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Blueprint for Action on the Social Determinants of Health and Health Equity

National Action Meeting
Viva! Health Project
Portuguese-Canadian National Congress

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Introduction

- health disparities are pervasive, incredibly damaging and solidly rooted in overall social and economic inequality
- but, action is possible:
  - many jurisdictions have developed comprehensive policies and programs to address health disparities – and there are enough indications of how these policies can be effective
  - there will be windows of opportunity:
    - Ontario will be releasing a new 10 year health strategy, and equity will be a prominent theme
    - the LHINs have the potential to guide and support local initiatives on health disparities
  - there are innovative community-based initiatives across the country --- and in the Portuguese community -- addressing the impact of health disparities on the ground

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Today

- goal today is to set out a broad blueprint for action:
  - will highlight promising policy directions that can address health inequities
  - will set out 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
- to set the context for the really excellent Viva! report
  - to provide some ideas for your discussion
  - to give some sense of how these overall directions might be relevant for your community planning and mobilization

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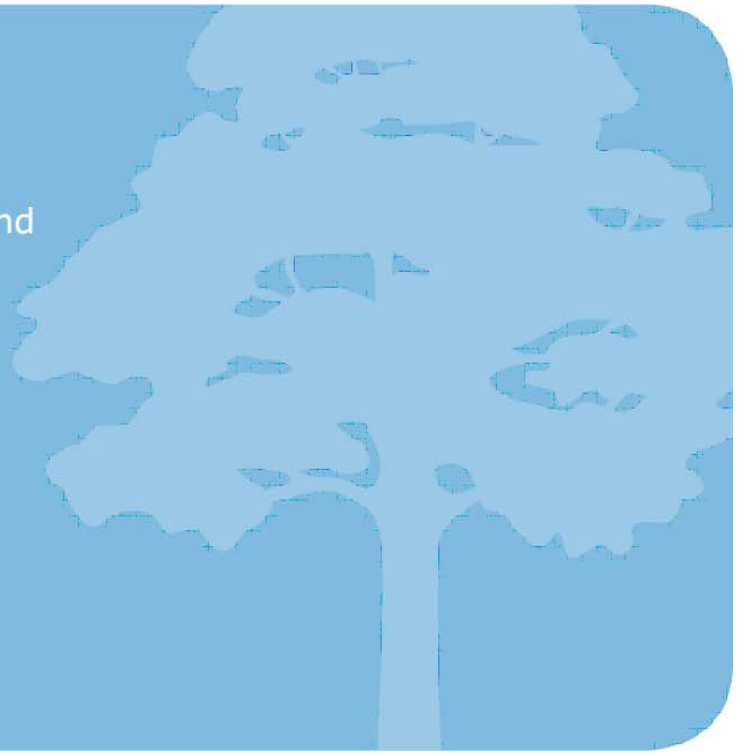
Wellesley Institute

funds and supports community-based research on housing, poverty, social exclusion, and other social and economic inequalities as key determinants of health disparities

commissions comprehensive comparative and other policy research

identifies and mobilizes for policy alternatives and solutions to pressing issues of urban health and health equity

works in diverse collaborations and partnerships for social innovation and progressive social change



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Health Disparities Are Well Documented

- all advanced countries – even those with best overall health – have significant disparities in health outcomes
  - considerable evidence that health disparities have increased in many countries → often the immediate challenge is seen to be preventing health disparities from continuing to worsen
- Canada-wide disparities have been equally well documented
  - while infant mortality rates have been declining overall, infant mortality rates in Canada's poorest neighbourhoods remain two-thirds higher than those of the richest neighbourhoods
  - men in the lowest income quintile live five years less than men in the highest
- 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

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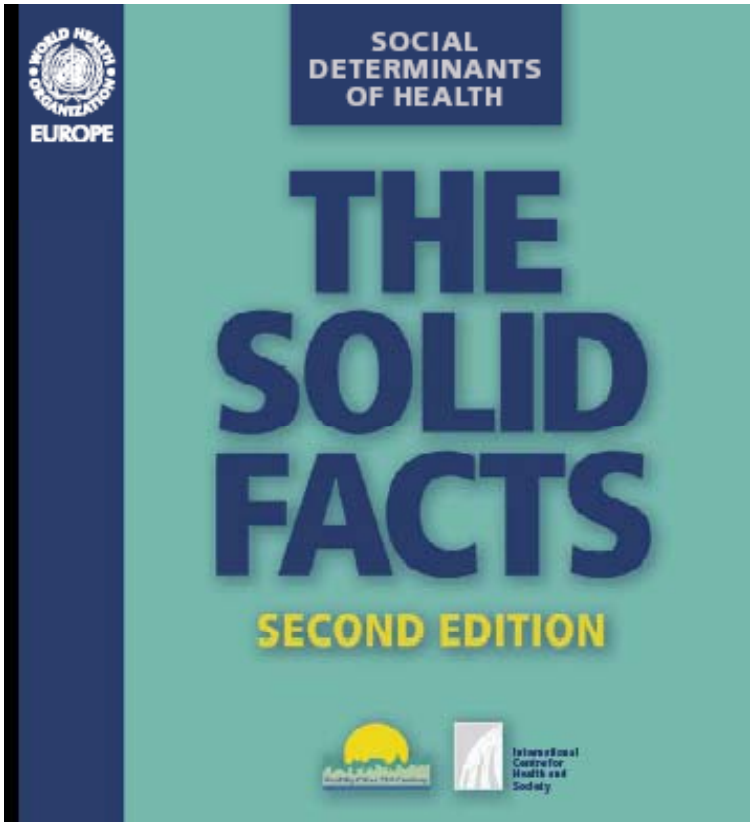
Roots Lie in Social Determinants of Health

- 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, social exclusion, housing and social safety nets on health outcomes is well established here and internationally
- real problem is differential access to these determinants – many analysts are focusing more specifically on social determinants of health disparities



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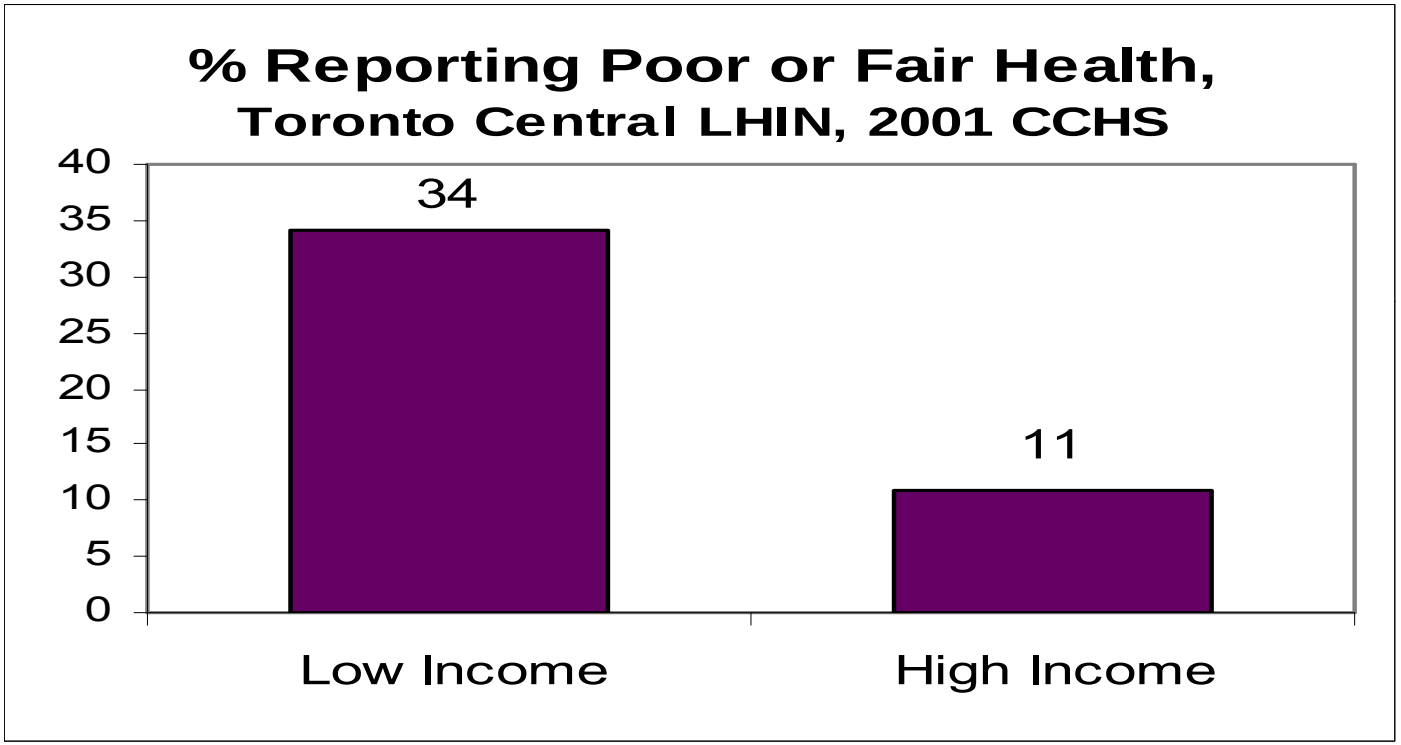
Lower Income: Poorer Self-rated Health



Three fold difference in self-rated health among lowest and highest income neighbourhoods.

Canadian Community Health Survey 2001, Respondents
Glazier et al. Primary Care among Disadvantaged Populations. Primary Care.
ICES Atlas, 2006. www.ices.on.ca/intool

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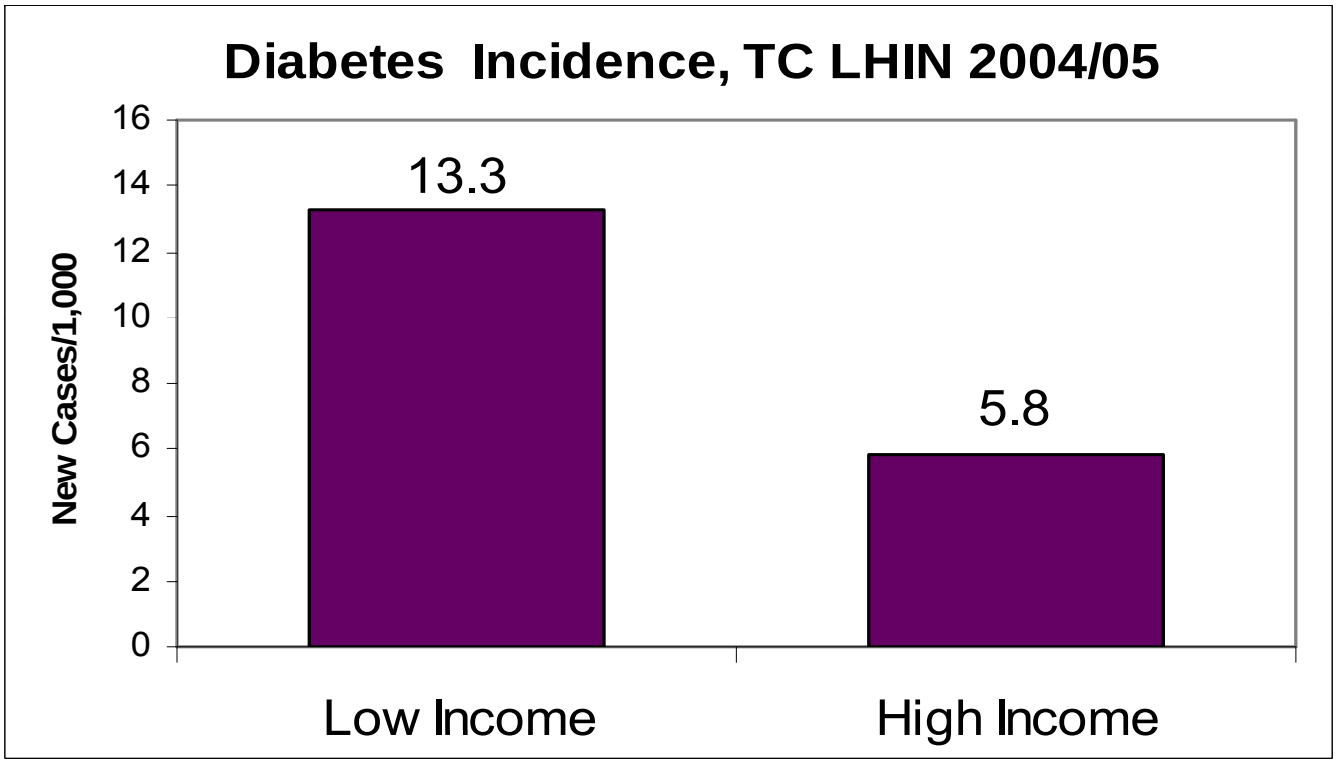
Lower Income: Higher Diabetes Rate



Two fold difference in Diabetes Incidence among lowest and highest neighbourhoods.

Age Standardized Rates. Data Source: Ontario Diabetes Database, 2004/05
www.ices.on.ca/intool

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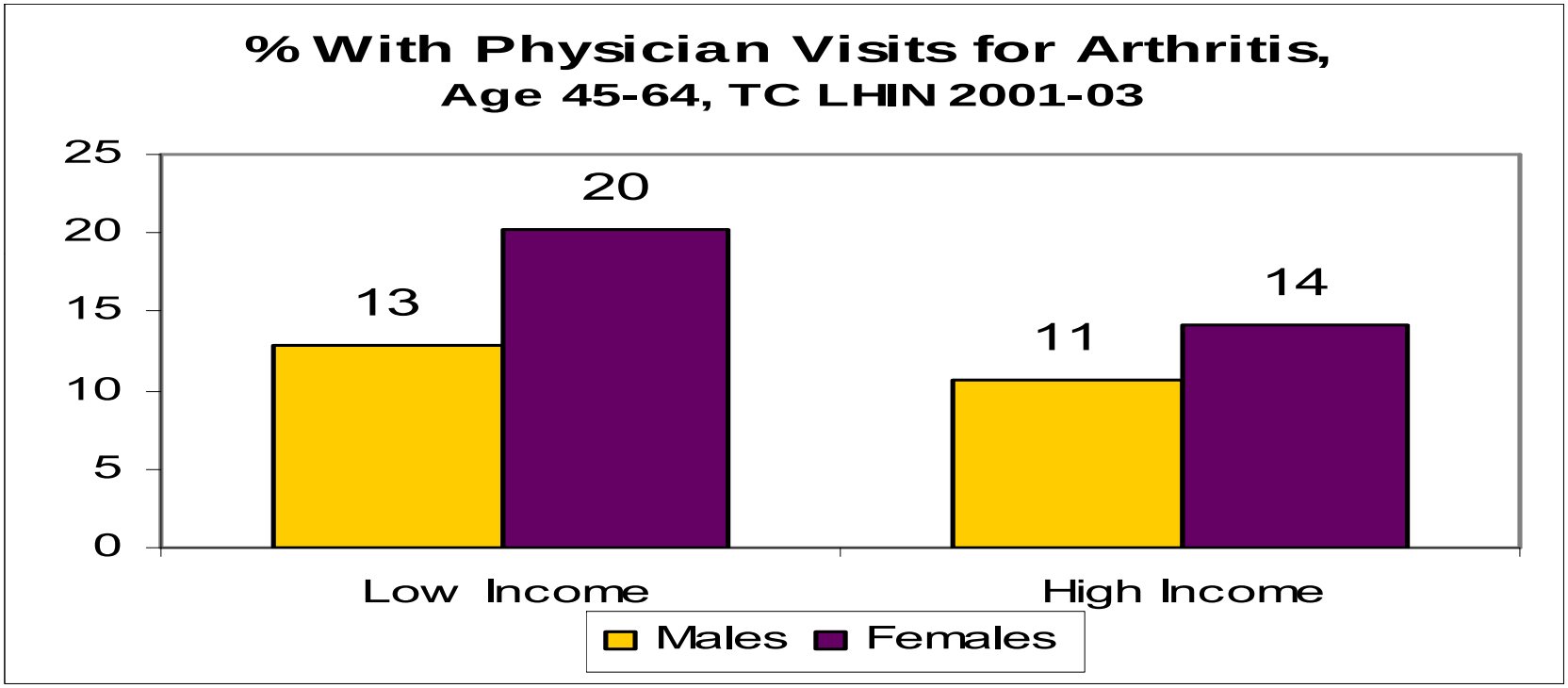
Lower Income: More Physician Visits



Proportion of Residents with physician visits for Arthritis is higher in Lower Income neighbourhoods, especially females.

Neighbourhood Income Quintiles

Toronto Community Health Profiles Partnership, www.torontohealthprofiles.ca

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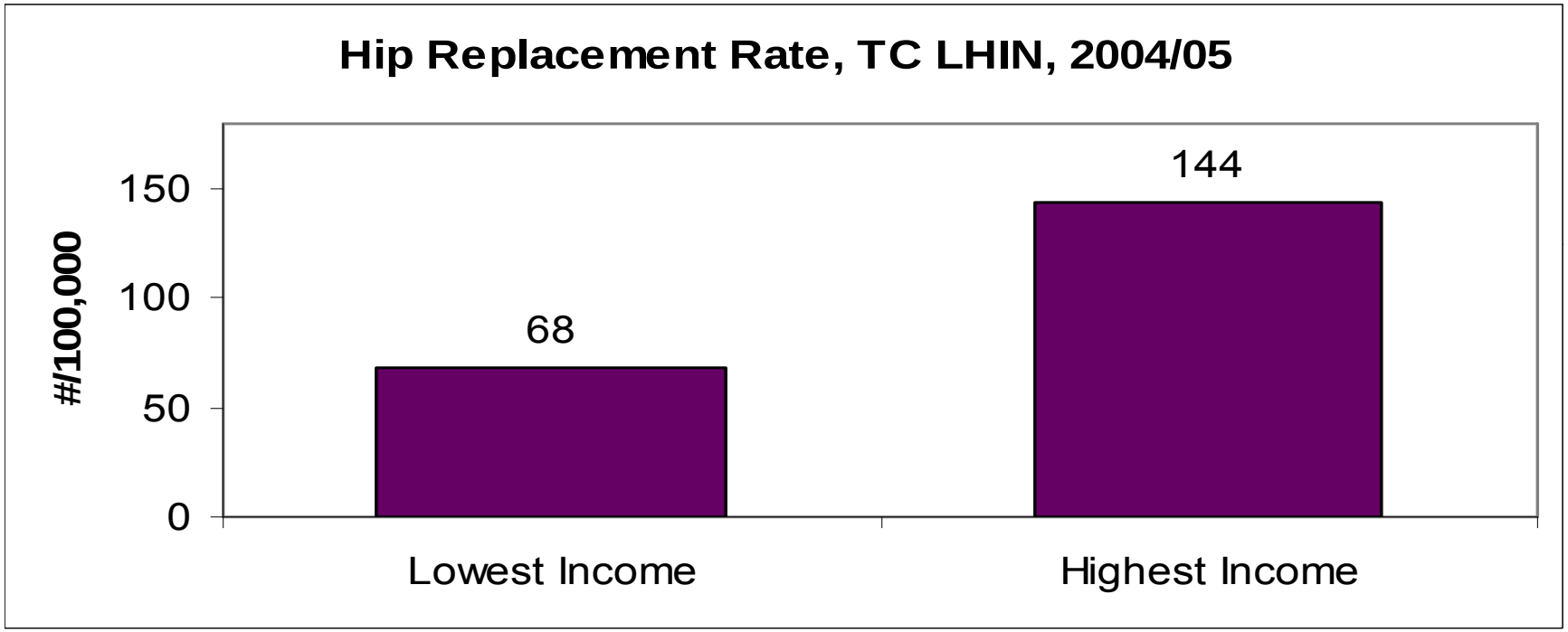
Lower Income: Lower Hip Replacement Rate



Despite poorer health and greater need/potential to benefit from diagnosis and treatment in lower income groups, the hip replacement rate is higher in the highest income neighbourhoods.

Age Standardized Rates. Total Hip Replacements per 100,000 Population by Neighbourhood Income Quintiles. .Source: Institute for Clinical Evaluative Sciences (ICES) November 2006

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Systemic Health Disparities

- this Ontario and Toronto data shows a consistent health gradient:
  - people with lower income, education or other indicators of social conditions and position tend to have poorer health
  - this holds all along the social hierarchy
  - the gap between the health status of the best off and most disadvantaged can be huge – and damaging
- the Viva! report shows that Portuguese people are over-concentrated in lower income and educated positions:
  - we don't have specific epidemiological data by ethno-cultural background
  - but combining these overall patterns and socio-economic data and analysis of Viva! report → Portuguese people face significant health inequalities
  - which is no surprise to agencies and front-line community people

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Health Equity = Reducing Unfair Differences

- the most common definition of health equity is the absence of socially structured inequalities and differential outcomes
- so the goal is to reduce those differences in health outcomes that are **avoidable, unfair and systematically** related to social inequality and disadvantage
- this concept is:
  - 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

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A Positive Vision of Health Equity

- as equal opportunities for good health
- nested in a society in which poverty, inequality and social exclusion – and their impacts on ill health – have been reduced
- consumer/patient driven care and delivery, with individual and community needs at the heart of planning
- culturally appropriate care – crucial in diverse society
- equitable access to a full and seamless continuum of health and social services
- health and human services systems that focus on the most disadvantaged
- investing 'up-stream' in preventive and health promotion

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1: Look Widely for Ideas and Inspiration

- there is always much to be learned from policies, programmes and initiatives in other jurisdictions
- a number of countries have made lessening health disparities a top national priority and have developed comprehensive policy frameworks and/or action plans:
  - many European countries
  - UK, New Zealand
- 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

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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 – idea of *Health in All Policies* or *Healthy Public Policies*
  - 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

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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

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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
- re-frame issue of reducing health disparities as not just about health but also as investments that build social cohesion and enhance human capital

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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
  - Ontario is considering this in major cross-Ministry project on health equity
- English *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

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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
- here in Ontario
  - first of all, the Ministry should set equity targets – just as for waiting times and other priorities
    - reduce health disparity in region by X%
    - ensure utilization patterns reflect ethno-cultural diversity and needs of local population
  - how these objectives are achieved is then up to local LHIN, 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

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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, especially for most disadvantaged

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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
  - language and culture → ensure culturally competent care and build anti-racism/oppression approach into service provision
- one effective policy direction is to invest in those models that focus on the most vulnerable communities
  - e.g. Community Health Centres, public health and other community-based service providers have explicit mandates to support the most under-served communities
  - multi-service neighbourhood centres and other community-based providers

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7: Target Interventions To Most Disadvantaged Populations

- one component of comprehensive and successful health equity strategies is to target resources and services to specific areas or populations:
  - 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 foundations 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 value of the VIVA! Health Project report
  - also highlights the potential of community-based research to provide rich local needs assessments and evaluation data – e.g. PIN project

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8: Enhance Equity Focused Primary Care

- 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 such as better collaboration:
  - 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

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9: 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
  - and from community-based providers
- regional health authorities have been an important enabler and lever for planning and promoting local initiatives across the country →
  - it is at the LHIN level that the key directions discussed will be implemented
  - will highlight briefly how this could be done
- most fundamentally, LHINs need to make a clear commitment that health equity is a top priority in their regions – and devote the staff and resources to make it happen

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LHIN Action on Equity

- the LHINs have considerable powers:
  - they should use all the levers and resources at their disposal to build equity into service provision across the system
  - first of all, by setting expectations such as requiring health equity plans from service providers
  - they can build equity into all aspects of ongoing performance management – from clear targets and indicators through incorporating equity into service accountability agreements with providers
- the LHINs need to build addressing health disparity into their resource allocation strategies and into their funding relationships with health care providers
  - so that equity is one factor considered in all resource decisions and service provision
  - at the same time, strategically target some investments and service interventions to reduce language, navigation and other barriers to equitable access and support the most disadvantaged populations

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LHIN Action on Equity: II

- LHINs will need to prioritize patient-centred care – and ensure it is driven through an equity lens – so that well focussed program interventions take account of the more challenging circumstances and greater needs of disadvantaged populations
- they need to support and enable innovative community-based service provision:
  - fund or pilot new ways of addressing barriers or supporting hard-to-serve communities
  - including the many innovations underway within Portuguese providers
  - encourage on-the-ground collaborations and partnerships among health care providers and beyond
- they must build the voices and interests of the whole community – including marginalized and traditionally excluded – into their governance and planning
  - critical to understanding the real local problems and identifying community solutions that will work

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10:Collaborate Across Sectors

- LHINs need to build on already established networks of community-based service providers
- they need to encourage and support cross-sectoral collaboration to address the impact of the wider social determinants of health:
  - fund and encourage health providers to link their programmes to appropriate social service and other providers
  - for example, explore hub models for services by locating health services in neighbourhood centres and other non-health settings
  - and concentrate these innovations and investments in under-served communities
  - the five GTA LHINs should create a planning table to link health and other providers addressing SDoH on the ground

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11: 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
  - VIVA! Report provides data that Portuguese community do less well on smoking, drinking and other health behaviours
  - which highlights that 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
  - specific efforts need to be made to address language, cultural and other barriers to disadvantaged communities getting appropriate health promotion information and support

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12: 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:
  - starting to collect equity-relevant data
  - dedicated funding lines to LHINs for pilot projects, and expectations that each LHIN will support local and community-based service innovation
  - 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

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Conclusions: Action Needed

- there isn't a magic plan that can be applied in every region or community 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 mobilize widespread community support for equity-driven reform in health and social policy

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Reframing Health Reform Debate

- importance of values and framing – we need to define equity as essential to a productive, cohesive and fair society
- 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

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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 forward looking ideas into their advocacy

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Key Messages: Blueprint for Health Equity

- 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

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Blueprint for Health Equity: II

- build equity into health system reform – and into the core fabric of the new LHINs:
  - 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

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Contact Us

- these speaking notes and further resources on 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