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Backgrounder for Roundtable

Delivering Equity: Community-Based Models for Access and Integration in Ontario's Health System

Delivering Equity: Community-Based Models for Access and Integration in Ontario's Health Care System

Executive Summary

Canada's Medicare system was based on Tommy Douglas' and many others' desire for equity in health care. Medicare did make a tremendous difference in improving access to physicians and hospital services regardless of ability to pay. However, that does not mean that we don't still have important disparities in health and health care. For example, poorer Canadian men are twice as likely to die within the first five years of their retirement as are richer men. Poorer women are 25% more likely to die of heart attacks. Aboriginals have the worst health status of all Canadians.

There are also important disparities in access to health care. For example, in Ontario heart attack patients who are wealthier and better educated are more likely to receive specialized investigations, rehabilitation, and specialist follow up. These different factors tend to add together. For example, wealthier, better educated, urban, non-aboriginal, non-disabled, southern Ontario women are much more likely to get a Pap smear test for cervical cancer than women with different socio-economic and health histories and circumstances.

Of course, disparities in health occur only partly because certain groups face access barriers to the health care system. Disparities are also related to certain groups being less resistant to illness because of their social and economic circumstances.

It is almost always very difficult to identify a specific root cause for disparities in health because health care interacts with the determinants of health in complex, unpredictable ways. But, sometimes in complex systems, small changes in the right inputs can lead to major changes in outcomes. The Federal Provincial Territorial Health Disparities Task Group noted that "The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities."

The Ontario Health Quality Council identified equity as one of its nine attributes of a high performing health care system in its first report in 2006:

There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language.

This definition, while providing a good starting-point for shaping health care policy and delivery, can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. In their second report in 2007, the OHQC identified a three pronged approach to developing a more equitable system keyed on three of the other attributes:

1. Improving the *accessibility* of the health system through outreach, location, physical design, opening hours, and other policies.
2. 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.
3. Cooperating with other sectors to improve *population health*.

Again, this approach can be broadened further to include an anti-racism/oppression approach. However, the OHQC definitions of health care equity seem to offer pragmatic and productive prospects for advocacy groups to build on and to promote their agendas. The Ontario government has many initiatives currently in play focusing on equity in general and health equity in particular.

There are several promising developments underway within the Ontario government that are focussing on health equity and that open space for community discussion and input. One is a major cross-Ministry research initiative that aims to lay the policy framework for more coordinated and integrated approaches to health equity. Its goal is to develop policy frameworks and tools that will help to minimize systematic and remedial disparities in health and social well-being along the social hierarchy. At the same time, the Ministry of Health and Long-Term Care has created a new health equity unit to lead and coordinate its efforts to address inequitable access to care. And several LHINs have identified equity and diversity as crucial issues and are developing strategies to address the impact and foundations of health disparities.

All of which means that there are strategic openings for an innovative and solid community-based vision and approach to health equity to have a major impact on health and social policy in Ontario. This roundtable is part of articulating such a vision of health equity, discussing how to achieve it in practice and planning how to effectively contribute to policy development.

Why health equity matters: access to care, determinants of health, and outcomes

Canada's Medicare system was based on Tommy Douglas' and many others' desire for equity in health care. As a boy in Winnipeg he had experienced the cruelty of nearly having an amputation because his family couldn't afford more expensive care. There was terrible suffering in Canada because poorer people couldn't afford access to care and couldn't get their needs met with the charitable care that was offered by some health care providers. Until Douglas became premier of Saskatchewan in 1944, Canada had basically the same system as the US.

Within 25 years Canada had universal coverage for hospital and physicians services from sea to sea to sea while the US adopted policies which continued widespread disparities in access to basic medical services.¹ These policies initiated in the 1960s have left 47 million Americans without any coverage and tens of millions with such inadequate coverage that 750,000 declare bankruptcy because they can't pay their health care bills.

Medicare did make a tremendous difference in the equity of access to physicians and hospital services. Even though many problems remain to be solved, none of us would ever wish to have continued on the US track.²

However, that does not mean that we don't still have important disparities in health and health care. For example, poorer Canadian men are twice as likely to die within the first five years of their retirement as are richer men.³ Poorer women are 25% more likely to die of heart attacks every year and poorer men are 35% more likely to die of heart attacks each year.⁴ Aboriginals have the worst health status of all Canadians.

Of course, disparities in health occur only partly because certain groups face access barriers to the health care system. Disparities in health are also related to certain groups being less resistant to illness because of their social and economic circumstances.^{5,6,7}

It is almost always very difficult to identify a specific root cause for disparities in health because health care interacts with the determinants of health in complex, unpredictable ways. For example, several studies in different countries have found that new immigrants are more likely to suffer from depression because of their history of trauma and dislocation, as well as lower socio economic status.^{8,9,10,11} But they are also less likely to use mental health services because they face particular access barriers to the health system.¹² Untreated depression can aggravate the course of diabetes and other diseases¹³ which could then worsen the person's depression. Some people find themselves in a downward spiral where their unfortunate life circumstances damage their health which in turn leads to loss of income and further deterioration of their living standards. The US Institute

of Medicine noted in its 2003 report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,¹⁴

To a great extent, attempts to separate the relative contribution of these factors risks presenting an incomplete picture of the complex interrelationship between racial and ethnic minority status, socioeconomic differences, and discrimination in the United States.

Especially when combined with other factors such as gender, disability, and sexual orientation, access to the health care system becomes a complex web of causation.¹⁵ But, sometimes in complex systems, small changes in the right inputs can lead to major changes in outcomes.¹⁶ After all, less than 20 grams of vitamin C will prevent scurvy for a year. The Federal Provincial Territorial Health Disparities Task Group noted that “The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities.”¹⁷

There are serious disparities in access to health care

Despite over thirty years of universal coverage for physicians and hospital services in Ontario there remain inequalities of access to these services. For example, in Ontario heart attack victims who are wealthier and better educated are more likely to receive specialized investigations, rehabilitation, and specialist follow up.¹⁸ Wealthier Ontarians who have a stroke are more likely to receive rehabilitation,¹⁹ are more likely to get preventive care such as screening tests for colorectal cancer,²⁰ have more hip and knee replacements, cancer surgery (in total), and MRI scans even though lower income Ontarians tend to be sicker than wealthier ones.²¹ Higher income Ontarians even have shorter delays to hospital when they have chest pain.²² Better educated Ontarians are more likely to get care for depression²³

Non-English speakers are less likely to get a variety of services including tonsillectomies and insertion of ear tubes.^{24,25} Five groups confront language barriers to health care: those first language is neither English or French, aboriginal communities, immigrants and refugees, deaf persons, and, depending on location of residence, speakers of only one of Canada's official languages.

Unfortunately, there is little Canadian data on health care access by race or ethnic group. Americans do keep data on access by race and these reveal deep disparities.²⁶ Even though there are fewer access disparities in Canada than the US because of universal coverage for physicians and hospital care,²⁷ it seems overwhelmingly likely that we have similar problems here. As the Ontario Human Rights Commission has noted, “despite laws to address racial discrimination having existed for over 60 years, racial discrimination and racism

persist in Ontario.” The Commission produced two papers in 2002 which do note access barriers for non-English speaking ethnic groups and visible minorities.^{28,29}

Several key themes emerged from the Commission’s research and consultation that are crucial for health and health care services:

- Racism and racial discrimination continue to exist and to affect the lives of not only racialized persons, but also all persons in Canada.
- Racism operates at several levels, including individual, systemic or institutional and societal.
- Racial discrimination can occur through stereotyping and overt prejudice or in more subconscious, subtle and subversive ways.
- Organizations have a responsibility to take proactive steps to ensure that they are not engaging in, condoning or allowing racial discrimination or harassment to occur. Obligations in this regard range from collecting numerical data in appropriate circumstances, accounting for historical disadvantage, reviewing policies, practices and decision-making processes for adverse impact, and having in place and enforcing anti-discrimination and anti-harassment policies and education programs, to name just a few.

Women receive more of some health care than men and less of others. For example, Ontario women are 50% more likely than men to get a prescription for a benzodiazepine or valium-like drug.³⁰ On the other hand, women with heart disease are less likely to receive diagnostic tests and surgery.³¹

There are also geographic disparities in health care. Rural Ontario residents are less likely to get a number of services including appropriate follow up care for diabetes³² or appointments with a dermatologist for acne.³³ Northern Ontario residents tend to have more illnesses and live shorter lives.³⁴ Because of their higher illness burden, northern Ontario residents tend to have higher utilization rates for various services including hip and knee replacements, cataract surgery, heart procedures, cancer surgery, MRI scans.

There is also evidence that gay, lesbian, and transgendered Canadians face barriers to accessing health care services.^{35,36}

A recent Canadian study of 21 wealthy countries found that in Canada lower income Canadians had more family physician services than upper income Canadians, in accordance with their need for care.³⁷ However, like most other countries with universal systems, lower income Canadians had major differences with respect to specialty care.

These different factors tend to add together. For example, wealthier, better educated, urban, non-aboriginal, non-disabled, southern Ontario women are much

more likely to get a Pap smear test for cervical cancer than women with different socio-economic and health histories and circumstances.

What is health equity?

Human beings seem to have an innate sense of fairness. But there are many different definitions of equity, equitable, and equality which are used differently by different people. Some relate more to outcome and some relate more to process.

In their first report in April 2006, the Ontario Health Quality Council identified equity as one of its nine attributes of a high performing health care system:

1. Safe
2. Effective
3. Patient-Centred
4. Accessible
5. Efficient
6. Equitable
7. Integrated
8. Appropriately resourced
9. Focused on Population Health

In that first report, the Council noted,

There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language.

This definition, while providing a good starting-point for shaping health care policy and delivery, can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. In their second report in 2007, the Council had re-defined equity as,

People should get the same quality of care regardless of who they are and where they live.

The Council claims that this change in definition is to “plain language” their terms and that there has been no change in intent from the original definition. In their second report, the OHQC identified a three pronged approach to developing a more equitable system keyed on three of the other attributes:

1. Improving the *accessibility* of the health system through outreach, location, physical design, opening hours, and other policies.

2. 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.
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Again, this definition, while providing a good starting-point for shaping health care policy and delivery, can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. However, the OHQC definitions of health care equity seem to offer pragmatic and productive prospects for advocacy groups to promote their agendas. (See next section.)

It is a lot easier to get meaningful action initiated by government if the language used with them is a close to what they are using themselves. This makes it much easier for civil servants, many of whom are sympathetic to calls for more health equity, to support recommendations made by community-based service providers, analysts and advocates.

What is the Ontario Government doing regarding health equity?

There are several promising developments underway within the Ontario government that are focussing on health equity and that open space for community discussion and input on the meaning of health equity and how to achieve it in practice.

One is a major cross-Ministry research initiative that aims to lay the policy framework for more coordinated and integrated approaches to health equity. It involves extensive research on policy in other jurisdictions, the underlying foundations of health disparities, and possible policy levers and approaches to address health inequity in a comprehensive and coordinated manner. Officials from the highest levels of key Ministries across the government are participating.

The Ontario project is focussing on how to level up the gradient of health: the well-documented patterns of people's health status and opportunities being worse, the lower down the social hierarchy – whether along lines of income inequality, employment security, education, race, gender, or the complex interaction of many such factors. Health disparities are seen as a telling indicator of much broader social and economic inequality, and the levers and means to create more equitable health and well-being lie in many fields of social, economic and health policy.

The definition employed by the Ontario project is:

The goal of an equity strategy is to minimize systematic and remedial disparities in health and social well-being between groups of people who have different levels of underlying social advantage.

Remedial here means avoidable, and therefore changeable through policy and program action. The goal is to reduce the gap between the health of the most and least advantaged groups.

The project knows there is a creative connection between a ‘bottom-up’ approach building on the insights, experience and successes of community-based initiatives addressing health disparities on the ground, and a ‘top-down’ approach in which there is far better coordination across Ministries and departments so that collaborative and integrated policy action on health equity can be identified and sustained.

In addition, during the fall of 2006 and early 2007, the Ministry of Health and Long-Term Care consulted extensively and undertook intensive research to develop a ten year health strategy for Ontario. The release of the strategy was delayed by the election and its current status is uncertain. However, health equity is very likely to be a major issue in any strategy unveiled. More recently, the Ministry has created a new health equity unit to lead and coordinate its efforts to address inequitable access to care; its first manager was much involved in the consultations and development of the overall health strategy.

At a regional level, the Toronto Central LHIN has established a task force and commissioned a special adviser to the Board to develop a practical roadmap for how the LHIN can address health disparities within its mandate and area. Other Toronto LHINs have been developing diversity training and policies, and may also be interested in wider equity strategies.

All of which means that there are strategic openings for an innovative and solid community-based vision and approach to health equity to have a major impact on health and social policy in Ontario. We need to be aware of this context to most effectively frame our own community-based analyses of how to move on health equity.

What are the policy opportunities for those seeking more health equity?

There are many opportunities to use the OHQC’s framework for improving health equity and there are many examples of existing programs which could be beacons to better practices.

Improving Access

The OHQC defined accessibility as:

People should be able to get the right care at the right time in the right time by the right health care provider.

The OHQC suggested that improving accessibility could enhance equity through outreach, location, physical design, opening hours, and other policies.

An example of a practice which has facilitated improvements in access to health care for a disadvantaged population is the Toronto Client Access to Integrated Services and Information (CAISI) Project. The project's goal is to “reduce the plight of chronic homelessness by enhancing the integration of care between agencies at the individual and population levels using an electronic information system”

The clients give permission to a variety of agencies including shelters, drop in centres, outreach teams, hospitals, public health and Toronto ambulance, to link their electronic records. The record is an enhancement of the OSCAR McMaster system, which is an open source Ministry of Health-approved electronic medical record. The system is accessed through the internet so it allows multiple providers to communicate with each other about a very ill group of clients.

The CAISI project recently won the Canadian Information Productivity Silver Award for Not for Profit Efficiency and Operational Improvements.³⁸

Another example of innovation is the implementation of Advanced Access by some Community Health Centres and private practices in Ontario. With Advanced Access, many CHCs find they can eliminate weeks long waits for care for routine appointments.

In 2003, at the Rexdale Community Health Centre, which serves 6,000 patients in a disadvantaged community in northwest Toronto, patients faced a four- to six-week wait for appointments. The centre temporarily increased resources to clear its backlog and then went to same-day service. To achieve advanced access, services had to be redesigned as well. The Rexdale CHC enhanced the roles of two nurses, who previously spent a lot of their time telephone-triaging patients who were sent elsewhere for care. Now they spend much of their time dealing with patients with minor illnesses. The Lawrence Heights Community Health Centre in Toronto, the Saskatoon Community Clinic, and Cambridge's Grandview Medical Centre have also implemented advanced access.

All practices also found they could enrol new patients. Eventually, these facilities achieved new equilibrium, but the new enrolments were significant. Dr. Jeff Harries, a Penticton, B.C., family physician, said he was able to erase his wait lists and add 500 patients.³⁹

There are millions of Canadians who cannot find a family doctor to take them on as a patient. Increasingly family doctors screen new patients and are reluctant to add new patients if they have complicated medical problems. These people are disproportionately challenged by other disparities as well. Dr. Harries comments

that, "If every family doctor in the country went to advanced access, there would be no Canadian who didn't have a family physician."

Improving patient-centred care

The OHQC defined patient-centred care as:

Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.

The OHQC suggested that improving patient-centred care could enhance equity through providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.

An example of a practice which has facilitated improvements in access to health care for a disadvantaged population is Toronto's Access Alliance Community Health Centre Peer Outreach Worker Program.⁴⁰ Access Alliance provides care to new Canadians and focuses on those with the highest needs, especially refugees. The CHC uses neighbourhood ethno cultural networks and local and ethnic media to recruit and hire peer outreach workers. Many of these outreach workers have university educations and some have been trained as health professionals. They are paid for three months of training and then are offered three year contracts.

The outreach workers and staff from the CHC can deliver up to 20 education programs including six on parenting. The outreach workers also facilitate well child and women clinics conducted by the CHC's nurse practitioner and dieticians in community settings. The outreach workers recruit program participants through local agencies but also directly from community venues such as libraries, laundromats, places of worship, and shopping malls. As well as their group work, the outreach workers provide information and referral to culturally appropriate services, interpretation, and accompaniment to appointments with health and social service workers.

Access Alliance has trained nearly one hundred peer outreach workers and 80% have gained employment elsewhere after their initial contract with Access Alliance.⁴¹

The London InterCommunity Health Centre developed a diabetes program to deal with the special needs of the city's large Latin American population, which has a high rate of diabetes.⁴² The program includes screening of high risk populations, primary prevention, and follow up to reduce complications.

The health centre runs self-management diabetes follow up clinics with the Latin American population. The patients meet with a diabetes nurse briefly to identify the issues which require attention. According to the founding program

coordinator, nurse practitioner Betty Harvey, some of the time they need to see a professional such as the dietician. However, she says that 75% of the time, the most pressing issues affecting their diabetes are social rather than strictly medical. And after initial assessments, if the patient needs to see someone else, it's usually one of the community health workers or a social worker, all of whom are Latin American. They help their clients deal with a myriad of problems from illiteracy to landlord tenant problems.

The center conducts some clinics specially for diabetics in London who do not have family doctors or attend non-CHC family doctors. Three of these clinics per month are held at the centre for Spanish speaking people, one is held in a Cambodian church, and the other in a Polish community centre.

The centre has an electronic record for each patient it sees and keeps running calculations of the program's effectiveness. As of June 2006, the Centre's Latino diabetes self-management clinic showed an approximately 2% absolute decline in HgbA₁C levels after program intervention, from 8.9% to 6.95%.⁴³ Each 1% drop in HgbA₁C co-relates with a roughly 10-20% decline in cardiovascular risk.⁴⁴

Improving the effectiveness of the health system's work with other sectors to achieve population health goals

Intersectoral action for health has been described by the World Health Organization as⁴⁵:

A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.

People have suggested intersectoral approaches to health for many years. Unfortunately, intersectoral action has proven much harder to fulfill in practice than to describe in theory.⁴⁶ Around the world, a lively debate has developed about how best to promote intersectoral action on the broad determinants of health.

After twenty-five years, there is a growing recognition in the health sector that most complicated social problems require an intersectoral approach, one that works towards "healthy public policy". For example, child development, labour market adjustment, and air pollution all need the cooperation of three levels of government, multiple and diverse ministries and departments, and thousands of non-governmental organizations across many different sectors. Also, sometimes

the health sector should take an active leadership role while sometimes it should support other sectors.

The key barriers to effective intersectoral action by the health sector are:

- Not everyone places a high value on health. Sometimes, people place a premium on liberty and small government over possible health gains. Sometimes there are competing interests, e.g. the tobacco industry. Sometimes there are competing or conflicting public policies, such as reducing taxes or supporting economic growth that has adverse environmental health implications.
- Information on the scientific relationship between a social determinant and health status is a weak factor for making policy. Partly this is because, almost all people, even well-educated ones, are not trained to interpret scientific evidence and those holding competing values or interests may raise obfuscating questions which cause decision-makers to query the confidence of any information. Generally, government has a weak capacity for leading and analyzing research. Sometimes data are not presented in a strategic way that tells a story and suggests workable policy and program solutions that reflect the realities of how public policy is made (including the imperatives and constraints that decision-makers deal with).
- The key people interested in so-called healthy public policy come from the health sector. But the decisions about the social determinants of health are made in other sectors, e.g. housing, employment or by central agencies of government, e.g. cabinet office, department of finance. The way government is organized, and the “culture” within government, also affects what policy decisions are made and how.

It is easier to gain the cooperation of different sectors for effective action at the local or community level than at the national or even provincial level. However, action at higher levels (e.g. federal, provincial) tends to have more impact on population health. Intersectoral action at higher levels often generates more political conflict, especially around different values and competing interests. This is the central problem of intersectoral action. The most effective intersectoral actions are those at higher policy levels and yet it is at these levels where they are most difficult to implement.

However, effective action at higher levels usually requires action at the community level first. The most effective intersectoral action dexterously combines activity at all levels and creates positive feedback loops to sustain itself.

There needs to be a two-pronged approach to promoting more effective intersectoral action for health. First, the health sector needs to engage communities to develop local projects. Second, governments, especially senior

levels of government, need to be more effective at supporting effective local and regional activities.

Local action by the health system

An example of effective local health system engagement to promote intersectoral action is Regent Park's award winning Pathways to Education. The residents of Canada's oldest public housing project face many significant challenges to health and accessing health care services. Incomes are less than half the Canadian average. Over 80% of residents are immigrants and English is a second language for nearly 60% of Regent Park adults. Health care access is reduced, for example for pap smears, mammograms, and infant immunizations.⁴⁷

The Regent Park Community Health Centre identified education as the major determinant of the future health of neighbourhood children. In 2001, the health centre launched Pathways to Education with a number of partners. Pathways provides support for Regent Park children entering high school, including transit passes, tutoring, and mentoring. In 2005, the first pathways students graduated from high school.

From September 2001 to present, compared to Regent Park youth before Pathways, the program has⁴⁸:

- Reduced the dropout rate from 56% to 10%
- Enrolled 95% of the eligible high school age youth in the Regent Park community in the Pathways program
- Reduced absenteeism by 50%, and youth with serious attendance problems by 60%
- Increased the college/university enrolment of graduates from 20% to 80% (and over 90% of those were the first in their families to attend post-secondary institutions).

The long-term economic benefit to society for every \$1 invested in Pathways is \$12.

Provincial initiatives to support local action

But it is not enough just to launch local intersectoral action projects. The health sector must push issues up to regional, provincial, and national levels to be effective. The key factors are:

1. Cabinet level social policy coordination,
2. Based upon a strong value placed on equity, and
3. Common boundaries for governance and service delivery.

Saskatchewan

The Saskatoon Health Region has identified significant disparities in health and health care access within its catchment area.⁴⁹ For example, there are sixteen times as many suicide attempts in the poorest neighbourhoods than in the wealthiest, but only twice as many physician visits for mental health problems.

The Saskatoon Regional Intersectoral Committee is co-chaired by the Health Region's vice-president for primary health care and the city's director of parks and recreation. The committee include representatives from various provincial and federal government departments, municipalities, regional health authorities, housing authorities, educational institutions, tribal councils, police, and Métis organizations.

Saskatchewan established the Human Services Integration Forum in 1994. It includes associate and assistant deputy ministers from eleven ministries and secretariats. The development of the forum was spurred by a 1993 investigation of twenty-seven child deaths, which concluded that broad social policy initiatives were required in order to address the issues. The forum focuses on promoting better service integration. It links its work with the ten Regional Intersectoral Committees (RICs).

The forum supports a number of initiatives, including Saskatchewan's Action Plan for Children. The Action Plan has established the Children's Advocate Office, coordinated interdepartmental budget planning, supported the development of an early childhood initiative, and funded more than three hundred interdepartmental prevention and support grants to local groups. The forum also provides overall policy co-ordination to several provincial initiatives, including Integrated School-Linked Services, the Aboriginal Policy Framework, the Culture and Recreation Strategy, the Saskatchewan Training Strategy, the Restorative Justice and Aboriginal Justice strategies, Saskatchewan Assisted Living Services, and Health's Strategy for Intersectoral Collaboration. The most recent focus is Schools Plus, a plan to use the schools as a place to integrate services for children and families.

Saskatchewan has also re-drawn the boundaries for various government activities (health, social services, education, municipal government) to make them co-terminus.

Quebec

Quebec has coordinated its social policy around a series of health goals since 1987. Quebec's passed two public health acts in 1998.⁵⁰ The Public Health Act prescribes the mandates and responsibilities of the minister, the ministry and the other components of the public health system, including the National Institute of Public Health, the regional health and social services authorities, and local

community health centres.

The National Institute of Public Health Act established the Institute and details its specific mandates and responsibilities as the lead agency for public health. The Governor in Council appoints the board of directors and the director general/president. The minister can issue directives to the Institute with which it must comply.

The legislation outlines a broad program of public health well beyond simply controlling communicable disease. The public health system is charged with "exerting a positive influence on major health determinants, in particular through trans-sectoral coordination."

The National Institute of Public Health is responsible for developing a provincial health plan based upon the province's health goals.⁵¹ The Quebec regional health authorities are responsible for developing their own health plans which are consistent with the provincial plan. The CLSCs (Centres Locaux Services Communautaire), provide both public health and primary health care services. Under Quebec's public health legislation, the CLSCs are responsible for coordinating their local community's input into developing local public health plans, congruent with the provincial and regional plans.

Some other issues important for equity

The importance of health care financing policies

In 1971, primary health care reformer, Julian Tudor Hart noted that,⁵²

...the availability of good medical care tends to vary inversely with the need for it in the population served.

Hart went on to observe, "If our health services had evolved as a free market, or even on a fee-for-item-of-service basis prepaid by private insurance, the law would have operated much more completely than it does; our situation might approximate to that in the United States, with the added disadvantage of smaller national wealth. ..The more health services are removed from the force of the market, the more successful we can be in redistributing care away from its "natural" distribution in a market economy."

We have built our funding for health care partly on the basis of meeting population needs, partly on market allocation, and partly upon a legacy of previous decisions. For example, the spending for hospitals in a community is partly based upon provincial population and needs-based funding for specific programs like cancer care, and partly based upon historical global allocation.

As a result there are several funding policies which aggravate health care disparities. For example, the current capitation funding formula for some new primary health care programs is based upon the use of medical care in the OHIP fee-for-service system, unadjusted for health or socio-economic status. As a result, a roster of young men pays very poorly because the average young Ontario man has no chronic illnesses, little need for routine reproductive care which requires most women to regularly use the health system, and a misguided belief in his own immortality.

But, if an Ontario capitation funded practice has a lot of young men who have mental health problems or addictions, the practice will not be compensated to provide the care their patients need.

Another financing issue is the development of a funding formula for the LHINs. Other jurisdictions have integrated equity mechanisms for adjusting population-based funding for health care services.^{53,54} Ontario has investigated this issue for many years, but now there is increased urgency because of the establishment of the LHINs.

The importance of primary health care

Primary health care is particularly important for remedying health disparities. PHC is the key actor for addressing barriers to access to the health care system. PHC and local public health are also the key actors for initiating intersectoral action at the community level.

There are considerable implications – and policy opportunities - for Ontario because it is engaged in a major redesign of its PHC system. There has been unprecedented growth in new service models directed at private family doctors and communities such as family health networks (FHNs), family health groups (FHGs), Family Health Teams (FHTs), Family Health Organizations (FHOs), and Community Health Centres (CHCs)..

Community health centres seem especially well placed to plan a major role in an equity agenda. CHCs have an explicit equity goal.⁵⁵ As the Ontario government has expanded the program in the last four years, it has identified CHCs as having major roles in addressing access barriers for populations with particular challenges or social conditions that affect health.⁵⁶

On the other hand, other PHC models, such as family health teams (FHTs), are not given an explicit role in achieving equity targets.⁵⁷ The policy challenge is to build equity across many forms of primary care initiatives.

The importance of good management in the health care system

Fairness is a widely held social value. We all want to be treated fairly and also

feel that we are treating others fairly. Canadians pride ourselves on an international reputation for diversity and tolerance. Good management combined with adequate resources should be able to untap these values to ensure a health system that treats people fairly and, perhaps more importantly, is seen as treating people fairly.

There are key roles to be played by all levels of management and service provision to ensure that creative attempts to eliminate inequities in health care are intertwined with other efforts to improve the overall quality of care. In fact, programs which improve the outcomes for the most at risk persons will also improve the health and health care of those who are at less risk because of their socio economic status or their genetic make-up. For example, if we design a health care system which provides compassionate high quality care for an indigent, non-English speaking newcomer with schizophrenia, then we will also improve the care of all people suffering from schizophrenia whatever their social circumstances.

To create a high performing health system which continuously reduces disparities in health and health care, equity must become a pre-occupation of all employees of the health system from CEOs through administrative, clinical, personal care, and support staff. In particular it is crucial that administrators have performance targets for equity in their contracts, with bonuses for their achievement. They and their staff should be trained in implementing equity improvement within the context of overall quality improvement efforts.

We need better information to make this process for more effective. But we shouldn't let lack of information become an excuse for inaction. The data always get better the more they are used.

Conclusion

The implementation of our Medicare system greatly improved access to health care, particularly for poorer Canadians. But there still are persistent disparities in health status and access to health care. Disparities in health occur only partly because certain groups face access barriers to the health care system. Disparities in health are also related to certain groups being less resistant to illness because of their social and economic circumstances.

Recently, the Ontario government has launched initiatives looking at general societal inequalities and specifically at health care disparities. There appear to be many strategic openings for an innovative, community-based vision of health equity to influence Ontario health and social policy. This roundtable is part of articulating such a vision of health equity, discussing how to achieve it in practice and planning how to effectively contribute to policy development.

Endnotes:

¹ Medicare for those over 65 and certain chronic conditions and Medicaid for the extremely poor. These policies initiated in the 1960s have left 47 million Americans without any coverage and tens of millions with such inadequate coverage that 750,000 declare bankruptcy because of the inability to pay their health care bills.

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