Health Equity Roundtables Dialogue Highlights

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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.

Context

The Health Equity Roundtables were held on December 5 and 6, 2007, hosted by The Wellesley Institute, 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 into action in Ontario, the dynamics of health equity principles, the reality of current health equity practice, and possible next steps.

The Roundtables provided small group/plenary discussions and presentations: Dr. Michael Rachlis, Health Policy Consultant, provided a background paper, Delivering Equity: Community-Based Modes for Access & Integration; and Bob Gardner, Director of Policy and Research at The Wellesley Institute, gave an overview of the current public policy environment and openings for health equity in Ontario. Margot Lettner, who writes, researches, and teaches health and social policy, facilitated the two sessions.

These Dialogue Highlights reflect the main points of discussion, consensus, common themes, and different perspectives expressed over the two Roundtable days.

Next steps

Participants identified three critical and time-sensitive steps that some want to work on now, with or without an immediate organizational or personal commitment to longer-term participation:

- **Funding formula meeting:** some participants were interested in meeting again soon as an informal, ad hoc “panel” to develop a community response to the Health Based Funding Model (HBAM) and related funding formulae currently being developed by the Ontario Ministry of Health and Long-Term Care (MOHLTC) and to ensure that funding recognizes and resources health equity. About 10 people met January 9 at the Wellesley Institute and they will be doing further work on funding issues. For information contact Bob Gardner at Wellesley.
- **“Sharpening” meeting:** many participants were interested in meeting again to focus in and refine Roundtable ideas to take advantage of current and emerging “policy windows” and timelines. Wellesley will post a page on its website to collect material generated by the Roundtable and to facilitate ongoing discussions
- **Dialogue with CIC:** some participants undertook to look for access points to open new dialogues with Citizenship and Immigration Canada (CIC) and the Mental Health Commission of Canada (Kirby Commission) about immigration and mental health

The Health Equity Coalition (HEC) is also active, particularly with the LHINs, and its work will present further opportunities for Roundtable participants and others to collaborate with its members as its strategic agenda develops early in 2008. Participants should contact Christine Oluwole-Aine, Coordinator, HEC, at healthequitycouncil@gmail.com for further information.

The health equity and public policy environments

Participants identified six themes drawn from new opportunities in the public policy environment, as well as suggested by some possible components of an action plan on health equity, as "working material" for these follow-up meetings. Note that these themes should be read in the context of the discussion points – pro and con – reflected in Section 4, Framing Our Advocacy:

- **let's get going with "early wins":** confirm and prioritize concrete, front-line, direct service, community- and equity-based models, programs or services that currently exist and can be adapted/replicated for implementation in 6-12 months (a full list of so-called "early wins" brainstormed at the Roundtables is in Appendix A)
    - endorsed by communities, clients, and providers
    - policy- program- and communications-ready that are proven to work, with therefore both relatively low risk for implementation and outcomes
    - can be positioned to reflect the broader structural/systemic changes that are needed
- **let's not lose our bigger picture:** structure ideas and messages into strategic "investment bundles" that are determinants-focused, work towards targeting health disparities, and so cut across policy areas and government ministries/silos
- **let's start shifting funding:** prioritize the need for a 'let's just do it' fund for those things that are ready to go and that can also act as "wedges" to start shifting funding for longer-term impact that supports health equity
- **let's position around public policy/political opportunities and look for "fit":** several specific policy and organizational changes have created new policy openings and opportunities to engage policymakers/influence policy impacts, e.g.:
    - MOHLTC development of its first 10-Year Strategic Framework for health policy in Ontario

    - Ontario Cabinet Office/MOHLTC active development of provincial health equity agenda, start-up of new Health Equity Office and spring 2008 symposium
    - Ontario Ministry of Health Promotion (MHP) consideration of its own health equity agenda
    - Premier's poverty/equity agenda, positioning for Ontario Budget 2008 (pre-Budget Consultations, winter 2008)
    - start-up of LHINs
    - new Ontario Ministry of Aboriginal Affairs
    - December 2007 release of Statistics Canada national immigration data
- **let's work with the right people:** do we have the right partners around the table?
- **let's popularize knowledge:** do we want to develop a "blueprint" for health equity? Do we want to raise public and media awareness? Do we need a knowledge network/"think tank", more focused central steering committee with coordinator, reference group at Toronto Central LHIN?

Framing our advocacy

Participants identified 10 key points to frame our continuing discussions and any more defined piece of work to move health equity forward:

Opportunities

Paradigm

- Recognize that health equity and disparity are fundamentally about privilege and power, and that rebalancing these socio-economic structures is one objective of health equity work, e.g., who do we recruit as health providers, how are they trained, how do we model organizational and service structures?
- Consider that moving to a regional structure of health care delivery is a paradigm shift and LHINs will play a central role (for example, this shifts our current system focused on "ownership" of individual clients belonging to individual providers to a new system where institutions/providers are responsible for specific populations of clients)

Strategy

- Look for commitments and opportunities that government has made or opened and "stretch" them or use them as "levers" to include health equity; find value in intermediate or incremental outcomes
- Recognize that the health sector has the knowledge, experience, and tools to change many of its own policy, administrative, and service/clinical practices and approaches that can enhance health equity – the sector can collectively be a problem-solver at the front-line, as well as an advocate of broader structural/systemic change that is cross-sectoral. We can also learn from "micro" strategies such as intake processes/outcomes and replicate into broader strategies
- Pool our individual/organizational/sectoral "pockets of knowledge and experience" into a deeper, broader foundation that can strategically support our work, including development of "stories" that show how a person seeking specific care navigates the current delivery system and highlights that system's "anatomy" and its relationship to health equity, poverty, and social justice

Research

- Scan current/emerging health equity landscape to build more comprehensive "inventory" of issues and front-line responses and solidify the evidence-based case for health equity
- Build health equity research framework grounded in human rights principles, focused on community-based research, and defined by human-rights based outcomes; look at race/ethnicity as a determinant of health (e.g., do racialized people receive the same quality of care? Perceptions of differential care?)
- Consider that existing knowledge based on both quantitative and qualitative data has gaps because of how it's structured, sourced, and analyzed; consider looking to community-based research when making decisions
- Communicate what makes community-based models work: commitment to engagement and action, accountability, people-centred, holistic process, community-based research, visible services in the community, peer-based services, resources (e.g., flexible, targeted, incentive-based, conditional funding that moves to core/long-term funding), metrics that measure outcomes not process (e.g., models and metrics that work such as Street Health, Access Alliance, Ontario Women's Health Network, East Mississauga Health Network, Queer Exposure)

Accountability

- Consider development of health equity "scorecard" or "report card structure and/or related measures that integrate current work in e-health and indicator development so we can

assess the performance of public policy, institutions, community-based providers (e.g., is it "healthy public policy?" Should the Ontario Government use a "health equity impact statement" to assess policy proposals? What tools do LHINS, Ontario Health Quality Council (OHQC) need?) As indicators and metrics have or are being chosen, it's imperative to engage policymakers now

Participants also considered the risks and challenges raised by engagement and "partnership" with government, especially the "fit" between community and government agendas both political and public policy, and created this second set of points to frame the health equity discussion going forward:

Risks and Challenges

Paradigm

- Are we working for a paradigm shift in health services or working so everyone is healthy? Should we have a "split strategy" for advocacy that works towards both?
- How do we build on front-line experience and policy work already done by community organizations? We know a lot and we know what to do; if the goal is to build an inventory of suggestions for a policy document, "it's all been done "
- How can we integrate the philosophical, political, and process work of feminists into our health equity work?
- Health equity work on the ground will be "Band-Aids" unless the fundamental issues of privilege and power are addressed? We need to understand how institutional racism and historical disadvantage influence health current health inequalities and how mobilizing against racism can play a role in the reduction of these inequalities.

Strategy

- Do we move forward with "early wins" embedded in a broader strategy that addresses structural/systemic issues, do we focus on what's promising as just as important as what's proven to work; or do we move forward first on structural/systemic issues? Is the concept of "early wins" one of co-option? Does incrementalism maintain the status quo?
- How do we deal with the problem that if health equity means "everything is all about health" then other sectors (e.g., housing, social services) as well as key policy actors (e.g., Cabinet Office and the Ministry of Finance) will see this as a threat that health will continue to demand an increasing share of the Ontario budget?

- What has to change so we don't "hit the brick wall," i.e., the evidence is there, we present it, nothing happens? What are the incentives to drive the institutional changes?
- How do we avoid health equity being the "flavour of the month"?
- How do we ensure that we understand the words and definitions we're using and that language engages rather than stops dialogue, e.g., "patient-centred" or "people-centred" care? Meaning of "evidence"?
- How do we link our health equity work with the public vs. private financing debate in health care?

Accountability

- How do we build better organizations that better reflect and represent our clients and ourselves?

The first brief?: 10 really good ideas

While Appendix A captures the "early wins" discussion in detail, participants identified 10 current models, programs, services or projects most frequently as solid proposals to build government engagement on health equity and deliver real change to communities.

"Early wins" are new or enhanced options that could enhance health equity in 6- 12 months. They are policy-, program-, and communications-ready changes that could be proposed to government as ideas that communities have engaged on, endorsed, and proven to work with therefore both relatively low risk for implementation and outcomes. They're "really good stuff" that we should just do; some also fit with current government commitments or directions:

- **oral health:** implement current, identified community-based oral health needs to deliver Ontario Government's recent commitment
- **non-insured access:** eliminate 3-month waiting period for OHIP eligibility on arrival in Ontario (reference points: impact on CHC service capacity and funding; impact on older clients, pregnant women and children; recent elimination of waiting period for members of the Canadian Armed Forces residing in Ontario)
- **chronic disease:** broaden current, identified community-based chronic disease needs to include link with diabetes and poverty and influence Ontario Government work on chronic disease prevention and management strategy (reference points: LHINs mandate, Association of Ontario Health Centres (AOHC) June 2007 Conference)

- **geriatric/aging, palliative care:** target fit between populations that don't have access to current supportive home care services through Community Care Access Centres (CCACs) and proposed Aging at Home program, including better engagement and consultation with community organizations by LHINs
- **improved access:** implement "Advanced Access models throughout Ontario as quickly as possible to ensure that all Ontarians have timely access to a regular primary health care provider
- **team-based care:** implement "shared care" specialty care based upon the Hamilton Mental Health Shared Care model as a measure of quality health that also delivers health equity.
- **system navigation:** implement "navigators" to assist patients with certain serious and/or chronic conditions use the system appropriately so that peoples' expectations of their right to health care match their real experience with delivery of health care, e.g., almost all other provinces are using nurse navigators in their cancer systems.
- **mental "wellness":** leverage opportunity presented by new Mental Health Commission of Canada/current Citizenship and Immigration Canada (CIC) to address de-stigmatization; conditions that demarginalize; impact of culture shock on immigrant communities in language that recognizes the positive dynamics/resilience of community life; data collection/disaggregation that provides evidence across health status/trends, intersectionality and its cost-effectiveness (reference point: U.S. health data across race/ethnicity with caution to use data to support demarginalization not profiling); clearinghouse of culturally competent support services available on landing
- **Aboriginal Healing and Wellness Strategy:** work from AHWS as a model for health equity and organizational philosophy/structure; and endorse its continued funding after 2009
- **non-formal, alternative settings:** document and advocate for good models that aren't part of the formal health care infrastructure and have little/no recognition or funding, which include community-based peer workers; traditional healers, and providers of complementary or alternative medicine.

Appendix A

Taking action on health equity: "early wins"

Roundtable participants identified these current models, programs and services as "early wins" that the Ontario Government and/or LHINs could support as new or enhanced options to deliver health equity in the next 6-12 months.

"Early wins" are policy-, program-, and communications-ready changes that could be proposed to government as ideas that communities have engaged on, endorsed, and proven to work with therefore both relatively low risk for implementation and outcomes. They're "really good stuff" that we should just do; some also fit with government commitments or directions.

These are all examples that participants felt had demonstrated real impact or showed promise for addressing health disparities. They arose out of brainstorming type discussions; there would need to be further analysis and prioritization to determine which examples and ideas were actually moved forward.

Models – Funding

- Work from premise that funding determines delivery models, follows function, creates/produces "competition barrier" to integration; strategic analysis of funding models and alternatives (e.g., Ontario Prevention Clearinghouse (OPC) models for transferability of best practices equity strategies)
- Develop funding formulae proposals based on health equity that are also evidence-based (contrary to current proposed HBAM model)
- Consider that CHCs are "dumping place" for the vulnerable but can't/won't meet service outcomes because funding doesn't match high-need client load by providing focused funding for specific population groups (homeless, HIV/AIDS care, senior care)
- In primary health care capitation models, add incentives for higher-need clients and high-need communities.
- Change funding formulas so middle managers not be funded with dollars allocated for patient care since they see no actual clients
- Integrate prevention into funding formulas

- replicate SETO, regional social service and health networks
- Ensure accountability of Family Health Teams to communities as well as to MOHLTC. The ministry should consider re-allocating primary health care budgets to LHINs over time. FHTs and other new primary health care models should have equity goals and targets.
- Consider effect of territoriality/turf, technology (e.g., is e-health an obstacle?), paternalism

Models - Service Delivery

- Build on announced system expansion, replicate and expand Community Health Centre (CHC) model of care (core elements that work: CHCs build analysis of health disparities into their service provision, provide link between primary health care and determinants of health as well as access to those services related to determinants)
- Broaden Community Care Access Centre (CCAC) model, e.g., link with Aging at Home
- Enhance and plan for expansion of current shared care models
- Highlight models of care where there is good encouragement/continuity of care through the entire care process
- Use integrated intake model and expand from micro to macro (think integrated system)
- Assess and align current models against urban health framework and LHIN diversity framework
- Share best practices on web (i.e. MOHLTC)
- Complete environmental scan of current deliverables/gaps in health equity as well as current/coming on-stream/proposed initiatives ("mark the moment when health equity went mainstream")
- Identify startling/shocking health disparities (pilot   make a difference)
- Break the health system into distinct pieces for specific action (e.g., Integrated intake assessment)
- Implement advanced access in primary health care and shared care models for medical specialists
- Expand Navigator Concept/Care Coordinator concepts
- Expand community-based peer outreach workers (e.g.,. nutrition, public health)
- Expand parallel provision/integration of alternative/complementary health care practices

- Enhance equity/diversity capacity-building (anti-racism, anti-discrimination, anti-oppression training) at system and institution levels in health/cross-cutting sectors; and build organizational workforce that reflect the communities they serve
- Proposed policy and program planning model:

Specific Programs and Services

- Special focus on Health Equity for women, children, aboriginal people and the elderly
- Increase access to dental/oral healthcare for those with no coverage aged 19-64 years
- Expand public drug OHIP formulary coverage and address pricing
- Replicate Healthy Child Screening Model (i.e., St. Joseph's Health Centre has five-year history leading Early Years screening in schools for health/physical screening at Kindergarten and can model evidence for increasing onsite supports and taking a determinants perspective from the start)
- Develop Toronto Drug Strategy (harm reduction)
- Eliminate Three-month waiting period for OHIP eligibility (non-insured access)
- Modify Aging at Home (e.g., act quickly, target populations that don't have access or are under housed, aging population must be engaged by LHINs immediately through better engagement/consultation of appropriate small organizations, broaden CCAC beyond acute care follow-up, resources for care at home, link with homelessness)
- Expand Ontario diabetes strategy to include prevention, equity, determinants focus
- Implement more advanced and integrated linguistic services using hybrid model and campaign for language access and, more broadly, disparities mandate in particular for immigrant and Aboriginal health
- Work with Citizenship and Immigration Canada (CIC) on immigrant health equity issues (e.g., more emphasis on mental health/mental wellness issues and de-stigmatization of mental illness in new immigrant populations (emphasize holistic model), consider informal mechanisms that precede formal healthcare and can facilitate/create barrier (e.g., English as a second language classes, child care), consider why "healthy immigrant effect" deteriorates post-migration, enhance settlement advice and community resources on landing, provide retraining and job opportunities to newly emigrated health care workers)
- Support continuance of Aboriginal Healing and Wellness Strategy beyond 2009 and consider adapting as a model; consider adapting approach of Ontario Federation of Indian Friendship Centres to setting formal workplace protocols/mandates requiring staff to reflect physical, mental, emotional, and spiritual aspects of human health and existence in their

policy and program work; enhance cultural competency (including linguistic access) in health delivery for both Aboriginal peoples and newcomers; consider adapting and protecting Aboriginal communities' collective right to ownership, control, access, and possession of information that comes from or is generated within them

- Develop action plan for enhanced support services in supportive housing
- Develop more "teeth" in Ontarians With Disabilities Act

Research, Data Collection/Analysis

- Ministry should develop collaborative framework for the collection of data and disaggregated data that support health equity principles and goals and includes intersectional data analysis (e.g., gender, income, race/ethnicity)
- Two month test group on how data on income and health across group sectors can move strategies forward
- More standardized collection of health indicators from current census data, review need for additional data to complement health equity tracking
- Bio-medical research to complement qualitative evidence about health disparities
- Linked data sets and relevant data collection
- Develop community-based "standard of proof" and definition of "evidence" and "community-based research" so that all the voices are heard (e.g., Streethealth)
- Cost savings are part of showing what works and should be collected where appropriate; cost data should also be use carefully so they don't become the main argument
- Linkages on data collection issues-education and Black focus schools (racial profiling issues) and media education
- Disaggregate parts of the system to focus action on intake (integrated intakes-replicate St. Chris), assessment, e-health
- Make linkages on data collection issues-education, racial profiling issues, media education
- Advocate for new MOHLTC Health Equity Unit to support evidence-based outcome research
- Require health educators and providers to open door to collect data for equity monitoring
- Advocate for MOHLTC health equity project and/or LHINs to dedicate 5% of their budget to community-based research

Advocacy Opportunities

- Engage Ontario Health Quality Council (OHQC) to ensure health equity is part of their 2008 Report Card, link with poverty reduction (reach out to other organizations-CDA, OCDPA; in the absence of data, provide examples of actions, stories and strategies that are addressing the inequities we know exist)
- Influence development of Canadian Index for Well-Being to be grounded in health equity (engage Charles Pascal, Atkinson Foundation)
- Create forum for networking opportunities among community groups/agencies
- Create series of "Anatomy of Disparity" stories for different population health groups, e.g., diabetes, that shows all the people and places that contribute to disparities (social and health)
- Create parallel "Anatomy of Equity" stories, e.g., diabetes – how would system and roles look from determinants perspective?
- Create parallel "Anatomy of Poverty" stories, i.e., make conceptual, actual, and interministerial link between poverty reduction and health equity (e.g., special diet allowance campaign that's interdisciplinary, multi-sectoral, action focused and advocacy model transferability critique policy change)
- Profile chronic Disease links to health inequities (why? Chronic Disease Prevention and Management (CDPM) inserted into every LHIN as priority; focus of Ontario Health Quality Council 2008 Report; focus of Association of Ontario Health Centres (AOHC) 2008 Conference in June)
- Use international context provided by WHO 2008 Report on Social Determinants of Health
- Engage Toronto Central LHIN through Bob Gardner, especially while stewardship role of LHINs still developing (GTA/LHIN urban health and diversity frameworks, share Bob's Toronto Central framework with other LHINs)
- Consider how public health can engage and influence LHINs when Toronto Public Health must deal with five different LHINs
- Support/influence Public Health Agency of Canada (PHAC) agenda that every new health investment must take inequalities into account
- The Toronto Central LHIN has asked hospitals to develop equity plans by October 2008; should use this opportunity to get "right stuff in"
- Learn from organizations that have taken strong advocacy positions on public policy
- Use untapped resources (e.g. primary care physicians, Family Health Teams)