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Health Equity Now: A Working Paper on the Best First Steps for Ontario

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Commissioned Grants

Commissioned research at the Wellesley Institute targets important new and emerging health issues within the Institute's priority research areas. The projects commissioned may speak to current policy issues, or they may seek to inform and help shape deliberation on policy issues just over the horizon. Wellesley's commissioned research reflects community voices, interests, and understandings, and includes the community fully in the research wherever possible.

Wellesley Institute Community Roundtables on Health Equity

Health equity is high on the agenda of the Province and LHINs. Wellesley initiated a series of forums with community-based health and social service providers, researchers, advocates and others to flesh out what a community-based framework for addressing health disparities would look like. We also commissioned research and backgrounders to facilitate these discussions and move a community-based health equity agenda forward.

About the Author

This paper was prepared by Margot Lettner, Principal, Wasabi Consulting, ml.wasabi@rogers.com, on behalf of The Wellesley Institute.

Context

The Focus of this Paper

What is health equity? What are health disparities? How do they affect urban health? And what are the “best first steps” to move the health equity agenda forward in Ontario?

This Working Paper provides an overview of the work of a group of community-based service providers, policy analysts, researchers and advocates active in health equity in Ontario, brought together by The Wellesley Institute, to talk about current policy openings and opportunities at the provincial and local levels. To date, the group has held two collaborative events: the Health Equity Roundtables, December 5 and 6, 2007, in Toronto, Ontario; and the follow-up Health Equity Working Session, February 28, 2008, also held in Toronto.

This paper sets out a vision of how to start operationalizing health equity in Ontario, based on the concepts and lived experiences discussed at the Roundtables and the best advice given by participants, as well as supplementary analysis done on behalf of The Wellesley Institute. There is vibrant community-based conversation and practice in innovative, front-line service delivery across Ontario. This paper identifies and describes a menu of changes, from “early wins” that are immediately actionable, to promising initiatives that show real potential but may require further assessment or mid-term evaluation, to catalysts that invite broader, more system-level change. It gives an overview of the policy context and rationale to support these changes. It also provides a complementary perspective to the Briefing Note by Dr. Michael Rachlis, *Operationalizing Health Equity: How Ontario’s Health Services Can Contribute to Reducing Health Disparities*, March 2008, www.wellesleyinstitute.com.

This paper is, itself, a work-in-progress on health equity realities and strategies. Many people and organizations are involved in this work, and this paper cannot capture all these efforts; in fact, this is one gap that it identifies, as well as the need for better forums to exchange and build innovative practice. It does suggest, however, some approaches and answers to these questions for various audiences: policymakers and decision makers who are looking for a place to start implementation and see improved health outcomes; service providers, communities, researchers, and advocates who are actively engaged in change; and people and organizations who may not work in the field but who are becoming aware of the issues and looking for some basic information and resources.¹

¹ For more detailed discussion, refer to the Backgrounder *Health Equity Working Session*, Margot Lettner, February 2008; the Backgrounder *Health-Based Allocation Model (HBAM)*, Dr. Michael Rachlis, February 2008; the Briefing Note *Operationalizing Health Equity: How Ontario’s Health Services Can Contribute to Reducing Health Disparities*, Dr. Michael Rachlis, March 2008, and the Briefing Note *Health Equity and Health Care Finance: Looking Toward Ontario’s Health Based Allocation Model (HBAM)*, Dr. Michael Rachlis, March 2008, all available online at <http://www.wellesleyinstitute.com/health-equity-roundtable-report>.

The Current Health Equity Landscape in Ontario

There is considerable activity and intelligence around health equity in Ontario: tremendous interest from diverse service providers, policymakers, sectors, and communities; broad willingness and enthusiasm to contribute community perspectives; vibrant conversation and practice in innovative, front-line service delivery that address health disparities; and key enablers, such as Community Health Centres (CHCs), public health, community advisory panels, and core funding.

First, at the provincial level the Ministry of Health and Long-Term Care (MOHLTC) is developing a ten-year strategic vision and plan for Ontario's health care system. It is expected that equity will be a prominent direction in the new strategy and the Ministry has established a unit to coordinate policy activities on health equity.

Although not directly related to health equity, the Ontario Ministry of Health and Long Term Care is also developing the Health Based Allocation Model (HBAM) to fund the province's new Local Health Integration Networks (LHINs). While HBAM attempts to allocate funding based upon regional health needs and may resolve some equity issues based on its use of income quintile as a socio-economic indicator, its reliance on hospital service utilization patterns may not be able to reflect unmet or emerging needs, may not capture the need for 'up-stream' health promotion and preventative services, and may not identify the specific needs of under-served and disadvantaged populations. Further study could clarify potential weaknesses and identify methods for their mitigation.²

A number of key Ministries and central agencies in the Ontario government are engaged in a comprehensive policy research initiative on health equity. This recognizes that cross-sectoral action and collaboration across policy fields will be critical in addressing the underlying social and economic foundations of health disparities.

In March 2008, the Ontario Government also announced that it will develop an interministerial Poverty Reduction Strategy through The Cabinet Committee on Poverty Reduction, led by the Honourable Deb Matthews, will report by the end of 2008. It will be built around the Ontario Child Benefit, and will include targets and indicators. To kickstart the strategy, three priority programs were announced: dental services to low-income Ontarians with an investment of \$135 million over three years; increased investment in student nutrition to \$17.9 million annually for delivering nutritious meals and snacks to children and youth in schools and community settings (plus one-time capital funding); and affordable housing initiatives that include \$100 million to all 47 municipal service managers to repair existing housing stock and expanded availability of

² For further detail, see Dr. Michael Rachlis' papers on the Roundtables page at <http://www.wellesleyinstitute.com/health-equity-roundtable-report>.

loans to municipalities to undertake social housing capital repairs. While health equity is not formally part of this agenda at this time, these early announcements touch on some initiatives that participants in the Health Equity Roundtables have identified for early action, such as dental care and social housing infrastructure. There is also an evidence-based link between poverty/income security, income/wealth distribution, employment, and health outcomes that correlates low income with poorer health relative to higher income quintiles. Health equity may, in fact, get some policy/program traction through the government's interest in poverty reduction.

Second, the new Local Health Integration Networks (LHINs) will need to operationalize health equity as part of their mandate in response to the new provincial strategy. Several LHINs have already identified diversity, equity and health disparities as critical problems and have been moving to develop local health planning and delivery solutions.

Third, a range of community-based groups and networks have been coming together to address health equity. For example, the Health Equity Council is a community based organization based in the Greater Toronto Area engaging in advocacy, research, organizational change, capacity building, community partnerships and collaborations that enhance diversity, equity and inclusion in all facets of health and wellness. Its members are drawn from hospitals, health promotion organizations, community health centres, community based agencies and educational/advocacy organizations across Toronto. The GTA Community Health Centres have developed an equity-based planning tool called the Urban Health Framework.

Fourth, working locally across the GTA, The Wellesley Institute hosted the Health Equity Roundtables on December 5 and 6, 2007, in Toronto, Ontario. Thirty five participants, bringing together service providers, policymakers, researchers and advocates active in health equity, met to talk about current policy openings and opportunities to move health equity forward to action in Ontario – with the provincial government and/or the LHINs - the dynamics of health equity principles, where current health equity practices are working and why, and possible next steps. This is one part of a great deal of research and policy work Wellesley has been doing on health equity and the social determinants of health.

The key outcome of the Roundtables was an initial list of about 60 current models, programs and services determined to be workable ideas, many of which are already in practice, that the Ontario Government and/or LHINs could support as new or enhanced options to deliver health equity in the next 6-12 months.³ On February 28, 2008, participants sharpened this list into a strategic action agenda of 18 ideas – the “best first steps” that this paper focuses on – as their

³ For the initial list of “early wins,” see Appendix A, Backgrounder *Health Equity Working Session*, February 28, 2008, posted at <http://www.wellesleyinstitute.com/health-equity-roundtable-report> .

advice to and the foundation of an engagement strategy with the Ontario Government and the LHINs.⁴

What is health? Health disparities? Health equity?

There are many definitions of health, used for many purposes, but the definition adopted by the World Health Organization (WHO) in 1978 remains a good working standard:

[Health is] a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity. It is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO, Alma Ata, 1978)

Similarly, there are many definitions of health disparities or inequities but, simply put, disparities are differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage. Health equity, then, works to reduce or eliminate socially structured inequalities and differential outcomes. It is linked with broader ideas about fairness, social justice, and civil society. Or, put simply, health equity means equal opportunities for good health.

The clear research consensus is that the roots of health disparities lie in broader social and economic inequality and exclusion. The most effective conceptual framework for health disparities is therefore grounded in a determinants of health approach, i.e., it looks beyond the traditional definitions of health, as well as beyond the historical analyses of the causes of illness and injury, and focuses on a broad range of socio-economic influences and outcomes that affect both individual and community or population health, such as income/wealth distribution and poverty, early child development, education, employment and working conditions, housing, gender, race and ethnicity, citizenship and immigration status, language, ability, sexual orientation, age, racism and discrimination, social exclusion, and natural and built environments.

So, many of the most important factors producing health disparities are far beyond the health care system itself. And much of the solution to health disparities lies in macro social and economic policy – and in policy collaboration and coordination across governments that may be beyond the scope of the policymakers in a local community. But this does not mean that changes to make the health system more equitable cannot have a major impact. Pervasive and

⁴ For the discussion themes and questions, see the Backgrounder *Health Equity Working Session*, February 28, 2008, posted at <http://www.wellesleyinstitute.com/health-equity-roundtable-report>.

damaging health disparities – with the more disadvantaged people being sicker and needing more care – shows the effects of this wider inequality. A great deal can be done within the health system to address the harsh impact of these disparities and enhance the well-being of even the most disadvantaged.¹

The question then becomes how to get started. In Ontario, two very different organizations have arrived at similar interpretations of health equity. In their second report to the Ontario Government in 2007, The Ontario Health Quality Council identified a three-pronged approach to developing a more equitable system based on maximizing three of the other attributes:

- Improving the accessibility of the health system through outreach, location, physical design, opening hours, and other policies
- 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
- Cooperating with other sectors to improve population health

The Health Equity Council, working from its 2005 conference *Health Equity and Diversity – Local Realities and International Perspectives*, has collaboratively arrived at this living definition of a People's Health Equity and Diversity Charter: A Framework for Action:

Fair and equitable health outcomes across diverse communities will result from utilizing an inclusive health framework for publicly funded and other universally accessible health services. This requires policies, planning, education and training, funding, and research that clearly recognize racism/racialization and all other forms of exclusion and oppression as fundamental social determinants impacting health and wellness. We further recognize the intersecting and compounding impact of various forms of marginalization, including, but not limited to, race, national or ethnic origin, class, spirituality or faith, sex, gender, sexual orientation, age, mental or physical disability (visible and invisible), immigration or family status, and identified arising from these, on individuals' and communities' state of health and well being.⁵

⁵ Health Equity Council, 2005, *Health, Equity and Diversity Conference: Local Realities and International Perspectives Conference Report*.

What can be done now: Ontario’s “Best First Steps”

Although most of the root causes of health disparities lie outside the health system, a great deal can still be done within this system to move the health equity agenda forward. Governments and community-based providers can identify and reduce barriers to access. They can target investments and interventions in the most health disadvantaged communities and populations. They can build equity and diversity into all service delivery and planning. And they can enhance equity-focussed primary and preventive care.

While evidence gaps continue to exist for relationships among specific health outcomes, determinants and/or communities/populations, enough credible evidence does exist to raise health disparities as a critical emerging public policy issue. There is vibrant community-based conversation and practice in innovative, front-line service delivery across Ontario. There are also promising directions for change, mostly at and from community-based advocates, service providers, and researchers. The working principle for moving forward should be “think big, but get going.”

What follows is the advice - by consensus - from participants at the Health Equity Roundtables on “the best first steps” to get health equity going in Ontario, supplemented by additional analysis by The Wellesley Institute. This is strategic advice from community voices with lived experience providing direct service in the Greater Toronto Area most affected by health disparities – and in some cases, receiving health care as members of these communities and of the public. This advice, however, doesn’t preclude representations and ideas from other communities currently not directly involved in the Roundtables.

These first steps are broken into three groups: “early wins” that are ready to go; “promising directions” that show real potential but may need further assessment or mid-term evaluation; and ‘catalysts” that open the door to broader, more system-level changes. They are further identified by whether their main thrust is towards direct service delivery, community-based research, or community engagement.

1. “Early Wins”

Direct Service Delivery – Government/Service Provider Partnerships

Primary Care Follow-Up Protocol, Cardiac

Opportunity: a disproportionate number of cardiac patients who are discharged from hospital are readmitted for post-discharge conditions that community-based follow-up care could prevent or reduce.

Action: implement pilot Primary Care Follow-Up Protocol for post-discharge cardiac patients for community-based follow-up primary care focused on preventing or reducing readmission, and expand to other post-discharge follow-up care for other chronic diseases based on evaluation.

Three-Month OHIP Waiting Period

Opportunity: Ontario’s current three-month waiting period for OHIP eligibility results in people being effectively non-insured for access to health care, which puts recent immigrants and other vulnerable populations at heightened risk.

Action: eliminate the current three-month waiting period for OHIP eligibility.

Aging At Home

Opportunity: the new Aging at Home program must reach the full diversity of seniors from ethnoracial and ethnocultural communities in Ontario, incorporate the impact of broader determinants of health into its planning and ensure culturally appropriate care geared to the specific needs of diverse communities.

Action: ensure that vulnerable populations that may not have been reached during recent LHINs’ consultations are represented before guidelines and other implementation decisions are finalized, build ongoing participation of diverse communities into program monitoring and evaluation, and recognize that homeless seniors need parallel forms of support (or, far better, adequate supportive housing).

Dental/Oral Health Care

Opportunity: to kickstart its Poverty Reduction Strategy, the Ontario Government has announced that dental services will be provided to low-income Ontarians with an investment of \$135 million over three years.

Action: track the commitment and ensure increased access to dental/oral health care for people with no OHIP or private supplementary health insurance coverage who are aged 19-64 years; and explore local collaborations, e.g., dental clinics

Community-Based Research

MOHLTC Health Equity Unit

Opportunity: there are currently gaps in evidence-based outcome research in health equity that would identify best practices and promising approaches, and a new unit of the Ministry that is looking to establish credibility and expertise in health equity.

Action: propose a series of community-based research projects or scoping research funded by the MOHLTC Health Equity Unit that respond to specific gaps in outcome research and undertake to build an inventory of best practices/promising approaches and knowledge dissemination within and outside the Ontario Government. A broader Roundtable on the potential of community-level innovation to address health disparities, similar to those recently hosted by the Wellesley Institute but with province-wide representation from providers, policymakers, researchers, and advocates active in health equity, would provide current and constructive Ontario-wide perspectives. This dialogue would provide additional foundation for the research projects/scoping research.

Community Engagement

Engagement strategy with the LHINs

Opportunity: the LHINs currently have relatively limited equity and diversity-relevant baseline data to support responsive local health planning and delivery systems.

Action: develop pilot projects to work with the LHINs on collection and disaggregation of data along key demographics and determinants of health, and on implications of the HBAM funding formula (particularly for prevention initiatives) at the local level. The mid-term goal should be to scale these local experiments up to develop standardized diversity and equity-relevant data to be collected across the Province.

Hospital Equity Plans

Opportunity: Toronto Central LHIN requires all hospitals to have Equity Plans by October 2008.

Action: propose LHINs resourcing to support hospitals to work collectively across their institutions to build equity processes into the planning process itself and promote common principles, mechanisms and outcomes among the individual plans.

Aboriginal Healing and Wellness Strategy (AHWS)

Opportunity: the Aboriginal Healing and Wellness Strategy (AHWS) is under review in 2008.

Action: support continuation of the Aboriginal Healing and Wellness Strategy (AHWS) as a model of holistic primary care and prevention that recognizes and respects diversity within and among communities.

2. Promising directions

Community-Based Research

Alternate Funding Case Studies

Opportunity: to respond to and inform continuing development and potential consequences of HBAM and related funding formulas, demonstrate how funding models influence or determine service delivery and quality as well as labour relations issues (e.g., who works where, historical funding inequity between health and social service budgets).

Action: develop pilot, local, community-based projects focused on specific populations or neighbourhoods to develop alternative funding scenarios for key postal-code level GTA communities based on allocations that control for specific socio-economic determinants of health, as opposed to only historical utilization rates, control for costs that are specific to health equity but also demonstrate cost efficiency (e.g., translation costs and asthma management), and highlight emerging HBAM conceptual and implementation issues.

Action: develop pilot CBR projects that compare quality and cost outcomes based on community funding assessments vs. funding models.

Action: develop pilot CBR projects that collect differentiated data around determinants of health such as income and race/ethnicity that could be used to adjust HBAM funding allocations after the formula has been applied (public health and settlement services are good data sources).

Community Engagement

Engagement Strategy with the Ontario Government, Poverty Reduction Agenda

Opportunity: the Ontario Government has announced that it will develop an interministerial Poverty Reduction Strategy through The Cabinet Committee on Poverty Reduction, led by the Honourable Deb Matthews, by the end of 2008, built around the Ontario Child Benefit, including targets and indicators, and kickstarted by new or enhanced priority programs in dental care, student nutrition, and affordable housing.

Action: track the commitment and highlight the evidence-based correlations between a poverty reduction agenda, health disparities, and health equity.

3. Catalysts

Direct Service Delivery – Government/Service Provider Partnerships

Advanced Access Protocol, Primary Care

Opportunity: chronic wait times of four weeks plus for appointments for primary health care

Action: implement advanced access in primary health care and shared care models for medical specialists.

Community Health Centres (CHCs) Service Provision to OHIP Non-Insured

Opportunity: currently the only access to health care for people without OHIP coverage is through CHCs, which generally provide care and arrange and fund hospital treatment. However, the funding is nowhere near adequate for the CHCs and there is tremendous inconsistency across hospitals and the system on how people without insurance are treated. Many people without insurance do not receive the care they need and suffer poorer health as a result.

Action: enhance services with high proven equity potential by recognizing the role and responsibility that CHCs have assumed and increase funding CHCs to provide health care to non-insured clients; consider creation of specific task force to explore reform options and make recommendations.

Peer Researchers/Workers, Navigator Concept/Care Model

Opportunity: there are programs currently in the field that use community peers as researchers and service providers in collaboration with other practitioners to ensure community ownership and validation, as well as provide “navigation” of the health care system to community members.

Action: replicate current best practices in peer-based research and service delivery by developing community-based research projects that recruit, train and involve peer inclusion researchers from communities specifically affected by health disparities as partners in the conception, development, creation, and dissemination of their stories and show the people and places that contribute to health and social disparities; and/or as community-based peer workers in front-line outreach and service system navigation services, e.g., public health, nutrition (models: Street Health, Access Alliance, Ontario Women’s Health Network (OWHN)). Link: Participatory Media Series

Community-Based Research

Core Definition of Health Equity

Opportunity: currently there are various definitions of health equity in use in various jurisdictions, as well as several Ontario-made definitions (e.g., Ontario Health Equity Council, Health Equity Coalition, former Premier’s Councils) but no one working description of what health equity means in practice in Ontario that finds common traction among communities, service providers, researchers, advocates, and policymakers.

Action: working from existing definitions as representing current context and experience, craft consensus on a working description of health equity to inform the development and implementation of programs, services and projects by both government and communities, as well as community engagement strategies.

Community Engagement

Support LHINs’ Prevention Agenda

Opportunity: the LHINs’ current primary focus is on “downstream” curative health services.

Action: work with the LHINs to rebalance the focus “upstream” on prevention approaches and resourcing that work from a determinants of health perspective and through an equity lens.

Participatory Media Series

Opportunity: policymakers, decision makers, the media, and the public need to hear the story of health disparities to ground their understanding of the critical importance of health equity, and people with lived experience of disparities and health outcomes need to tell their stories.

Action: create a series of “Anatomy of Disparity” case studies and key messages for different population health groups, e.g., diabetes, and/or different determinants, e.g., poverty, through participatory media (film, print, visual) that involve people with lived experience in the conception, development, creation, and dissemination of their stories and show the people and places that contribute to health and social disparities.

Action: create a parallel series of “anatomy of poverty” case studies and key messages to make the conceptual, actual, and interministerial link between poverty reduction and health equity that is interdisciplinary, multi-sectoral, and action-focused and can be used as a model for comment and analysis of other determinants of health and lead to policy/program/funding changes.

Chronic Disease and Health Disparities

Opportunity: the LHINs’ mandate includes Chronic Disease Prevention and Management (CDPM) as a priority planning and service initiative, based on provincial frameworks.

Action: profile the link between chronic disease and health disparities and develop a CDPM model through an equity and diversity lens – develop these ideas with partners at upcoming 2008 events, e.g., Association of Ontario Health Centres (AOHC) Annual Conference, June 2008).

Broaden the Base: New Community Partners

Opportunity: the increased awareness about health equity among government and health care system partners, together with the policy openings created by the current mandates and work of MOHLTC, other socio-economic Ontario ministries and the LHINs, opens concurrent opportunities for broader-based alliances among community-based voices.

Action: build relationships with new partners such as public health, addictions and mental health, CHCs, settlement services, and labour around their specific experiences with health disparities; and develop parallel engagement strategies both for internal sector/profession/sector audiences and external audiences of policymakers and decision makers.

Next steps

There are several parallel community-based “big picture” strategies to move Ontario’s health equity agenda forward. Ongoing activity includes:

- Participants from the Health Equity Roundtables hosted by The Wellesley Institute are continuing to meet to both shape community-based strategies and advise Wellesley in its ongoing informal conversations with the Ontario Government and LHINs, as well as explore possible partnerships among its members
- Wellesley will undertake formal briefings with the provincial government during summer 2008, based on an “first steps” health equity implementation strategy, advance analysis of the probable implications of the HBAM and related funding formulas, and proposals for specific health equity “gap” research and knowledge dissemination
- Although Wellesley has completed its formal advisory work on health equity with Toronto Central LHIN, it continues to be available as a community-based resource as TCLHIN considers and implements the recommended strategies
- The Health Equity Council continues to build relationships that access community and provider knowledge and experience with the LHINs

Consultations on the Ontario Government’s Poverty Reduction Strategy, reporting to Cabinet in fall 2008, are another window for influence and action on health equity because of the broad socio-economic determinants that frame poverty. Community-based organizations are working through a variety of mechanisms, from formal submissions to urgent action alerts for their members to respond and contribute to this discussion.

With hospital health equity plans coming on stream and the anticipated provincial health strategy, fall 2008 is emerging as a planning window for both proactive and reactive policy engagement from communities that traditionally work together and, perhaps more importantly, across communities and sectors. It will be critical to ensure that community-based experience, values and insight shape the evolution of health equity policy and action in Ontario.



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