Statistics Canada 2006 Census as denominator of rate
2. Classification is by Natural Breaks
Health inequity costs lives. How do we move forwards?
“Good artists copy
Great artists steal”
Jobs, Picasso,
TS Elliot, Stravinsky
Improving health services

- A high quality and efficient health system is based on the matching of population need to the resourcing of effective interventions to meet those needs.
- A more equitable health system is more efficient.
- If Ontario is to bend the cost curve for health there is a need to deal with upstream issues that increase risk of illness but also a need to ensure that effective treatments are given to people at highest need.
Health equity enshrined as way to improve health systems in Ontario

• The French language Act
• Local Health System Integration Act
• Canada Health Act
• Future of Medicare Act
• Charter of Rights and Freedoms
• Ontario Human Rights Code
• Excellent Care for All Act
Health inequity

Health inequities are avoidable differences in health usually caused by:

Social determinants of health
Inadequate social response to differences in need
Inadequate health response to differences in need
Health Equity helps users to align *services* with *need*—enabling better health outcomes

Source: Health Equity Audit: A Guide for the NHS, UK Department of Health
In this simplified example, those with the most need get the lowest level of service: the undesirable “inverse care law”

Source: Health Equity Audit: A Guide for the NHS, UK Department of Health
Two forms of health equity

• horizontal equity
  – equal treatment of those with the same circumstances

• vertical equity
  – individuals who are unequal should be treated differently according to their level of need
In this simplified example, there is a good alignment between high need and high service provision: a desirable situation.

Source: Health Equity Audit: A Guide for the NHS, UK Department of Health
Inequity is often unintended

• That does not mean that inaction is excusable

• We need to take action on SDOH

• We need to take action on services
  – Tools for data collection
  – Methods for analyzing data
  – Health equity audit
  – Health equity impact assessment
  – Adaptation of prevention, promotion, treatment
We have great people doing great things

- MOHLTC health equity department
- HQO Health equity strategy
- TCLHIN roadmap
- CCO strategy with PHO
- TPH services and research
- HEIA tool and training and community
- TCLHIN data collection tool
- Power study, ICES, CAMH, CRICH
- CERIS focused services
But there are too few of them.

Plan or plan to fail

- Not co-ordinated
- No clear capacity development
- No clear targets
- No indicators
- No person who is in charge
- Some people take part others do not
We can see that there are disparities. We know dealing with them will help everyone. But many of us do not do it.
The Bystander effect

- May be because it is not clear who needs to do what
Decide who is responsible for what and what you can do (McKenzie 2010)

<table>
<thead>
<tr>
<th></th>
<th>Differential rates</th>
<th>Inequitable health response</th>
<th>Inequitable social response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health care provider Organisation</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service system</td>
<td>XX</td>
<td>X</td>
<td>XX</td>
</tr>
<tr>
<td>Societal / legislative</td>
<td>XX</td>
<td>X</td>
<td>XX</td>
</tr>
</tbody>
</table>
Multi-level needs: multi-level solutions
System level (Hansson et al 2010)

- Health equity may have the potential to reduce disparities for IRER groups
- One way of achieving this is by population-based, flexible services based on needs
- Using local data and knowledge helps produce a better need resource curve
Multi-level needs: multi-level solutions

Clinical services

• Systems can develop equitable funding but services need to connect with their communities – structural competence
• Interventions needs to be equitably effective
• Clinicians need to practice equitably
Why I like TCLHIN Roadmap

• Equity data collection
  – Base action on evidence

• Leadership and culture change
  – This only works if we all take part, everyone should be a leader in equity

• Direct intervention
  – Clinical services but also links between clinical services and organizations involved in SDOH
But it leads to difficult questions

• If I am not helping with health equity am I part of the problem?
• If I agree with health equity, do I agree with redistribution of funding?
• If I agree health equity is quality should it be part of my quality assessment?
• If I agree with health equity am I happy to move some funding upstream?
• We are all part of the solution
• Toronto is best when we build on our history of diversity, use the knowledge available throughout the world to build a better future
An effective team has a plan. Different players have different roles. But everyone has to work together if we want to win.
Thank you

wellesleyinstitute.com

@kwame_mckenzie

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