WELLESLEY INSTITUTE
advancing urban health

Commissioned Research Report

Health Equity Working Session, February 28, 2008 - Backgrounder

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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 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.

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, one of which was a "sharpening" meeting. Many participants were interested in meeting again to better focus on and refine Roundtable ideas to take advantage of current and emerging "policy windows" and timelines. The Health Equity Working Session on February 28, 2008 responds to this interest. As well as hosting this session, The Wellesley Institute will also post a page on its website to collect material generated by the Roundtable and subsequent Working Sessions to facilitate ongoing discussions.

The "Best Early Wins": What are the Criteria?

At our first Health Equity Roundtable on December 5-6, 2007, we came up with a list of about 60 current models, programs and services that we believe are "early wins," i.e., 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.

Appendix A to this Backgrounder, which originally appeared in the *Health Equity Roundtable Dialogue Highlights* prepared by The Wellesley Institute and sent to participants in January 2008, contains this "first list" as a refresher for today's discussion.

First, an update on community-based advocacy work since December 2007. The Wellesley Institute is continuing discussions with the Ontario Ministry of Health and Long-Term Care around scoping out MOHLTC's health equity work. Wellesley is also facilitating identification and resolution of health equity issues with the LHINs, particularly the Toronto Central LHIN. With both organizations, Wellesley has opportunities to lead or facilitate presentation of community-based solutions, like our "early wins" list, to move this agenda forward. The Health Equity Council (HEC) is also engaged, primarily at the local LHIN level.

One key question is: what do we do with the list in Appendix A? Should we prioritize it and create a shorter "strategic list" of the "best early wins", with a view to developing a phased strategy to engage the Ontario Government and/or the LHINs? Should we then bring it forward as part of the current mobilization work by the Health Equity Council, Wellesley, or others? If

we did so, how would we choose which 10-15 ideas would make the list? What criteria could we use and why?

"Best early wins" could be models, programs or services that meet some or all of these or other criteria. Not all these criteria would suggest the same list; they come from different perspectives and so suggest different strategies:

- **evidence-based**: it works and communities, researchers, and/or funders validate it
- **local or homegrown**: it works here, in Ontario communities
- **reachest farthest**: it makes a real difference for the most people
- **reachest deepest**: it makes a real difference for the most marginalized people
- **uses existing infrastructure**: it is program-ready and can be replicated
- **has strong endorsement**: people, communities, service providers, advocates, funders like it
- **"no-brainer":** it's a simple, straightforward, low-risk change
- **"leading edge"**: it's a new, creative, higher-risk change that shows leadership and partnership
- **fiscally neutral**: it can be funded using cost efficiencies or within existing budgets
- **investment opportunity**: it's an investment in people and communities that can build future capacity
- **great key messages**: it's a good communications story about people, communities, their testimonials, the power of community-government partnerships that will attract media and public interest
- **great profile**: it has the power to attract significant interest and resources from highly visible and influential members of diverse communities, sectors, and levels of government
- **great currency**: it has the power to align with current or emerging human rights, cultural, socio-economic, or political environments or events at the community, regional, provincial, national or global level
- **great fit**: it fits with current government policy and/or communications agendas, delivers on public commitments
- **other?**

Issues for Discussion

- ***What are the right criteria?***
- ***What are the challenges and opportunities in using these criteria, and how should they be addressed?***
- ***How can the Wellesley Institute and other organizations lead or facilitate further development of this work?***

A Strategic List To Deliver Health Equity Now: The 10 "Best Early Wins"

Based on the above discussion, one key question is: applying the criteria we develop, as discussed above, can we prioritize this list into a strategic list of 10-15 ideas – the "best early wins" - that could be the basis of the phase of an engagement strategy with the Ontario Government and/or the LHINs?

Moving such a list forward would not diminish the importance of the other ideas we identified at the December Roundtable; it would, instead, take advantage of current policy windows and community momentum to build relationships with policymakers and decision makers, ensure a high probability of successful implementation, and therefore support a phased mobilization that would move the other ideas forward for action as new policy windows open.

Another key question is: once we have a strategic list of the "best early wins," how do these ideas need to be further developed so that they're policy-, program - and communications-ready? Where are the gaps and how can we fill them?

There is also the question of how to present the strategic list. It could become a brief that argues for immediate change and response at the level of community-based models, services and programs with the message to deliver "health equity now," positioned as "phase 1" of a larger health equity mobilization strategy. It could become part of a larger policy paper that moves beyond new or enhanced models, services and programs to argue for a menu of specific policy changes. Or it could lead or support another kind of presentation.

Issues for Discussion

- ***Based on the criteria we've identified today and the "first list" of models, programs and services in Appendix A as a starting point, what are the 10 "best early wins"? Are there other current or emerging initiatives – other "really good stuff" - that should be part of this priority list?***
- ***Looking at the 10 we've chosen, what else needs to be done to make them policy-, program- and communications-ready? Where are the gaps?***

- ***How should this list be presented to policymakers and decision makers?***
- ***Who else should be involved?***
- ***What challenges and opportunities does this list present and how should they be addressed?***
- ***Again, using the criteria and "first list" we've identified, what are the next 10 "best early wins"?***
- ***How can the Health Equity Council, The Wellesley Institute or other organizations lead or facilitate further development and presentation of this brief?***

APPENDIX A

TAKING ACTION ON HEALTH EQUITY: "EARLY WINS"

(This Appendix originally appeared in the Heath Equity Roundtable Dialogue Highlights prepared by The Wellesley Institute and sent to participants, January 2008)

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. These examples 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 ***(Note: a separate Working Session on Funding will also be held on February 28, 2008, at The Wellesley Institute, facilitated by Dr. Michael Rachlis)***

- 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
- Propose 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)