WELLESLEY INSTITUTE
advancing urban health

Policy Consultation

E Health and Health Equity: Comments on Ontario's eHealth Strategy

| February 2009

Electronic Health and Health Reform

The potential of e health is enormous. More efficient flow of information can underlie enhanced access to services, better quality care and increased efficiency, and the better use of real-time data and knowledge can drive a more responsive and better performing system. The Wellesley Institute agrees that successful implementation of comprehensive e health is indispensable for progressive and innovative reform.

Jurisdictions across Canada, and around the world, have emphasized e health as one vital element of restructuring and re-aligning their health systems. Strategies normally include:

- electronic health records (EHRs) in which all of a patients' medical history is efficiently stored and easily accessible from many clinical locations;
- platforms and systems for the smooth exchange of patient and clinical information among providers across the system;
- ensuring that all providers, especially the smaller and less-resourced such as individual physician practices and community-based agencies, have sufficient resources and support to effectively use e health systems;
- integration or inter-operability of IT systems so that providers from different institutions and sectors can exchange data;
- health data management regarding service utilization, medication, treatment, outcomes and overall system performance; and
- a wide range of inter-related quality control, risk management and non-medical purchasing, human resources and other information systems in provider institutions.

At best, e health is effectively linked to other ICT-based innovations such as tele health, distance training and multi-site treatment and diagnoses.

eHealth Ontario

The Ontario Ministry of Health and Long-Term Care has amalgamated its various initiatives and programmes on electronic health into eHealth Ontario, with a mandate of providing "a single, harmonized, coherent province-wide eHealth Strategy and align it through a single point of accountability". [1] It recently released a new overall strategy in which it set out key directions for developing electronic health records and other elements of an electronic infrastructure. The Strategy will focus on implementing e health and EHRs in three priority areas: diabetes management, medication management and wait lists. It sets out detailed success indicators,

[1] http://www.ehealthontario.on.ca

targets and timelines, and identifies the many resource and organizational changes needed to realize these objectives.

eHealth, Equity and Health Transformation

Ontario is currently undergoing a fundamental transformation of its health system. The emerging overall provincial health strategy is founded on three fundamental pillars: quality and sustainability, patient-centred care to improve health, and equity. The case for EHR and eHealth as essential for sustainability, quality and better health care is commonly understood and frequently made. The Strategy sets out these connections clearly.

Our emphasis in these comments is that eHealth is every bit as crucial to meeting equity objectives, that equity considerations have to be built into all stages of the analysis and planning of eHealth, and that the equity impact of eHealth can be maximized through a number of concrete policy and program directions that we identify.

Scope of These Notes

This is not a comprehensive analsysis of the reform and equity implications of eHealth. We will develop a fuller analsysis at a later stage.

EHealth Ontario asked for input on its strategy. While extensive stakeholder and expert involvement went into development of the Strategy, community engagement for this round of consultation was quite limited; requests for responses to several specific questions within a week.

These comments respond only to the specific questions asked by eHealth Ontario in its on-line consultation exercise.

Question: Is the Strategy to achieve Ontario's eHealth clinical priorities on the right track?

The clinical priorities have been chosen after considerable deliberation, and they align well with other key reform initiatives currently underway. It would be ineffective to change them at this stage. Achieving these priorities will both significantly advance eHealth overall and contribute to better care in these critical spheres.

However, such priorities are never purely clinical. Systemic and pervasive health disparities in access to and quality of care and in health outcomes are a critical facet of the context for all

health reform and service delivery. Each of the three eHealth priorities needs to be thoroughly analyzed and planned in terms of:

- their impact on equitable access to services and health status;
- how they address specific barriers to equitable access and high quality care such as language, cost, availability of a full continuum of services, literacy, how well services are integrated, effectiveness of multi-disciplinary collaboration, etc.;
- their implications for the care needs and situations of particular health disadvantaged individuals and populations;
- how success in the priority will contribute not only to reducing disparities in the particular condition or inequitable access to particular treatments, but to reducing overall disparities in health outcomes.

These comments briefly illustrate how such an equity lens can be applied to each of the Strategy's priorities.

Building Equity Into eHealth Priorities

Diabetes management is an excellent choice from an equity perspective. Its incidence and impact is greater in more health disadvantaged populations and, like most chronic conditions, it follows a social gradient in which the poorer and more marginalized suffer most. If well planned and managed, improving diabetes management could have a disproportionately beneficial effect on the most disadvantaged. However, these equity implications are not actually acknowledged in the Strategy. One painful lesson of health system change is that if objectives such as equity are not explicitly included in strategic priorities and analysis, and in accompanying deliverables and resources, they simply will not happen.

Equity will need to be built into the eHealth strategy for diabetes management explicitly:

- the particular barriers – language, literacy, poor nutrition and living conditions, lack of access to IT for self-management – faced by disadvantaged individuals and populations need to be taken into account;
- at worst, monitoring and alerting will be very difficult for homeless people or for people who do not speak English;
- addressing these wider social conditions is part of understanding why it may be difficult for some to follow 'best practices', and to develop the necessary supports needed by those in challenging circumstances;
- poorer people tend to have more complex diabetes and general health needs and require more intensive interactions with health professionals;
- all of which highlights the potential of community-based programming targeted to the most under-served or vulnerable populations;
- equity should be built into the Strategy's goals and indicators:
    - an additional goal should be not simply to achieve improvement in the identified markers, but to reduce disparities in the markers along the social gradient;

- similarly, an additional complementary measurement could be reducing systemic differences in % receiving best practice care by income, language, gender, ethno-cultural background, neighbourhood or other social variables.

Equity implications for medication management include:

- A significant barrier to equitable care for many is access to medication – especially when secured through private or employment-based insurance. While this is beyond the mandate of eHealth, it does need to be understood if the goal is to improve quality of medication for all.
- A further unfortunate part of the context for this priority is inequitable access to primary care in the first place. If the strategy is designed to work through physicians, then a significant proportion of the population who do not have a regular primary care provider will potentially be left out.
- Literacy, language, cultural competence, and other barriers faced by disadvantaged individuals and communities will need to be taken into account in program design.

Equity implication for wait times include:

- Research data indicates differential access to particular surgical procedures by socio-economic status and gender. Does length of time on various wait lists vary systemically by SES, ethno-cultural background or other social factors? One goal of the better data that will result from effective EHRs is to identify such inequities.
- Research has demonstrated that homeless people receive poorer care in ERs; due to factors ranging from more complex health needs and mental health challenges to prejudice and lack of awareness from providers. The Strategy will seek to reduce the wait times for homeless and all other patients. Yet this highlights that the successful attainment of eHealth wait time targets will not solely be about efficient information flow and technology, but requires changes in the working cultures of hospitals and ERs.
- More broadly, reducing inappropriate ER use by homeless and other disadvantaged people – largely due to lack of primary care, preventative and other 'up-stream' care – has system as well as equity implications. If homeless people were better served by primary care and could rely less on ERs, this will help reduce bottlenecks and free up ER time for appropriate cases. Again, such challenges are not directly part of the Strategy's mandate, but are very much part of its context for achieving success.
- The goal of increasing access to community services is especially important for health disadvantaged populations. Efficient referrals and communication will be essential for success here, and contributing to more effective connectivity of the community sector will be a crucial goal for the Strategy. However, a broader problem is limited availability and accessibility of a full continuum of responsive and appropriate community-based services in many areas.

Question: What are the three top challenges in implementing the Strategy?

Health system coordination and governance

A key challenge is that there needs to be:

- a solid long-term commitment that this Strategy will be carried through – governments have not traditionally been good at ensuring that major strategies and investments continue over sufficiently long periods, especially if beyond their electoral mandates;
- clarity from the Province on the overall objectives and directions – this Strategy is the essential foundation for this clarity;
- enough central support and direction to those LHINs, institutions and providers that will be implementing the strategy on the ground.

And this needs to be combined with:

- sufficient local adaptability and flexibility to adjust implementation and development to specific and changing circumstances and immediate challenges;
- the LHINs will need to play the vital regional coordinating role here, but;
    - LHINs do not currently have the IT resources or planning staff to successfully lead this implementation and other key reform efforts;
    - pharmaceuticals, pharmacists and physicians are generally outside the LHINs' mandate. Considered positively and proactively, pioneering a key role for the LHINs in implementing the eHealth strategy offers the chance to address these cross-mandate collaboration issues concretely.

And, to really realize the potential of the eHealth and other system reforms:

- there needs to be flexible policy and funding to encourage local experimentation and innovation; plus
- a province-wide forum or infrastructure to identify promising practices or programs, share lessons learned, assess the potential of successful programs or best practices, and scale them up where appropriate.

Stakeholder and partnership relations

Such a massive reform will founder without the active support and buy-in of key provider groups and health care institutions. The history of health reform highlights the entrenched and well-organized power of the medical profession, hospitals and other major institutions, and the ways

in which resistance or lack of enthusiasm derails or delays reform. That the Strategy has involved key stakeholders from the outset will no doubt pay off. However, it will be important to not simply have technical experts, the usual stakeholders and association heads in planning groups, but to also involve a wide range of front-line and community-based providers and consumers. Innovative means of deliberative dialogue and community engagement can be deployed.

Careful attention will need to be paid to the structured incentives and drivers for implementation. These incentives should be approached in a coordinated manner: for example, linking eHealth and primary care reform, if physicians are being funded and encouraged to invest in EHR, then they can also be encouraged to develop information systems to support efficient referrals to community services at the same time. The LHINs can build participation in eHealth into their funding and service accountability agreements with providers within their mandates.

Successful implementation will also require a clear recognition of the constraints and pressures faced by small physicians' offices, under-resourced community agencies and even well-resourced but frantically busy Community Health Centres or hospitals. Making it easy for front-line intake workers or service providers to process and use EHRs will be vital. Proper training, adequate IT, specialized staff and trouble-shooting support will be equally crucial. It will be necessary to constantly demonstrate the benefits of this additional work and investments to the provider, and their patients.

Addressing non-medical and non-health determinants of health

A number of examples set out above highlight that there will be many areas in which the successful implementation of the eHealth Strategy will require it to intersect with wider reform initiatives and the wider social determinants of health. For example, the goal of reducing the incidence and impact of diabetes will not be achieved without addressing the underlying conditions in which people with diabetes live, especially the poorest and most marginalized. The Strategy will not succeed in its own terms if these wider constraints and determinants are not also addressed.

The challenge, of course, is that the Strategy has, quite properly, developed a focussed mandate and that addressing wider social determinants of health is well beyond its scope and control. However, the implications for the Strategy are two-fold:

- the Strategy needs to take the wider context of non-clinical and non-technical factors – availability of language services, culturally competent care – and the wider context of the determinants of health – the underlying social and economic inequality that underlie ill health and health disparities and the need to understand the specific and more complex needs of health disadvantaged individuals and populations – into account in its planning;

- an important way to operationalize this will be to engage in partnerships with community-based providers and organizations that are well-grounded in diverse and marginalized communities.

Question: How can the Wellesley Institute and its partners contribute to the success of the Strategy?

We have emphasized the importance of partnerships to the success of the Strategy. Wellesley has long played a key role in bringing together leading researchers, providers and other experts on pressing health reform issues; for example, we have convened a several year long series of Roundtables on Health Equity and have worked with senior Ministry and LHIN staff on its findings. We have also been active in many provider and health networks, and have facilitated many provider and community engagement initiatives. We are happy to broker eHealth Ontario's contact with such forums and with our cohort of expert researchers and analysts.

Wellesley has done considerable research and analysis on the social determinants of health disparities and on the policy and program directions needed to enhance health equity. We have partnered with MOHLTC on various equity policy, community engagement and performance management projects, LHINs (including developing a comprehensive health equity strategy for Toronto Central), leading academic and research institutions, and a wide range of community-based providers and networks. We are happy to share our research and experience on operationalizing health equity and on applying a health equity lens or approach to complex health systems issues.

Next Steps

We have sketched out some complex issues in our responses to the consultation questions, but theses answers are inevitably brief and partial. Our intention is to undertake further research and analysis, and provide a more comprehensive policy brief in the coming weeks on key directions for building equity into eHealth strategy and implementation. We would like to meet with senior staff at eHealth Ontario to discuss this analysis and how we can contribute to your efforts.