

Blueprint for Health Equity

Speaking Notes

How Soon Is Now?

Canadian Federation of Nurses Unions Conference

Moncton, August 2007

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Introduction

- health disparities are pervasive, incredibly damaging and solidly rooted in overall social and economic inequality
- but, action is possible:
 - there are innovative on-the-ground initiatives across the country addressing the impact of health disparities
 - many jurisdictions have developed comprehensive policies and programs to address health disparities – and there are enough indications of how these policies can be effective
- goal today is to set out a broad blueprint for action:
 - will highlight promising policy directions that can address health inequities
 - both short-term interventions that can make a difference in cutting disparities quickly and longer term policies that can lay the foundation for health equity
 - and then some ideas for community mobilization to pressure governments to move

A Blueprint for Health Equity

- health disparities are produced by a wide range of complex factors – the most important of which are far beyond the health care system
- much of the solution to health disparities lies in macro social and economic policy – and in policy collaboration and coordination across governments
- but a great deal can be done within the health system
 - identifying and reducing barriers to access
 - targeted investments and interventions in the most health disadvantaged communities and populations
 - local and community-based action to address disparities on the ground
 - enhancing equity-focussed primary and preventive care
- local programmes and planning are vital → enabling and building on local initiatives is a key component of good policy

Pervasive and Systemic Disparities in Health Outcomes

- men in the lowest income quintile live five years less than men in the highest
- life expectancy at birth, on average, is five to 10 years less for First Nations and Inuit peoples than for all Canadians
- while infant mortality rates have been declining overall, rates in Canada's poorest neighbourhoods remain two-thirds higher than those of the richest neighbourhoods
- disparities exist in all provinces and territories -- in Ontario, risk-adjusted rates of death in hospital following a stroke were 36% higher in the worst regions than in the best
- that some get sicker and die sooner because of income, race or where they live is a shocking indictment of the state of Canadian society

Health Equity = Reducing Unfair Differences

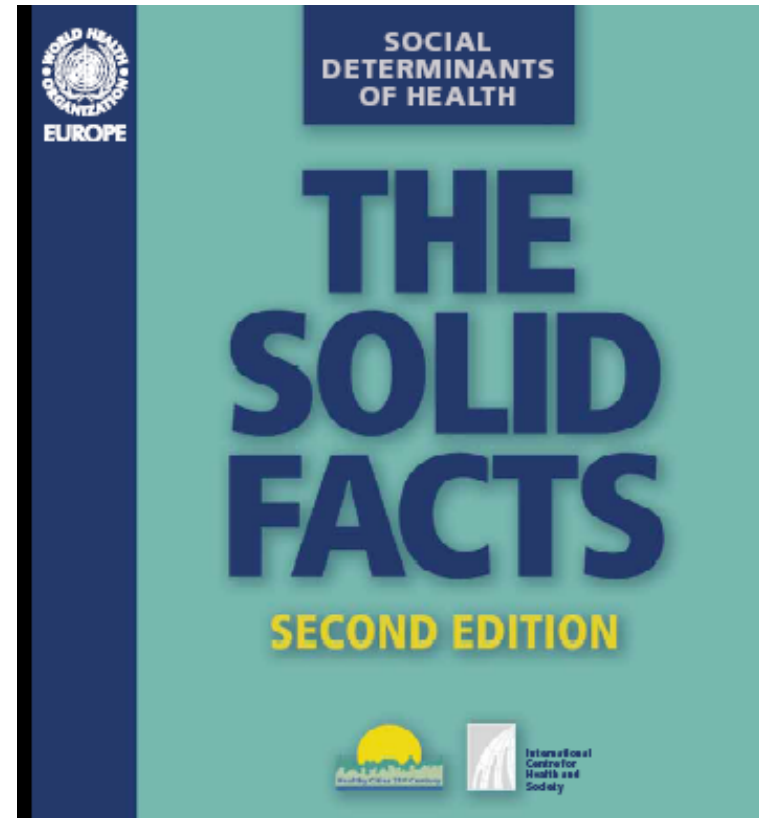
- the most common definition of health equity is working to reduce differences in health outcomes that are **avoidable, unfair and systematically** related to social inequality and disadvantage
 - clear, understandable & actionable
 - it identifies the problem that policies will try to solve
 - it's also tied to widely accepted notions of fairness and social justice
- this definition sees health equity as the absence of socially structured inequalities and differential outcomes
- a more forward-looking and positive vision of health equity = equal opportunities for good health

1: Look Widely for Ideas and Inspiration

- there is always much to be learned from policies, programmes, investments and initiatives in other jurisdictions
- a number of countries have made lessening health disparities a top national priority and have developed cross-sectoral policy frameworks and/or action plans:
 - UK, New Zealand
 - many European countries
- also increasing international and high-level attention:
 - World Health Organization, especially its Commission on Social Determinants of Health
 - European Union, with its *Closing the Gap* project to tackle health disparities
- look broadly for policy solutions, and adapt flexibly to local/provincial circumstances

Roots of Disparities Lie in Social Determinants of Health

- clear research consensus that roots of health disparities lie in broader social and economic inequality and exclusion
- impact of key determinants such as early childhood development, education, employment, working conditions, income distribution, racism, social exclusion, housing and deteriorating social safety nets on health outcomes is well established
- real problem is differential access to these determinants – many analysts are focusing more specifically on social determinants of health disparities



2: Think Big: Macro Policy Is Fundamental

- social and structural basis of health disparities means that many of the policy solutions to health disparities lie outside the health system
- reducing overall social and economic inequality may be the most significant single way to reduce health disparities → requires a significant commitment and re-orientation of social and economic policy
- need to build equity into all macro social and economic policy:
 - not just as one factor among many to be balanced, but as core priority
 - some jurisdictions have built equity consideration into their policy processes – e.g. a change in tax policy or new environmental policy would be assessed for its differential and equity impacts
 - Canadian Index of Wellbeing = idea that how well a country is doing cannot be captured by GDP or stock market indexes, but should include social, cultural and other facets of wellbeing

Commitment to Equity: Sweden

- social welfare policy was seen to be key to reducing health disparities
- coordinated national policy to reduce the number of people at risk of social and economic vulnerability
 - focus on inclusive labour market, anti-discrimination, childcare, affordable housing and other policies
 - equitable access to improved health care was seen to be just one part of this broader package
- emphasized partnerships with community service providers and organizations – in both policy development and service delivery
- its national public health strategy has 12 key objectives – five of which, defined as fundamental to all the others, are about improving social and economic determinants
- similar directions in other Nordic countries – sometimes seen as a distinct model of social policy, one that arose out of a political culture with strong consensus on social solidarity

3: Think Big, But Get Going

- one problem is that health disparities can seem so overwhelming and the policy solutions so daunting
- everything can't be tackled at once:
 - need to split strategy into actionable components and phase them in
 - but coordinate through a cohesive overall framework
- need to recognize that fundamental policy action on equity takes time – need patience
- pick issues and levers that will show progress and build momentum for action on equity
 - look for collaborations on issues with broad consensus – e.g. child poverty
 - and initiatives that will show results and build momentum – linking schools, local health and social services to enhance early years services for high-need children, families and communities
 - re-frame issues from what other Ministries should do to reduce health disparities to common goals -- investments that build social cohesion and enhance human capital are of interest to many departments

4: Act Across Silos

- significant improvements in health disparities require broad cross-sectoral coordination of public policy
 - a number of countries have solid high-level commitments to reducing disparities, but few have implemented comprehensive policies
 - there is a clear consensus that integrated cross-sector policy frameworks are needed
- *UK Tackling Health Inequalities; A Programme for Action* was published in 2003:
 - committed to reducing inequalities in health outcomes by 10% by 2010
 - argued that links across government are essential to sustaining long-term change
 - spelled out specific targets for reduced child poverty, more affordable housing, early childhood development, employment, building healthy communities, and broad national redistributive and social policies that Departments were responsible for

5: Set and Monitor Targets

- clear consensus that a vital part of comprehensive policy on health equity =
 - setting targets or defining indicators – that build on available reliable data and make the most sense in the particular policy context
 - closely monitoring progress against the indicators or targets
 - disseminating the results widely for public scrutiny
- e.g. under the British Programme for Action:
 - a 2005 status report assessed how each Department was doing against the targets – most were on target
 - as in other countries, concrete targets and public scrutiny were certainly part of holding governments and providers accountable that progress
 - so too was high level attention and support – e.g. social exclusion unit in Cabinet Office, clear commitments from Prime Minister
- further lessons:
 - build equity considerations into policy at design stage – not afterthought
 - use tools such as Health Equity Impact Assessments

Act on Equity Within the Health System

- evidence shows that health care system has less impact on health than broader social and economic factors
- this doesn't mean that how the health system is organized and how services and care are delivered are not crucial to tackling health disparities
- while there was a significant focus on social and economic policy in those countries emphasizing health equity, all also saw transforming the health system as an indispensable element of comprehensive strategy around health equity, including:
 - reducing barriers to equitable access
 - targeted interventions to improve the health of the poorest fastest – generally as part of community/local initiatives
 - primary care as a key enabler of health equity
 - enhanced community participation and engagement in health care planning
 - more emphasis on health promotion, chronic care and preventive programmes

6: Reduce Access Barriers

- critical part of health equity strategy is to identify and reduce barriers to access:
 - within system architecture: considerable evidence that private provision and payments -- such as user fees -- create greater barriers for poorer people
 - availability of specialist, primary and other care varies by region and neighbourhood → need targeted remedial plans to enhance access in under-served areas
 - language and culture → ensure culturally competent care and build anti-racism/oppression approach into service provision
- one policy direction is to assess what models have best served the most vulnerable communities and invest in them
 - e.g. Community Health Centres, public health and other community-based service providers have explicit mandates to support the most under-served communities
 - expand their coverage and impact

7: Target Interventions To Most Disadvantaged

- comprehensive and successful health equity strategies target resources and services to specific areas or populations as one direction for action
 - those facing the harshest disparities – to raise the worst off fastest
 - or most in need of specific services
 - or where interventions will have the most impact
- this requires sophisticated analyses of the bases of disparities:
 - i.e. is the main problem language barriers, lack of coordination among providers, sheer lack of services in particular neighbourhoods, etc.
 - which requires good local research and detailed information – speaks to great potential of community-based research to provide rich local needs assessments and evaluation data
 - involvement of local communities and stakeholders in planning and priority setting is critical to understanding the real local problems

8: Act Locally

- clear conclusion from leading countries is that action on equity cannot just come from senior governments → many of the most innovative and insightful programmes addressing health disparities have come from local authorities or community providers
 - emerging evidence that neighbourhood has an independent or reinforcing impact on health disparities
 - lived experience of health problems and opportunity structures always takes place in a local context
 - this requires that equity-driven interventions be locally focussed
- regional health authorities (RHAs) have been an important enabler and lever for planning and promoting local initiatives

Act Locally Systematically: Integrated Policy and Planning Frameworks

- to implement equity locally RHAs can:
 - use planning tools such as diversity lenses and health equity impact assessments
 - target investment and programmes in disadvantaged neighbourhoods
- build the voices and interests of the whole community – including marginalized and traditionally excluded – into their governance and planning
- enable innovation:
 - fund or pilot new ways of addressing barriers or supporting hard-to-serve communities
 - encourage on-the-ground collaborations and partnerships among health care providers and beyond

Cross-sectoral Collaboration at Local and Regional Levels

- back to British example – Health Action Zones and other models were designed to combine community development with targeted health care access and service improvements
- and in Canada, some RHAs have developed operational and planning links with local social services or emphasized community capacity building:
 - the Winnipeg Regional Health Authority and Manitoba Family Services and Housing have been partnering on a new model to integrate health and social service delivery – one-stop access models in various communities to deliver a broad range of health and social services directly and to refer on to other agencies when services aren't available
 - Saskatoon is developing cross-sectoral action on health equity:
 - began from local research documenting shocking disparities among neighbourhoods
 - focussing interventions in the poorest neighbourhoods – locating services in schools, relying on First Nations elders to guide programming, etc.

Challenge: Balance Between Local Initiatives and Overall Strategy and Objectives

- need enough flexibility to allow local experiments and interventions that best respond to local needs and situations
- but also need to ensure equity is addressed seriously and consistently in every region
- need provincial or national enabling policy and resources:
 - first of all, the Ministry must set equity targets and expectations
 - reduce health disparity in region by X%
 - ensure utilization patterns reflect ethno-cultural diversity and needs of local population, etc.
 - how these objectives are achieved is then up to local RHA, at best with significant community involvement in planning and priority setting
 - secondly, Ministry must provide the necessary financial incentives – e.g. earmarked funds to address equity or for special initiatives targeted to poorest areas
- in policy design terms, all of this can be seen as cascading expectations and incentives from the Ministry to RHAs and then into their service agreements with hospitals and other health care providers

9: Enhance Equity Focused Primary Care



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- considerable international evidence that expanding primary care can reduce health disparities
- major reforms are underway across Canada to restructure primary care
 - these system-level reform initiatives are an opportunity to build equity in by concentrating increased primary care in areas with poorest access or health status
 - think of practice innovations as well -- e.g. nurse practitioner and nurse-based clinics have been very effective in delivering primary care and managing chronic conditions
 - in terms of policy levers, it has been easier to establish CHCs and other clinics, than to reform private medical practice
- can also see primary care reform as a catalyst for wider changes – back to issue of collaborative action beyond health:
 - many countries have clinics that provide both health and wider social services in one place
 - new satellite CHCs are being developed in designated high-need areas in Toronto — and some will involve the CHCs delivering primary and preventive care and other agencies providing complementary social services out of the same location

10: Up Stream Through an Equity Lens

- investing in better chronic care management, preventive care and health promotion are seen to be vital elements of health reform
 - a very interesting primer has been developed by the Ontario Prevention Clearinghouse, Ontario Chronic Disease Prevention Alliance and other partners to help incorporate social determinants into chronic care management and support <http://www.ocdpa.on.ca/docs/Primer%20to%20Action%20SDOH%20Final.pdf>
- health promotion needs to be planned and implemented through an equity lens
 - anti-smoking, exercise and other health promotion programmes need to explicitly foreground the particular social, cultural and economic factors that shape risky behaviour in poorer communities— not just the usual focus on individual behaviour and lifestyle
 - equity-driven health promotion would ensure preventive, dental care, sexual and reproductive health, immunization and related public health services are provided in disadvantaged communities
 - specific efforts need to be made to address language, cultural and other barriers to disadvantaged communities getting appropriate health promotion information and support

11: Build on Imagination and Innovation

- I have been arguing that the way to proceed on massive challenge of health disparities is by ‘chunking out’ actionable projects, by experimenting and by relying on local community-based and other front-line innovations
- to realize this potential, senior governments need to develop a framework to support experimentation and innovation:
 - common data and information platforms
 - funding for pilot projects – available to CHCs, different practice models and community-based providers
 - dedicated funding lines to RHAs for pilots, and expectations that each RHA will undertake innovations
 - looking for results and value, but also need funding regimes that are flexible and not too bureaucratic
- then need a provincial or national infrastructure to:
 - systematically trawl for and identify interesting local innovations and experiments
 - evaluate and assess potential beyond the local circumstances
 - share info widely on lessons learned
 - scale up or implement widely where appropriate
- all to create a permanent cycle and culture of front-line driven innovation on equity

Conclusions: Action Needed

- there isn't a magic plan that can be applied in every country or region to reduce disparities, but we broadly know what is needed
- but knowing policy directions that will work doesn't mean governments will adopt them:
 - its unfortunately not just solid research or clear evidence from other countries that drives government action
 - its politics
- challenge is to try to shift public opinion:
 - still solid support for values of universal access and Medicare
 - but widespread worries about waiting lists, finding family doctors, etc.
- we need to find ways that providers, community groups, health unions, and other progressives can support each others' campaigns and coalesce around a few 'big ideas'

Reframing Health Reform Debate

- importance of values and framing:
 - if system is seen to be in crisis -- if issue can be defined as unreasonable waiting lists or bureaucratic ineptitude
 - it opens the way for simplistic privatization arguments
 - plus there is huge pressure from conservative politicians and doctors and commercial interests for increasing private provision
- one danger is that progressives can be seen as solely defensive – people know there are big problems in access and delivery:
 - Medicare can't be defended simply as some kind of defining Canadian icon or immutable value
 - the existing system has great strengths that need to be defended – especially universal access – and the inequitable impact of privatization does need to be highlighted
 - but do have to recognize that there are problems and bottlenecks that must be addressed -- and that people are really worried about
 - especially because this is where privatization proponents are making their pitch
- we need to couple a vigorous defence of universal access and the basic values of Medicare with a plan to address the health system's current problems and mobilize around a positive vision of the future



Second Stage of Medicare

- the Association of Ontario Health Centres and the Canadian Alliance of Community Health Centre Associations have done some tremendous work advocating for completing the second stage of Medicare
- they remind us that Tommy Douglas and the original founders of Medicare always saw the crucial goals of universal health insurance and access to hospital and medical care as just the vital first steps to a system that would keep people well and not just treat them when sick
- the Second Stage would:
 - increase the emphasis on preventing illness and promoting good health
 - develop cross-sectoral approaches to addressing the underlying social determinants of health
 - prioritize reducing health disparities
 - reorganize services to provide them in more flexible and integrated ways such as multi-disciplinary teams, comprehensive clinics, better local and regional coordination, and so on
 - through such changes – and through more democratic governance of health care planning -- ensure more timely, equitable and effective care
- progressive health groups in Ontario and beyond have been discussing how they can build such ideas into their advocacy

Vision for Health Equity

- if the Second Stage of Medicare and other reform initiatives are going to improve the quality of health delivery, we need to also make sure that everyone benefits and that fundamental health disparities are tackled
- we need an achievable and forward looking vision of what health equity could be
- first of all, Canadian governments need to adapt the best of what other countries are doing to our circumstances
- the roots of health disparities lie in broader social and economic inequalities and addressing these foundations must be the core of any equity strategy
- which means we need comprehensive and integrated strategy
- but don't wait for the perfect strategy – get going on what we can
- need to act across government departmental silos and sectors – policy collaboration and coordination are key
- there need to be clear targets and incentives – and ways to hold those responsible up to public scrutiny

Health Equity: II

- build equity into health system reform:
 - make equity a core objective – every bit as important as efficiency, sustainability and quality
 - reduce barriers to equitable access to services and care
 - target interventions and enhanced services to the most disadvantaged communities
 - mobilize key levers – such as enhanced primary care – that have the most impact on reducing health disparities
- encourage local innovation, initiatives and collaborations
- invest up stream in prevention and health promotion, also targeted to the most disadvantaged
- and, finally, pull all these components together, to learn from on-the-ground innovations and build on what is working well locally, to transform the whole system

About the Wellesley Institute

- funds community-based research on the relationships between health and health disparities, and housing, poverty and income inequality, social exclusion and other social and economic determinants
- works to identify and advance policy alternatives and solutions to pressing issues of urban health and health equity
- works in diverse collaborations and partnerships for progressive social change
- provides workshops, training and other capacity building support to non-profit community groups
- all of this is geared to addressing the pervasive and inequitable impact of the social determinants of health

- these speaking notes and further resources on policy directions to enhance health equity, health reform and the social determinants of health are available on our site at <http://wellesleyinstitute.com>
- my email is bob@wellesleyinstitute.com
- I would be interested in any comments on the ideas in this presentation and any information or analysis on initiatives or experience that address health equity