

Learning From Others

Health Equity Strategies And Initiatives From Canadian Regional Health Authorities

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The Wellesley Institute engages in research, policy and community mobilization to advance population health.

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Learning From Others: Health Equity Strategies and Initiatives From Canadian Regional Health Authorities



A. Introduction

Purpose

Health disparities are a topic of increasing importance in Canada. In the last two years, they have been the focus of national and international reports analyzing and documenting the problems and proposing strategies for addressing them. This report examines the strategic and operational response of leading regional health authorities (RHAs)¹ across the country to the problem of reducing health disparities.

This paper was commissioned by the Wellesley Institute as part of its Health Equity Roadmap project. Wellesley has been much involved in developing strategy and planning resources for Local Health Integration Networks (LHINs), other government Ministries and agencies, providers, community networks and other stakeholders in Ontario. It wants to build on lessons learned from the work of RHAs outside Ontario in addressing health disparities.

RHA efforts to reduce health disparities are important. Although comprehensive national and provincial strategies are also needed, activities at the regional and local level to plan and implement relevant programs, and to collaborate and coordinate with others are key. RHAs have considerable levers and powers and the extent to which they prioritize and act upon equity could potentially make a significant difference.

Methods

The research is based on a combination of key informant interviews and RHA website searches. In our investigation, we looked for both formal and informal strategies and tools. We looked for formal health equity strategies and commitments to equity in strategic plans and vision statements. Equity could be one explicit priority among several; or it could be a focus on particular disadvantaged populations. We inquired about specific equity-focused programs or initiatives, and specific assignments of responsibilities or resources to promote equity. However, the paper is designed to be illustrative, rather than comprehensive. Many interesting initiatives likely did not come to our attention. Readers are invited to write to the Wellesley Institute to supplement the draft.

We note that because the focus is on RHAs outside of Ontario, the LHINs' efforts are not represented here. However, the WI website provides a great deal of material on the LHINs' strategies. In addition, because the focus is on RHAs, the provinces of Alberta and PEI, which are not regionalized², are not included.

Another factor that affected what we were able to examine is how RHAs report on their work. Many RHAs do not publicly document all their service initiatives nor post them on their website. In addition, there may be a conceptual problem – an RHA may be working to reduce health disparities but may not formally define or report its efforts as such. Conversely, an RHA might report an activity as addressing disparities, but not clarify how it does so.

B. Contextual Issues

Regionalization

Over the 20 years since regionalization emerged as a strategy in Canadian provinces, it has undergone a series of changes. The number and size of regions have changed, as have the responsibilities and authority of RHAs. In 2008, Alberta, once one of the most strongly regionalized provinces, eliminated its regions without warning. PEI had abolished its regions shortly before. Also in 2008, New Brunswick went from 8 regions to 2.

Regionalization has been a political football. Although the priorities varied by province and the regions derived their authority from the provincial government, a strong rationale in the early years was to enable decisions to be taken in a less politically partisan way, to carry out healthcare within a population health framework and to be responsive to communities. However there is a widespread belief that the promise of regionalization has remained unfulfilled over time. Provincial health ministries have tended to reassert their authority and micromanage RHAs, which consequently have become more administrative bodies. The population health ambitions reflected in reports and analyses of the 1990s have given way to a more conventional healthcare focus in this century, emphasizing wait times, healthcare technology, and the expansion of health science education programs. The Health Accords of 2003 and 2004 reinforced this “back to the healthcare basics” approach.

Therefore, although we have focused on RHAs in this report, the role of provinces cannot be overlooked, as their policies and resources can constrain or facilitate work on health equity. For example, in BC, public debate about the Ministry’s plan to “re-direct” 10% of public health funding to new areas of priority has created uncertainty for programming. In Saskatoon Health Region (SHR), in spite of equity being a strong value at the regional level, an incoming government forced the health region to withdraw from an equity project to which its predecessor had previously committed. In Alberta, the recent dissolution of the former RHAs and the formation of one province-wide organization have made it more difficult to identify the structures (if they exist) through which health equity is being addressed in that province.

The role of public health is also a structural factor relevant to RHA equity strategies. In regionalized provinces outside Ontario, the public health functions are located within RHAs. As we discuss below, the public health community views itself in a broader role and has become the main champion in many places for working on the determinants of health and reducing health disparities. (This was also a primary focus in the early days of the Public Health Agency of Canada.) In SHR, interviewees were of the opinion

that the Public Health Officer's presence as part of the management team has meant equity programs have higher priority. An interviewee from the Winnipeg Regional Health Authority (WRHA) expressed a similar view with respect to community services being at the table with public health.³

In Quebec, the public health sector is in a league of its own. The public health department of each of the 18 RHAs (called Agencies) is supported by the *Institut national de santé publique* (INSPQ), a provincial agency for research and professional development in public health. The INSPQ is funded by the provincial government and is relatively well resourced with hundreds of employees. In Quebec, public health has historically encompassed a population health approach and several provincial laws reinforce its role with respect to health determinants and equity. For example, the "Public health law" of 2001 has a provision about social inequality⁴ and includes a section on Health Impact Assessment, requiring new legislation and regulations of non-health sectors to be assessed for health. There is also Bill 112, An Act to Combat Poverty and Social Exclusion (2002), a law that makes the reduction of poverty and social exclusion an explicit government priority. Although the size of these laws' impact is still unclear, they nevertheless establish a larger terrain for public health action than in other provinces.⁵

Health disparities

The related topics of health determinants and health disparities have been on the agenda in Canada since the 1990's. The issue has been especially at the forefront since 2008 when the WHO Commission on the Social Determinants of Health, the Chief Public Health Officer of Canada and the Senate Subcommittee on Population Health each published a major report on the topic. Earlier, in 2004, the Public Health Agency of Canada had been created and a year later, its national collaborating centres, including centres on the social determinants of health, healthy public policy and Aboriginal health. Not coincidentally, over the last decade, the public health community in Canada has reaffirmed its role in improving population health. As the delivery arm of the health system, including public health, RHAs therefore have an important role to play in addressing health disparities.

In this paper, we use the terms health *equity*, and reduced health *disparities*. Health equity carries a moral dimension, referring not just to differences in health status, but also to those deemed unfair and avoidable. Other terms are health inequities and health inequalities. Disparities are seen to arise both from inequitable health services and from inequities in the non-medical, or social determinants of health.

Correspondingly, the RHA approach is to address three aspects of health disparities: (1) health system changes to address disparities in access and use of services; (2) partnerships, collaborations and policy advocacy with agents outside the health system to address disparities due to social determinants; and (3) exercising a leadership role in monitoring health status and disparities and keeping population health goals on the societal agenda.

We have to work in two places, in our own backyard, as well as beyond to the neighbourhood.

We have to provide our own resources, provide support to others and provide leadership.

(WRHA interviewee)

We note that an RHA's approach to health disparities is likely to differ depending on the type of population it serves. RHAs in the northern part of Canada's provinces, for example, with a high proportion of First Nations and Métis residents have a population with lower average wealth than the rest of Canada but less inequality within the region. By contrast, RHAs such as Montreal and Vancouver have more diverse populations, and greater degrees of inequality. Other RHAs fall between these two situations, with pockets of rich and poor, but less extreme variation overall.

A WRHA interviewee stated that "In WRHA, not every board is dissolved; we still have lot of community boards, it makes us continuously aware that communities are different. Although there are some poorer areas, we have learned that even if a geographic area has on average higher indicator measures, there are still pockets of poverty within."

C. RHA Strategies and Tools

The following RHA strategies and themes emerged from results of our investigations:

- Local research and analysis of disparities
- Primary health care practices and resources
 - Location of services
 - Appropriate care
- Partnerships
 - Poverty reduction collaborations
 - Early childhood development
 - School-based strategies
- Public education and policy advocacy
- Community development and participation
- Aboriginal health
- Alignment: Reshaping RHA policy and practice
 - Corporate commitment
 - Health equity lens
 - Health care equity audit
 - Indicators and performance measures.

Local research and analysis of disparities

Most RHAs do needs assessments of their local population. These are increasingly including equity factors. Larger RHAs have research departments that do extensive studies on their populations. For example, Montreal RHA, through its public health department, has carried out extensive mapping identifying clusters of poverty and social problems linked to health disparities. The RHA's public health department is the main institutional partner of the Lea-Roback Centre, which studies social inequalities in health in Montreal. The public health department houses the Centre and several Centre researchers work in the department. Montreal's RHA also has a population health observatory on social inequality, *Observatoire montréalais des inégalités sociales et de la santé* (OMISS).

In Quebec City, the RHA's public health department recently prepared an advisory on public transportation that included a focus on the effects of transportation on equity, including social participation and access to health services.⁶

Vancouver Coastal Health (VCH), Vancouver Island Health (VIH), Interior Health (IH) and Fraser Health (FH) participate in Core Public Health Functions Research Initiative (CPHFRI), a collaborative program of research focused on public health systems renewal in BC. One of CPHFRI's goals is to "broadly inform public health systems renewal in Canada that, in turn, will contribute to improving population health and reducing health disparities."⁷

SHR has a Public Health Observatory and has conducted mapping and related analyses of health disparities in the community. SHR also partners with the University of Saskatchewan on research. The information is used for planning and resource allocation.

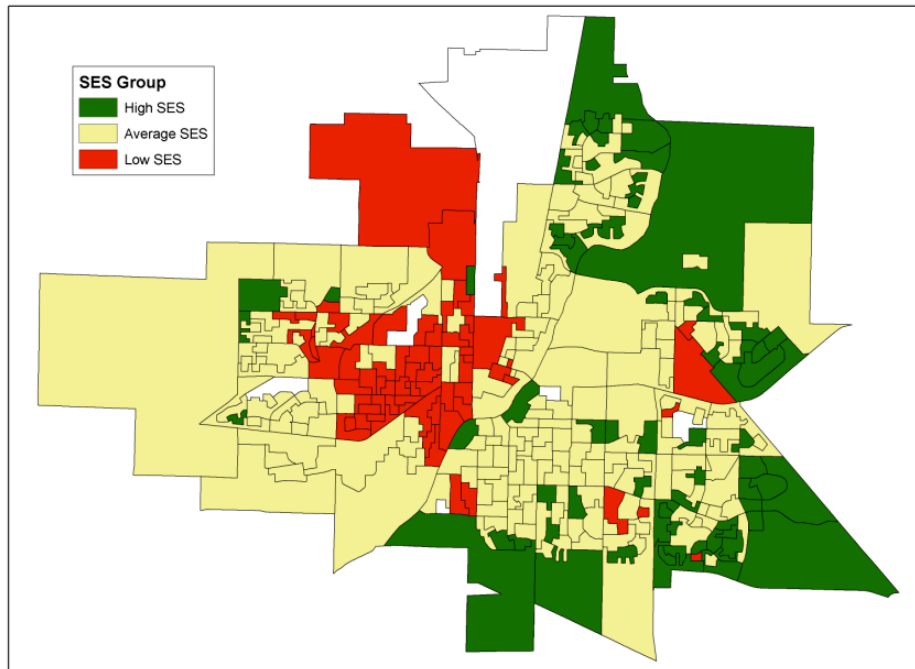
In 2006, the Saskatoon Health Region (SHR) conducted a study that examined disparities in health status between Saskatoon's neighbourhoods, which established there were significant and staggering disparities between low- income and affluent neighbourhoods for a range of health outcomes. The SHR also administered the Saskatoon Student Health Survey in 2006/2007 and 2008/2009 to students in grades 5 through 8; both surveys established geographical health disparities among children. Our investigations of health disparities led to a logical next step: a program of population health intervention research (PHIR).⁸

An important tool has been descriptive analysis using small area local geographies. It is valuable for knowledge translation to decision makers, resource allocation and program planning exercises. Uses include:⁹

- Research into neighbourhood/ environment/ group effects
- Neighbourhood profiles (descriptive Epidemiology for reporting and planning)
- Cluster analyses (based on key factor similarities) e.g. Hamilton Neighborhood analyses, Quebec Deprivation Index research (also used by CPHI), Saskatoon Health disparity research
- Needs assessment and health system planning

The usefulness of mapping health disparities and their determinants was increased by the development and adoption of the deprivation index¹⁰ which provides a methodology for categorizing neighbourhoods by quintiles based on income and other socio-economic factors (Figure 1).

Figure 1. Saskatoon Analysis of Dissemination Areas by Deprivation Index Quintiles¹¹



In 2008, several RHAs participated in the initiative by the Canadian Population Health Initiative (CPHI)¹² and the Urban Public Health Network (UPHN)¹³ to analyze and report on health disparities in 18 Canadian cities. This initiative was mentioned by several interviewees.

For WRHA, the community health assessment is about equity.

The ultimate goals of the community health assessment are to maintain and improve the health status of the entire population, and to reduce inequities in health status between populations.¹⁴

In addition to research on populations, some RHAs have conducted analyses of local environmental factors and effects on health disparities. For example, SHR has conducted mapping of food deserts, and has carried out food costing studies. These data are provided to local community partners as well as used internally.

Primary health care practices and resources

Inequitable access to health services is a direct pathway to health disparities, and one that is primarily the responsibility of the health system to address. Inequitable access can be due to many factors – location of services, additional fees and costs for services, or sociocultural barriers, to name three.

Several RHAs are directly addressing disparities in health services, most through improving and reorienting primary health care practices. What is entailed is a combination of providing services physically closer to where poorer people live, as well as changing practices of primary health care providers to be more responsive to the needs of marginalized people.

Location of services

VCH is examining ways to prioritize primary health care renewal in neighbourhoods with lower socioeconomic status and find ways to reduce barriers to access as part of a new strategic plan.

SHR's Building Health Equity (BHE) Program is a learning and community development intervention to work towards addressing health disparities in six inner-city neighbourhoods in Saskatoon. It is co-located with a local Métis organization and a First Nation in one of Saskatoon's poorer neighbourhoods. The public health services are a blend of school and community outreach, bringing together a mix of staff and disciplines, and include community development, childhood immunization, child health clinics, dental health measures, school health, breastfeeding, post-partum home visiting, tobacco cessation and public health inspection. BHE and public health are also to undertake advocacy initiatives at the local, regional and provincial government levels to address health disparities in Saskatoon. (SHR interviewee)

WRHA's new corporate building is in the inner city; the Access Centre, combined with social services, consolidates existing services where people are. Winnipeg's new Strategic Direction refers to enhancing (1) patient experiences (listening more carefully) and (2) quality and integration: improving access to services and care through more integration, thereby reducing disparities in access. (WRHA interviewee)

WRHA's experience with H1N1 is an example. Their equities strategy used a totally different approach, including a newcomer strategy, and focused on making immunization more accessible. "The strategy arose because providers on the ground knew that to be effective, they needed these kinds of strategies." (WRHA interviewee)

Appropriate care

Attention to appropriate care is illustrated in the May 2009 newsletter of RHA Central Manitoba, in its report about the Aboriginal support program:¹⁵

...adapting existing health programs and services to better serve the needs of Aboriginal people. The goal is to find ways to modify the components of the system to alleviate cultural conflict and support Aboriginal people to better navigate the health system.

Health care staff need to know about the culture and history of Aboriginal people and the clients need to learn how to navigate the system. To that end, two Aboriginal support workers have been hired to assist Aboriginal patients and clients when they come to the Portage District General Hospital. They assist them in many practical ways such as finding the service they need, explaining what type of examining they will be receiving,

how the emergency room system works, as well as providing translation if necessary. “One of their main tasks is to explain things to people, such as, in emergency: ‘That person didn’t get in ahead of you because of her nationality, but because she needs to be seen sooner because her condition is more serious than yours,’” said Sabot. “People like this service. The need is there. Even non-Aboriginal patients are asking for the Aboriginal supports workers’ help.”¹⁶

Attention to appropriate care is evident in other RHAs as well. Manitoba’s Central Regional Health Authority has a specific project focused on Aboriginal outreach for traditional health services care. VCH refers to developing culturally appropriate care and Cape Breton District Health Authority (CBDHA) refers to *cultural competency* in primary health.

Cultural competence can reduce disparities in health services, address inequitable access to primary health care and respectively respond to the diversity of Nova Scotia.¹⁷

In Nova Scotia as well, to improve health services, Capital District Health Authority (CDHA), in partnership with the Health Association of African Canadians, undertook research, engaging African Nova Scotian communities to talk about their health concerns and needs. This project adopted an Africentric philosophy, including one-on-one interviews on topics from current health concerns, to specific needs of seniors and the impact of racism on health.¹⁸

Partnerships

Partnerships and community collaborations are an important mechanism for RHAs in achieving their goals. The health system is limited in its ability to directly affect the social determinants of health, but RHAs can work with others to provide information, analysis, support and leadership in doing so.

RHAs cannot be seen as sole drivers for progress around determinants; we have to work with others. (WRHA interviewee)

One of the WRHA partnerships is with the United Way. Another is their integrated services initiative, which is a multi-sectoral collaboration with the provincial department of social services, to provide co-located services in Winnipeg’s community health centres.

Many other RHAs also collaborate with community groups working on food security and housing, including VCR, SHR and CBHDA (Cape Breton).

Poverty reduction collaborations

An emerging strategy in several RHAs, particularly those with larger cities, is to collaborate with other agencies in developing poverty action plans.¹⁹

In WRHA, the RHA partners with the Poverty Reduction Council. The Council was initiated with the support of the health region a few years ago. However, the recent partnership emerged partly as a result of the 2008 UPHN report, which showed that Winnipeg had one of the biggest gaps in health outcomes among Canadian cities. Before the report's publication, the WHRA population and public health team planned for when it would be released. They performed an internal environmental scan surveying programs to find out what they were doing to address disparities, both in terms of services and access, and with respect to root causes. The team received many positive responses about initiatives to try to close the gap, even though the region had no overall strategy. Following the report's release, the team followed up by creating a disparity reduction committee, and partnered with the Winnipeg Poverty Reduction Council to work on the determinants of health.²⁰ One of the projects being implemented is a school-based strategy in the poorer neighbourhoods of Winnipeg (see below). Another is to create an ongoing internal committee to address services (also see below). (WRHA interviewee)

The Saskatoon Poverty Reduction Partnership has recently been initiated, with major input from SHR. The community leadership body is chaired by the SHR Chief Medical Health Officer and the Executive Director of United Way. Both organizations have committed staff persons to facilitate and support the development of a longer-term coalition and plan. (SHR interviewee)

For more than a decade, poverty has been emerging as an issue of concern in Saskatoon. Recently, a wide array of community partners has come together with the Saskatoon Regional Intersectoral Committee (the SRIC) to develop an action plan for poverty reduction. This initiative builds on important work undertaken by community leaders over the last 10 years.²¹

Early childhood development

Several RHAs are focusing on early childhood development, with other partners, as a strategy to address social inequity. VCH, for example, advocates for public policies that strengthen protective factors for children with low socioeconomic status. VCH is part of a multi-sectoral initiative around early childhood development.²²

Public Health programming at VCH seeks to optimize the health of all infants and young children ages 0-5 years by using a wide range of community health care strategies with children, families and caregivers. VCH is also active in addressing the social and economic conditions that affect the health of children and families through a Population Health Team.

Working in coordination with public health, the VCH/Provincial Health Services Authority (PHSA) Paediatric/Child and Youth Council provides leadership to coordinate the planning and delivery of services and regional policies across the continuum of care from Health Promotion and Prevention to specialized acute care, rehab and ambulatory care. The

structure of this Council brings together the full spectrum of health care services all working towards the common goal of improving health outcomes for children and youth in the Vancouver Coastal Health area.

CDHA (Halifax) has an enhanced home visiting program that provides additional support to families needing extra support. Home visiting focuses on supporting parents, promoting a healthy parent-child relationship, fostering healthy childhood development and linking families with community resources that further enhance the opportunities for healthy growth and development of the child and the family. Families can receive home visiting support for up to three years or referral and linkage to other health and community resources.²³

We noted earlier that elements of SHR's BHE Program support early childhood development in poorer neighbourhoods of Saskatoon.

Manitoba's Healthy Child is a whole-of-government provincial program to improve the wellbeing of children of all ages in Manitoba, a program in which all the RHAs participate. Although not framed as a program explicitly addressing inequity, many of the elements are oriented to at-risk and vulnerable families. Elements of the program include Early Childhood Development interventions and school-based strategies.²⁴ The program uses the Early Development Instrument (EDI), a questionnaire that measures kindergarten children's readiness for school across several areas of child development. Interviewees from other provinces also spoke of the usefulness of the EDI.

VCH makes use of the EDI in its early learning partnership.²⁵

Understanding early child development

We have partnered with the Human Early Learning Partnership to share population data from a validated survey instrument called the Early Development Instrument (EDI).

The EDI is collected across the province and is used to establish a baseline estimate of the state of early child development at the age of school entry. This information is used to determine programs and policies that support the development of young children.

The EDI results are compiled into five subscales, or domains, that correspond to five general themes in early child development.

School-based strategies

School-based strategies are another form of partnership to address social determinants. SHR is working to support health-promoting schools, for example. All elementary schools in the health region are included, although neighbourhoods and communities with more complex needs are resourced more strongly.²⁶ The principle is to focus on equity and children and families, while at the same time having some universal

programs for population health. The focus is on conditions that support healthy behaviours, aligned with improved learning outcomes. Each school decides what support it would most need.²⁷

The Winnipeg Poverty Reduction Council has initiated an adopt-a-school model, where businesses are encouraged to support a school of their choice in the poorer neighbourhoods of the city. WRHA's corporate office is participating and has chosen one of the poorest schools in the city. As part of the initiative, employees are encouraged to volunteer at the school and provide support experientially as well as in other ways.

Although not a school-based strategy per se, Montreal RHA has designed an overall strategy for supporting youth aged 5 to 17, with equity dimensions, whose ultimate outcome is intended to be educational success.²⁸

Public education and policy advocacy

Many RHAs make efforts to share research knowledge they have accumulated with the larger community via websites or by holding and participating in forums to exchange knowledge. VCH's website provides links to various documents about early childhood development.²⁹ SHR's two reports analyzing health disparities have been published and made available on its website.³⁰

RHAs are increasingly taking a public role in communicating to the larger community about the determinants of health in general and the specific inequity problems prevalent in their communities. Some have used the CPHI and related UPHN reports to publicize the extent of disparities in their own regions. As we saw above, SHR and WRHA research and publications on disparities in their cities were the foundation of inter-sectoral activities to address poverty and other forms of social inequity.

SHR sees social marketing as a tool for population health.³¹ VCH has focused on the business community, advocating with the Board of Trade about early childhood development and its economic impact.

In Nova Scotia, CDHA (Halifax) hosted a public forum on poverty as part of the Canadian Public Health Association's conference held in Halifax in 2008. CBDHA (Cape Breton), as well, hosted a public forum on poverty as part of their Population Health Day, for which they had earlier also hosted a public forum on housing.

Advocacy about policies outside the health sector is a strategy that derives from the RHA mandate for improving population health status, which cannot be achieved without influencing the social determinants of health, particularly social inequity. Policy advocacy is strongly tied to research and education, which form the basis for policy, but goes further in that it focuses on proposals for change. Policy advocacy is also strongly tied to RHA strategies of working in collaboration with other sectors and community organizations. Multi-sectoral partnerships are an important strategy for many reasons. In addressing social determinants, particularly social and economic inequities, policy proposals are not self-evident and are often contested by different actors in the society.³² Participating in the formulation of social policy

or in efforts for its implementation can be difficult for RHAs, particularly in conservative environments.

VCH lists the following strategies for its population health priorities (2008) of “Reducing Health Disparities in VCH Communities”:³³

1. **Leadership:** Recognizing the existence of a health problem or health disparity and assuming a responsibility to redress it.
2. **Policy Development:** Healthy public policies are characterized by an explicit concern for health and equity, and by accountability for health impact.
3. **Partnership Development:** Partnerships are essential to facilitate the creation of health promoting environments and conditions for communities.
4. **Advocacy:** Advocacy represents the strategies devised, actions taken and solutions proposed to influence decision-making on a particular cause/issue, the purpose being to create positive change for people and their environments.

VCH has an Advocacy page on its website, which provides a document with guidelines and resources to assist staff interested in population health advocacy.³⁴

In Nova Scotia, Annapolis Valley Regional Health Authority has a Health Framework: Healthy Communities Advocacy Manual,³⁵ in which they argue that in challenging disparities,

Advocacy work will aim to improve people’s life circumstances and will strive to decrease health gaps. (Example: examine differences in income levels, abilities, gender, etc.)... Advocacy activities are an integral and essential part of the work of reducing health inequities and promoting health and well being for all.

In 2009, Montreal’s RHA submitted a brief for the provincial government’s action plan on poverty and social exclusion, in which it provided information on the relationship between poverty and health, data on disparities in Montreal, and policy proposals on early childhood development, housing, transportation, and food security, among others.³⁶ We noted above the 2010 policy advocacy on transportation and equity by the ASSCN (Quebec City RHA).

These interventions are a type of health impact assessment, in which studies are undertaken to identify the impact of non-health sector policies on health, and to advocate for or against these policies accordingly. As we noted above, this function is explicitly supported in Quebec laws and programs at the provincial level.

Community development

Several RHAs have community development programs, including VCH, WRHA, SHR and Montreal.³⁷ Health region employees work with and support community organizations and members, mostly in poorer communities, on improving the social determinants of health. A VCH interviewee described them as working at the “ground level, being responsive. They see issues at the neighbourhood level, and try with

others to find a way to meet the need”.

SHR’s Building Health Equity Program advocates for housing as part of its community development activities and is planning a mother centre in a planned community development project. SHR’s Population Health Promotion Practitioners are also community developers.

WRHA’s twelve community areas now each have a community development program. Three focus on local development, working with communities to build local capacity.

Community participation

Many RHAs are involved in other community participation efforts. CDHA (Halifax) includes seven Community Health Boards, led by volunteers who inform the RHA about the health needs of the region’s communities. The boards award community development grants to community-based projects and organizations for a wide variety of initiatives aimed at improving the health of citizens. Examples of such projects are: the North End Community Garden; the Fall River/Windsor Junction Seniors Academy; and the GED Preparation Program for the Mi’kmaq Native Friendship Centre.³⁸ An interviewee noted that their participation is a way to address inequity by ensuring that community members’ needs are addressed. A WRHA interviewee made the same point about Winnipeg’s community boards. Another Manitoba interviewee noted that the community health impact assessments done by every RHA every five years are a tool for equity by ensuring community-level needs are expressed.

In Nova Scotia, the Guysborough-Antigonish Strait Health Authority (GASHA) has promoted the use of Community Health Impact Assessment (CHIA), a version of Health Impact Assessment³⁹, and one of its community health boards developed a related tool. The efforts are part of the People Assessing Their Health (PATH) Network; a group that has been in existence for about 15 years to promote CHIA. PATH uses a facilitated process to engage communities in developing their own unique community health impact assessment tool (CHIAT). The CHIAT can then be used to examine policies, programs or services proposed by governments (local, provincial or federal), institutions and community groups, as well as major infrastructure projects.⁴⁰

Aboriginal Health

Aboriginal populations throughout Canada are known to experience serious health disparities. Some RHAs with high Aboriginal populations have created specific programs to address the needs, often in collaboration with local First Nations and Métis organizations.

For example, Manitoba’s NOR-MAN Regional Health Authority has an Aboriginal Health Strategy and the Churchill Regional Health Authority has Aboriginal-specific healthcare strategies.

In Saskatchewan, the Regina Qu’Appelle Regional Health Authority and SHR have Aboriginal Health programs. The Cypress Regional Health Authority has a representative work force program. Its brochure

states that, “A representative workforce is achieved when Aboriginal people are employed in all classifications and at all levels in proportion to their representation in the working age population.” SHR has a representative work force program, in collaboration with local First Nations and Métis organizations, to try to increase the number of Aboriginal employees and SHR interviewees referred to it as a tool for addressing health equity in the Saskatoon region, partly because the RHA is a significant employer there.

In BC, all RHAs have an Aboriginal Health/Wellness plan.

Alignment: Reshaping RHA policy and practice

We found some, albeit not extensive, evidence that concern about health disparities is moving beyond the departments of population and public health to the wider RHA.

Corporate commitment

In VCH, the Senior Executive Team has made reducing health disparities in the Vancouver region one of its strategic objectives, through reporting annually on health equities, and adopting an approach that involves a wide range of departments in developing an organizational response.

The VIH Strategic Plan has a section on reducing disparities in Vancouver Island. Entitled Strategic Priority: Improved Health of High Needs Populations, Five-Year Strategic Plan 2008-2013 (July 2009), the plan says:⁴¹

We have identified priority populations where the need for better health is clear, and where we have the ability to make improvements. They are:

- Residents in rural and remote locations;
- Aboriginal people;
- People with chronic diseases;
- Homeless/hard to serve populations; and
- Children and youth.

SHR has equity in its strategic plan, and an interviewee referred to recent organizational cutbacks intentionally sparing the programs targeting poorer neighbourhoods as an indication that equity is an organizational priority.

The SHR population health promotion framework explicitly commits to not increasing disparities no matter what is done, and plans use the phrase for intended outcomes “as more and proportionately more in poorer populations.” The SHR health status report presents data on disparities and has recommendations coming from the Public Health Officer that are used in planning. The region is developing a dashboard of indicators, made up of all departments’ contributions, and it is proposed that equity be one of the indicators. SHR has also developed a health care equity audit (see below).

The Regina Qu'Appelle Regional Health Authority recognizes addressing disparities in its strategic plan.⁴² The annual report provides an analysis of health indicators by socio-economic status. It also recognizes oral health disparities. In contributing to healthy communities, it commits to:

1. Building partnerships to positively impact community wellness;
2. Leading health promotion and prevention initiatives;
3. Reducing disparities in health status; and
4. Offering holistic service delivery, supporting traditional ways of healing, and engaging the voice of the community.

Other RHAs in Saskatchewan make reference to disparities, although no plans are specified other than working on health promotion and attention to social factors. Several also make reference to focusing on Aboriginal populations (e.g. Prairie North).

In Manitoba, an interviewee talked about a health inequity thrust in the province over the last year, spearheaded by the province's CPHO, to which the regional health authorities will respond. We noted above that WRHA Strategic Direction 2011 refers to enhancing patient experiences and quality and integration to reduce disparities in access.

In both Quebec City and Montreal⁴³, the RHAs have the reduction social disparities as one of their explicit goals.

Les interventions en santé publique, en agissant sur les déterminants de la santé, contribuent à la réduction des problèmes de santé et des inégalités sociales de santé ainsi que des problèmes psychosociaux importants.⁴⁴

Health equity lens

A new element contributing to the work on health disparities is the development and use of an equity lens at the program planning and practitioner levels. SHR, for example, has been developing and has almost completed a health equity gauge, a tool for planners to help them think through whether they are identifying and addressing disparities.⁴⁵

In WRHA, we described above the Population and Public Health planning group's work in 2008. The group used a type of health equity lens in its survey to the different departments to scan the internal environment for awareness and effort to reduce disparities. In BC, VCH and Interior Health (IH) have used a form of an equity lens to perform equity assessments (Figure 2). IH has also developed an Aboriginal lens to assess equity specifically in serving Aboriginal populations.

Figure 2. Application of an Equity Lens⁴⁶



Application of an Equity Lens

Health Equity Assessment

- Gap Analysis stage
- Identify vulnerable populations
- Circumstances that increase vulnerability
- Practices to reduce or mitigate these circumstances

Another equity lens that was mentioned by a few interviewees is the women’s health lens being developed by POWER in Ontario.⁴⁷

Healthcare equity audit

SHR through its Public Health Observatory has developed and is using a healthcare equity audit, as a tool that will become part of the region’s quality assurance programs.

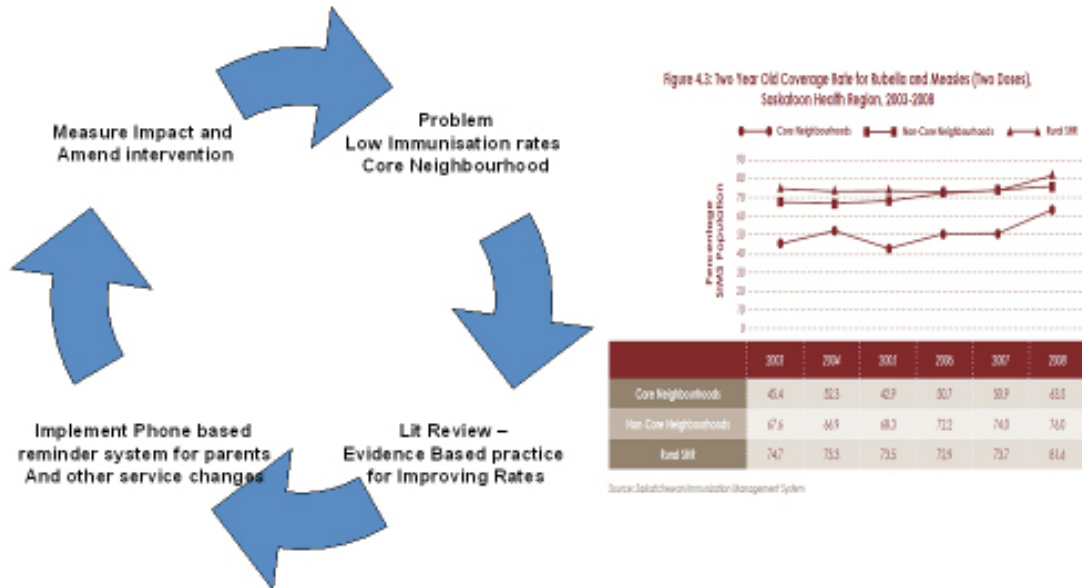
The first aim of the program is to identify systematic disparities in access to and uptake of needed healthcare services in the Saskatoon Health Region, and to understand the factors that contribute to them. The second aim is to identify interventions that have been shown to work in addressing these factors and in reducing disparities, and to promote their implementation in SHR. Finally, the program will evaluate the impact of these interventions, once implemented.

The audit has already been applied to immunizations (Figure 3), is currently being used for diabetes services, and will be used to for surgical services.

Figure 3. Health Care Equity Audit on Immunization⁴⁸

The SHR interviewee clarified that this is an audit of health *care*, rather than *health*, explaining that, “The Health Region sees itself as champion of health and keen to work with other agencies whose mandate can impact on health to do what they can to improve health. But the major role of the Region is securing and in many circumstances providing healthcare to the local population. Those delivering health services are very committed and are doing a lot. They are doing a great job with the people they serve. However, we need to ask if we are getting to people equally. Do we know if we are reaching the people who need care the most? We can’t do this unless we audit our work systematically.”

Health Care Equity audit Immunisation



Indicators and performance measures

VCH is looking at ways to measure and report on indicators related to equity of care in hospital settings building on work done at St. Michael’s Hospital in Toronto. In relation to health outcomes, given the focus on child development, one of the performance measures will make use of the work at UBC on child development measures. As we noted above, VCH is also connected to CPHFRI, which is also examining the issue of the funding formulas in relation to health disparities.⁴⁹

We also noted above that SHR is developing a dashboard of indicators among which equity is one.

D. Conclusion

This project has surveyed RHA-based efforts to address health disparities, as summarized in Table 1 below. Work is uneven across the country. There are valiant efforts in some RHAs with more resources and stronger leadership on this challenge. However, if other efforts are being made, they are not explicitly identified, let alone placed at the forefront of RHA agendas. Indeed one interviewee mentioned that, “given the current government, it is hard to work directly, so we focus on grassroots, multiple local actors to create pressure up. We focus on local tools and practice.” Nonetheless, there is much to be learned from efforts across the country. This table highlights the different types of strategies and initiatives.

Table 1. List of RHA Strategies to Address Health Disparities Discussed in This Paper

Collaboration and Partnerships	<ul style="list-style-type: none"> • Multi-sectoral collaborations for addressing disparities, including poverty reduction and Early Childhood Development • School-based strategies, with a focus on those in poorer neighbourhoods • Aboriginal health programs
Re-orienting services	<ul style="list-style-type: none"> • Increased primary health care in poorer neighbourhoods • Locating more services where marginalized people are; outreach • Focus on appropriate care for people in need, including Aboriginal health programs and cultural competency
Research and Analysis	<ul style="list-style-type: none"> • Studying local conditions and assessing needs to locate disparities • Mapping disparities and use of a Deprivation Index • Population/Public Health Observatory as a structure for the above
Education and Advocacy	<ul style="list-style-type: none"> • Publishing studies on disparities, including community mapping • Community education on disparities as a social determinant of health • Policy advocacy for addressing disparities
Community development and participation, focusing on marginalized groups	
Lenses and indicators	<ul style="list-style-type: none"> • Dashboard of indicators to include equity • Equity lens • Health care equity audit
Equity in RHA corporate statements and plans	

The problems of health disparities will only increase if not addressed, and the strategies and tools we have uncovered provide a resource for other organizations and practitioners. As we can see from the findings in this report, RHAs have considerable abilities and resources. The extent to which they prioritize and act upon equity could make a significant difference in the degree of disparities we experience in Canada.

Because this report focused on RHAs we have not covered the work of other jurisdictions or organizations. In Alberta Health Services' Healthy Public Policy, Health Promotion Disease and Injury Prevention is notable, working in the non-regionalized context. In Ontario, the work of the LHINs and the Ontario Agency for Health Protection and Promotion is known. Three areas were referred to by RHA interviewees: Toronto, Sudbury and St. Michael's Hospital.

Informing and supporting the efforts of the RHAs are many national and provincial governmental and non-governmental organizations. Mentioned by RHA interviewees were: in BC, the Provincial Health Services Authority) and the BC Public Health Association; in Saskatchewan, the Health Quality Council; in Manitoba, the Manitoba Centre for Health Policy; and nationally, the Chief Public Health Officer, the Public Health Association of Canada, the Canadian Public Health Association, the Urban Public Health Network, the World Health Organization and the Reference group on social determinants of health.

We note the important role in the RHA-based strategies played by population and public health. Although we did not explicitly refer to the 5 strategies of the Ottawa Charter on Health Promotion (build healthy public policy; create supportive environments; strengthen community actions; develop personal skills; and reorient health services), their congruence with the strategies and tools used by RHAs is evident. Finally, we note the important role of the public health officer and the status of public health as levers to advancing awareness, collaboration and focus on addressing health disparities.

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