Health Equity

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Date 2015

Toronto Stories

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Diversity puts us on the map

Charles Correa & Moriyama / Teshima Architects

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- We are greater when we all pull together

Pan Am Games

Harry Jones muscled his way over the goal line for the winning try in Canada's 22-19 win.

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What you already know

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Social determinants have contributed to a difference in life expectancy of 28 years in Glasgow

- A difference of 16 km in Scotland can result in a 28 year drop in life expectancy

- A boy from the poor Glasgow suburb of Calton could expect to live to 54, while a boy born in nearby affluent Lenzie is likely to reach 82. [1]

Social Factors Key to Ill Health
BBC Video [2]

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PHO and Cancer Care Ontario's risk list

Table 3: Percentage of Ontario adults (aged 30+ years) with selected modifiable risk factors, by socio-demographic factors, 2007–2008

Socio-demographic Indicator	Category	Current smoker (%)	Alcohol > 2 drinks any day (%)	Inactive (%)	Obese (%)
Aboriginal identity (off-reserve)	Aboriginal identity	**41.5**	**31.7**	46.6	**30.6**
	Non-Aboriginal identity*	19.5	23.4	53.0	18.2
Immigration	<10 years in Canada	**11.0**	**15.1†**	**66.2**	**8.5†**
	≥10 years in Canada	**15.2**	**15.9**	**59.3**	**15.3**
	Canadian born*	23.1	26.6	49.0	20.9
Neighbourhood income quintile	Poorest neighbourhood	**25.4**	22.7	**61.1**	**21.3**
	Richest neighbourhood*	15.0	25.5	47.5	16.4
Education	Less than secondary	**23.6**	**20.6**	**66.3**	**23.5**
	Some post-secondary	**25.2**	24.6	**55.9**	**20.1**
	Post-secondary graduate*	17.3	23.8	48.5	16.8
Urban/rural residence	Rural	**23.6**	**26.1**	50.8	**24.0**
	Urban*	19.5	23.3	53.4	17.9

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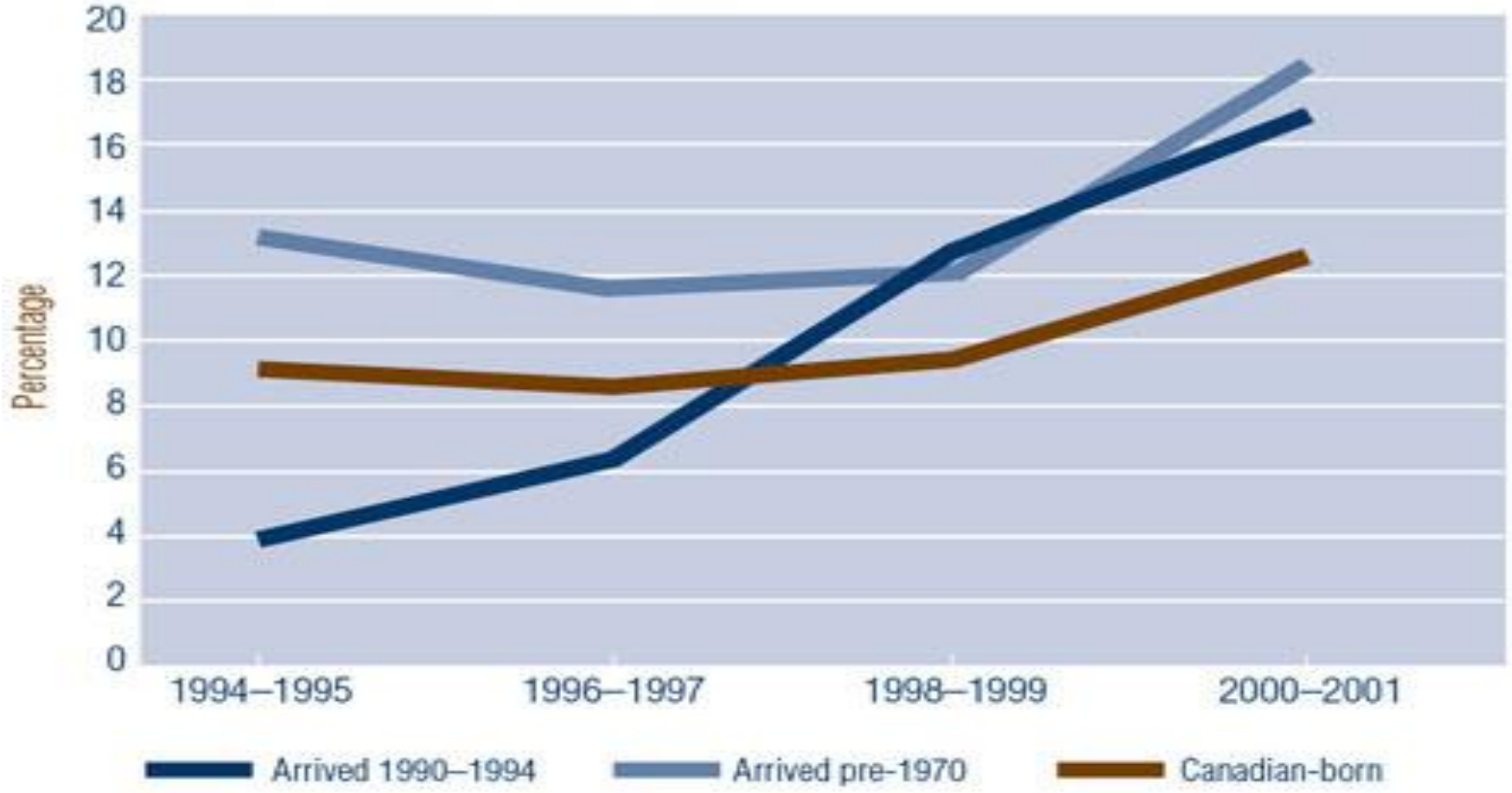

Percentage
20
18
16
14
12
10
8
6
4
2
0
1994–1995
1996–1997
1998–1999
2000–2001
Arrived 1990–1994
Arrived pre-1970
Canadian-born

Overweight or Obesity

Low rates: East/ South- east Asian
High rates: Black group

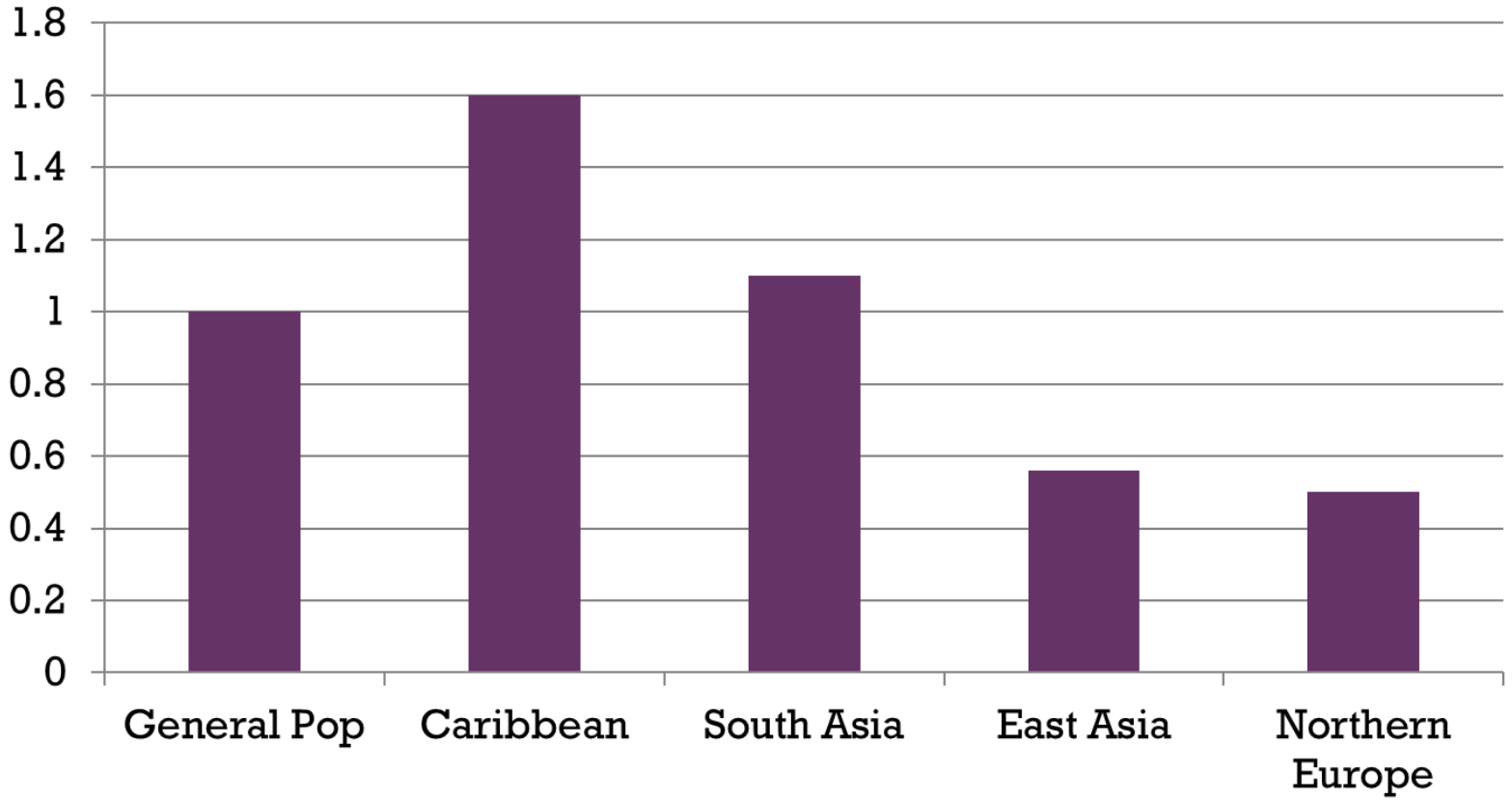
Pain or Discomfort

High rates: Black group

High Blood Pressure

High rates: Black, Latin American/Multiple/Other groups

Rates of psychosis for immigrants in Ontario (Anderson et al 2015)



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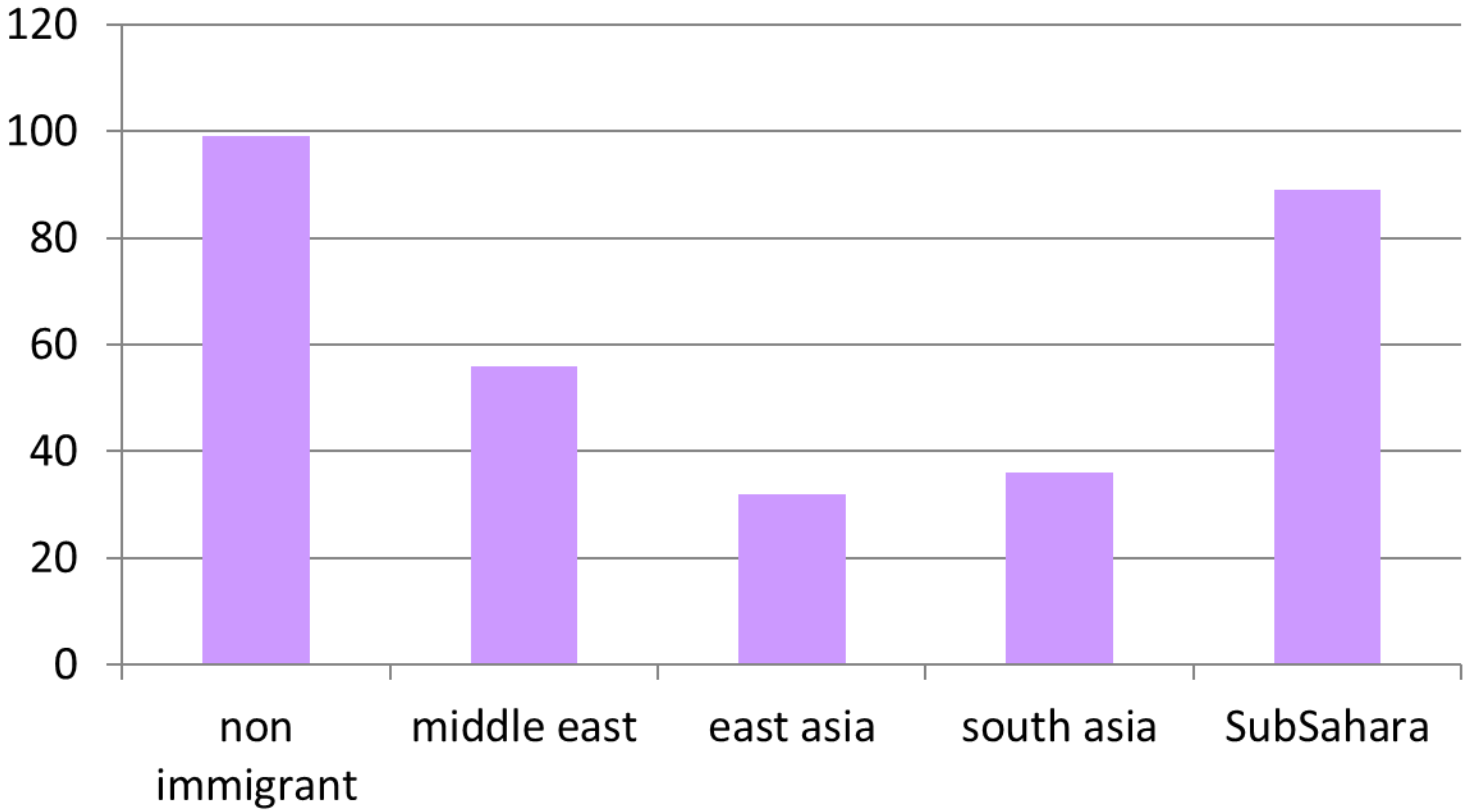
MH services costs 2008 Ontario per person means (McKenzie 2015)



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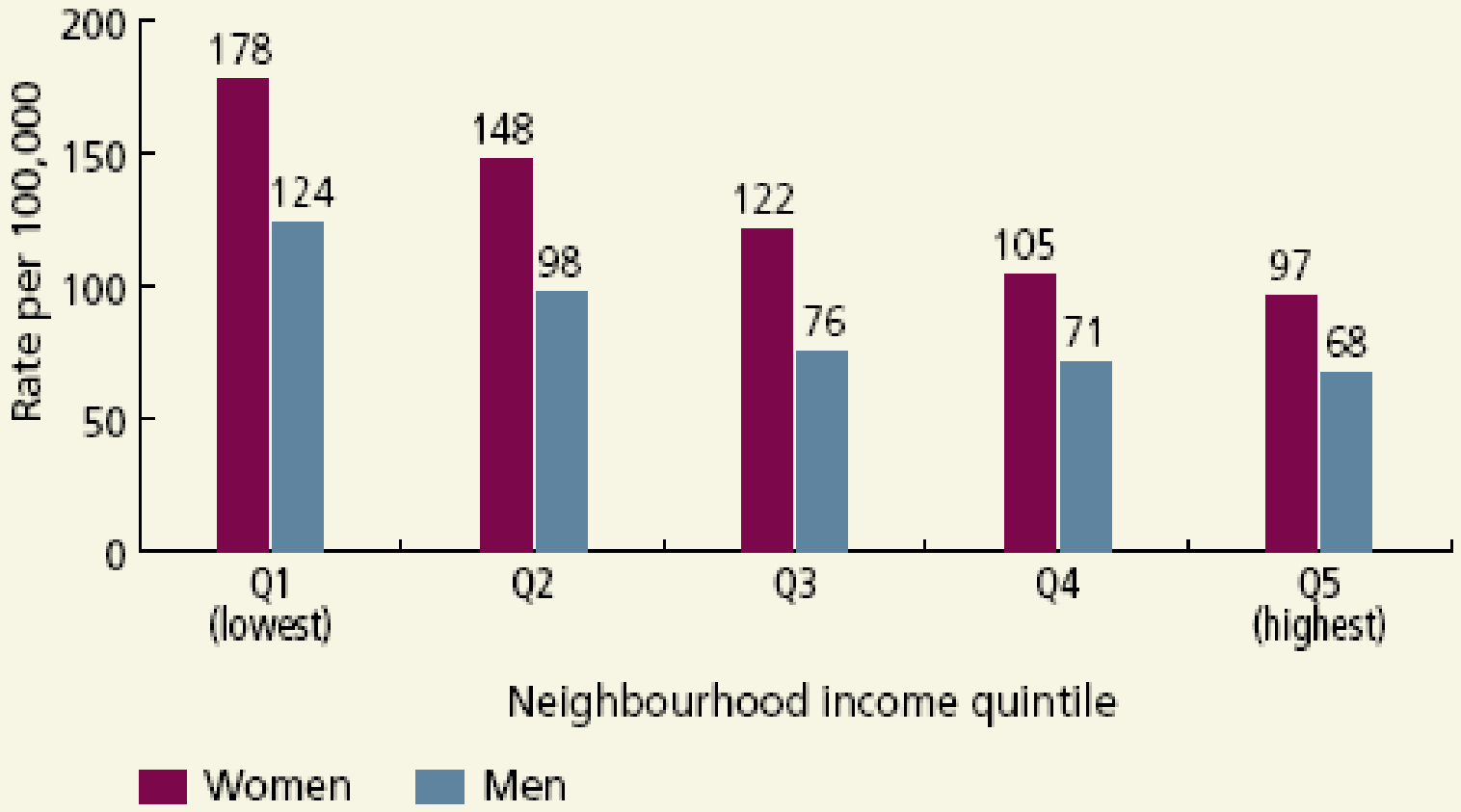
Those at lower income levels are significantly more likely to be hospitalized for depression (Power study)



THE THREE CITIES WITHIN TORONTO

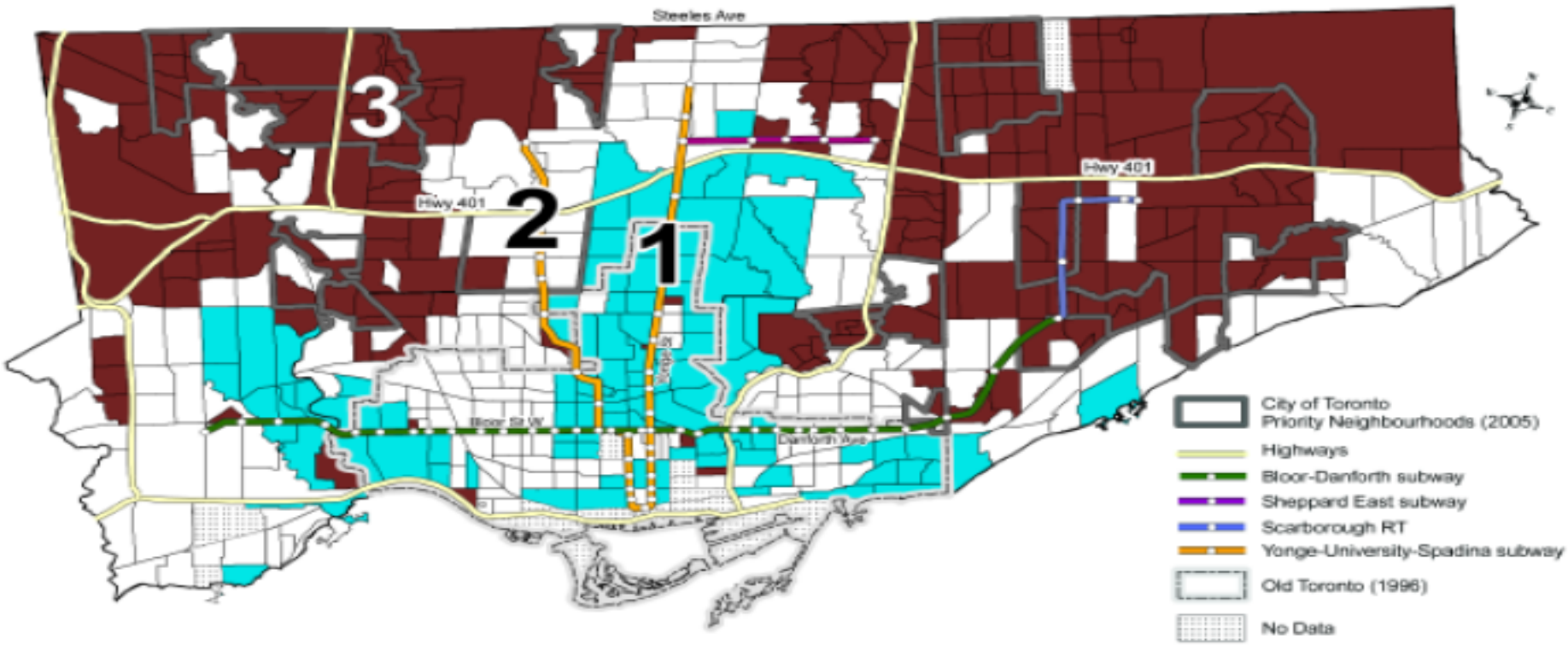
Income Polarization Among Toronto's Neighbourhoods, 1970–2005

BY J. DAVID HULCHANSKI, UNIVERSITY OF TORONTO

- Societal trends

MAP 1: CHANGE IN AVERAGE INDIVIDUAL INCOME, CITY OF TORONTO, RELATIVE TO THE TORONTO CMA, 1970-2005

Average individual income from all sources, 15 years and over, census tracts



Change in the Census Tract Average Individual Income as a Percentage of the Toronto CMA Average, 1970-2005

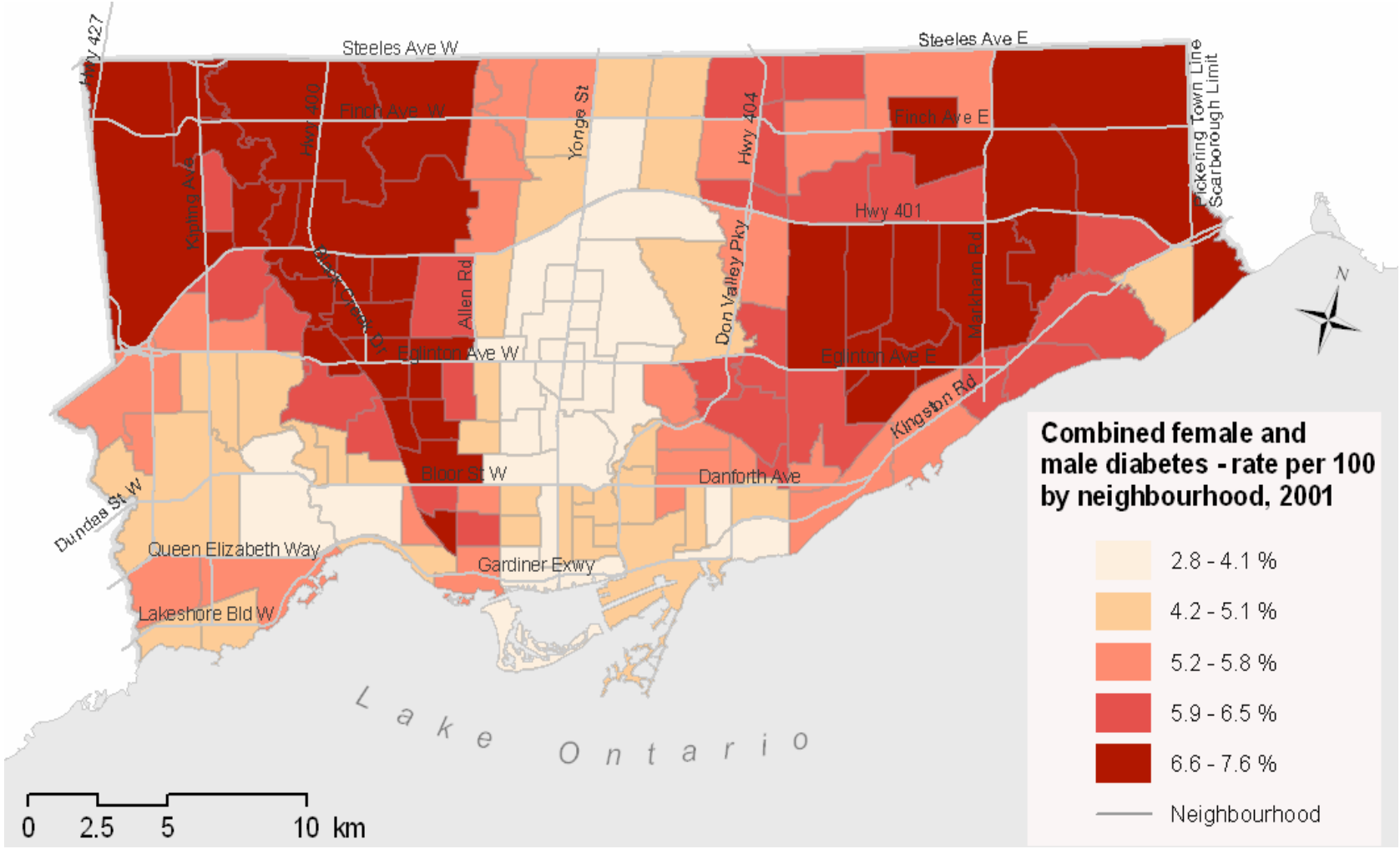
City #1
Increase of 20% or More
100 Census Tracts, 20% of City

City #2
Increase or Decrease
is Less than 20%
208 Census Tracts, 40% of City

City #3
Decrease of 20% or More
206 Census Tracts, 40% of City

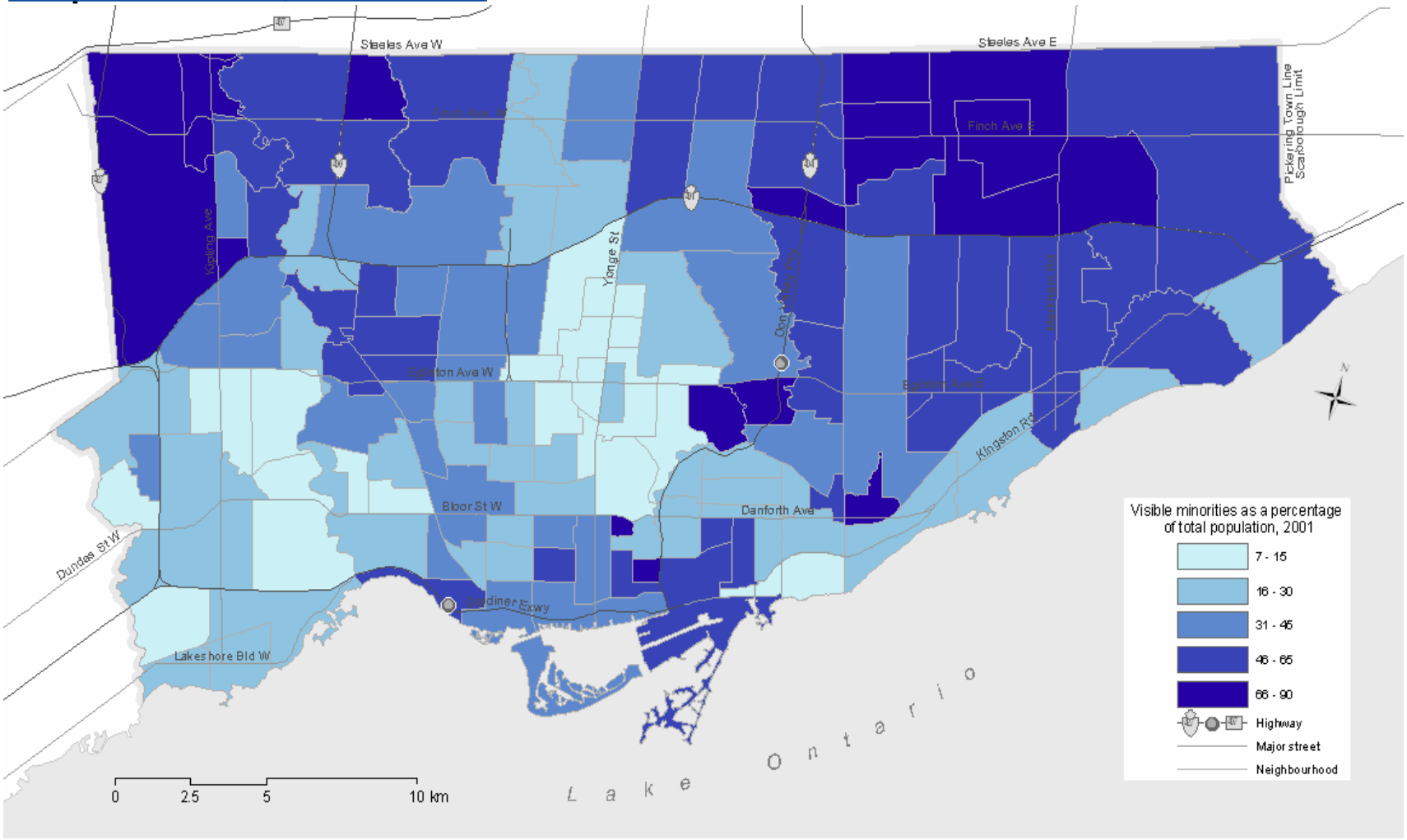
Note: Census Tract 2001 boundaries shown. Census Tracts with no income data for 1970 or 2005 are excluded from the analysis. There were 527 total census tracts in 2001

How it connects locally: Age-Sex-Adjusted Diabetes Rates, Toronto



Source: Glaizer, RH et. al. (eds.), *Neighbourhood Environments and Resources for Healthy Living –A Focus on Diabetes in Toronto: ICES Atlas.*Toronto: Institute for Clinical Evaluative Sciences; 2007.

How it connects locally: Concentration of Visible Minority Populations, Toronto



Source: Glaizer, RH et. al. (eds.), *Neighbourhood Environments and Resources for Healthy Living –A Focus on Diabetes in Toronto: ICES Atlas.*Toronto: Institute for Clinical Evaluative Sciences; 2007.

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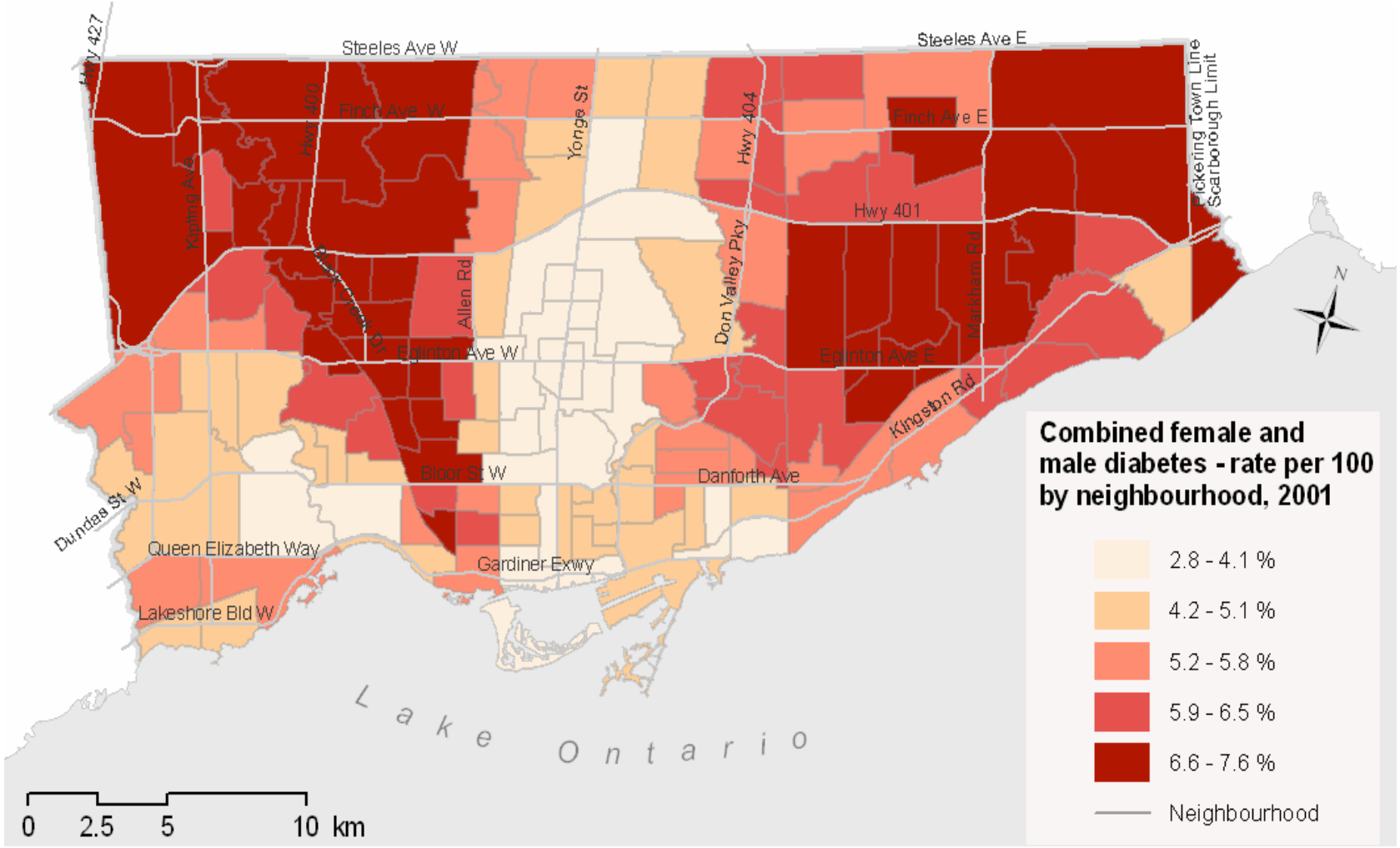
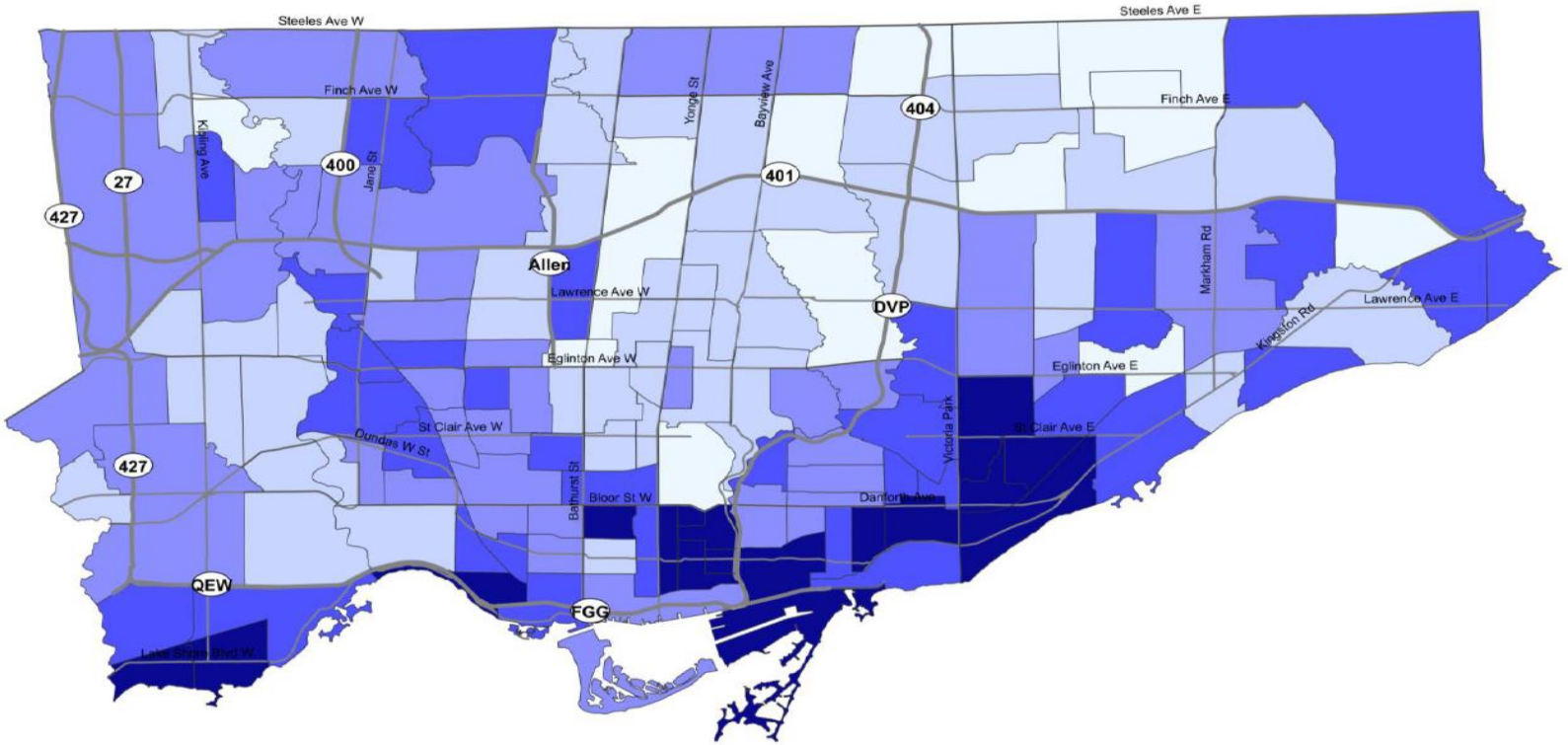


Source: Glaizer, RH et. al. (eds.), *Neighbourhood Environments and Resources for Healthy Living –A Focus on Diabetes in Toronto: ICES Atlas.*Toronto: Institute for Clinical Evaluative Sciences; 2007.

Map 1: Age-Standardized All-Cause Mortality by Neighbourhood, Toronto, 2007-2009 Combined



Age-Standardized Rate per 100,000 population

214.9 - 355.3	Highway
355.4 - 433.0	Major Streets
433.1 - 503.3	Neighbourhoods
503.4 - 592.7	
592.8 - 921.9	

N W E S

0 0.5 1 2 km

Data Source: Vital Statistics (Death) 2007-2009, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: Aug. 2012
Prepared by: Toronto Public Health
Contact: publichealth@toronto.ca

Note: 1. Statistics Canada 2006 Census as denominator of rate
2. Classification is by Natural Breaks

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Health inequity costs lives. How do we move forwards?

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"Good artists copy
Great artists steal"
Jobs, Picasso,
TS Elliot, Stravinsky

Improving health services

- A high quality and efficient health system is based on the matching of population need to the resourcing of effective interventions to meet those needs.
- A more equitable health system is more efficient.
- If Ontario is to bend the cost curve for health there is a need to deal with upstream issues that increase risk of illness but also a need to ensure that effective treatments are given to people at highest need.

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Health equity enshrined as way to improve health systems in Ontario

- The French language Act
- Local Health System Integration Act
- Canada Health Act
- Future of Medicare Act
- Charter of Rights and Freedoms
- Ontario Human Rights Code
- Excellent Care for All Act

Health inequity

Health inequities are avoidable differences in health usually caused by:

Social determinants of health

Inadequate social response to differences in need

Inadequate health response to differences in need

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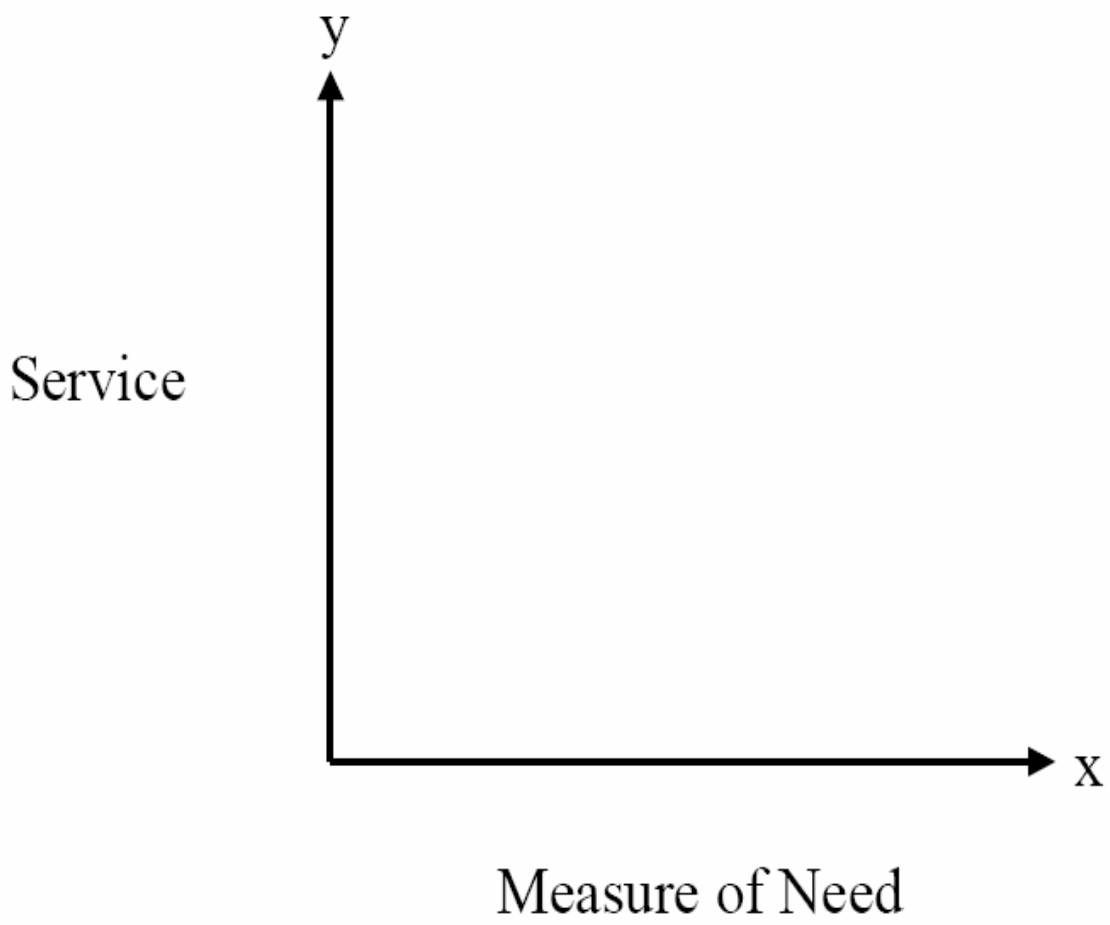
Health Equity helps users to align *services* with *need*—enabling better health outcomes



Source: Health Equity Audit: A Guide for the NHS, UK Department of Health

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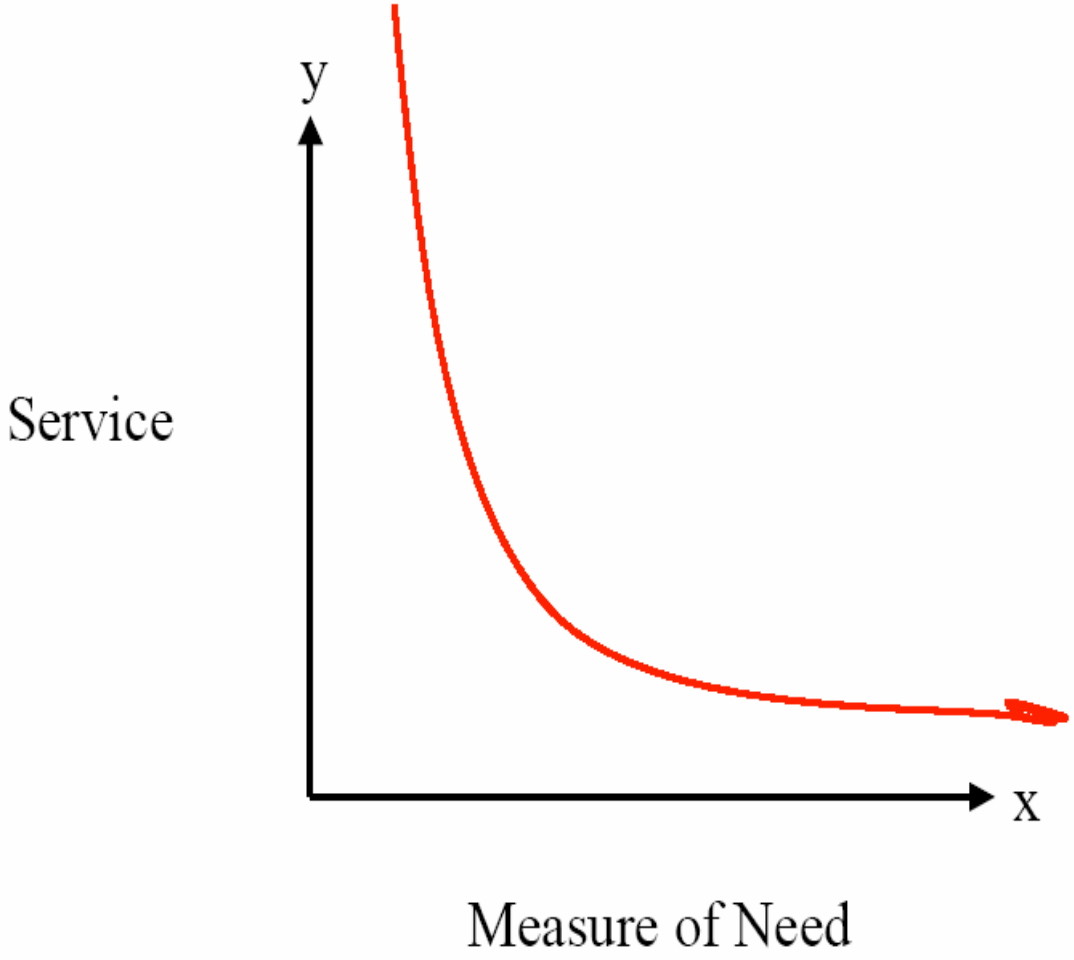
In this simplified example, those with the most need get the lowest level of service: the undesirable "inverse care law"

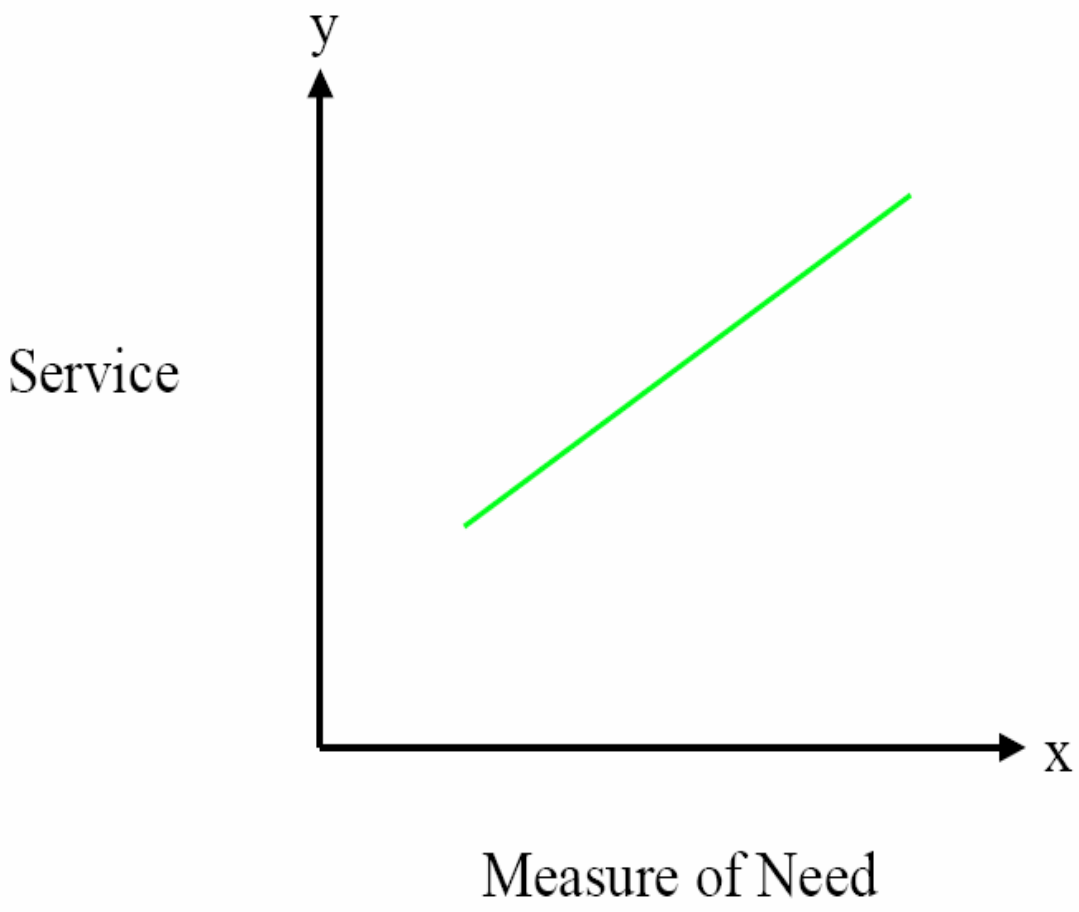


Source: Health Equity Audit: A Guide for the NHS, UK Department of Health

Two forms of health equity

- horizontal equity
  - equal treatment of those with the same circumstances
- vertical equity
  - individuals who are unequal should be treated differently according to their level of need

In this simplified example, there is a good alignment between high need and high service provision: a desirable situation



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Inequity is often unintended

- That does not mean that inaction is excusable
- We need to take action on SDOH
- We need to take action on services
  - Tools for data collection
  - Methods for analyzing data
  - Health equity audit
  - Health equity impact assessment
  - Adaptation of prevention, promotion, treatment

We have great people doing great things

- MOHLTC health equity department
- HQO Health equity strategy
- TCLHIN roadmap
- CCO strategy with PHO
- TPH services and research
- HEIA tool and training and community
- TCLHIN data collection tool
- Power study, ICES, CAMH, CRICH
- CERIS focussed services

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But there are too few of them. Plan or plan to fail

- Not co-ordinated
- No clear capacity development
- No clear targets
- No indicators
- No person who is in charge
- Some people take part others do not

We can see that there are disparities.
We know dealing with them will help everyone.
But many of us do not do it.

The Bystander effect

- May be because it is not clear who needs to do what

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Decide who is responsible for what and what you can do (McKenzie 2010)

	Differential rates	Inequitable health response	Inequitable social response
Clinicians		X	
Health care provider Organisation		X	X
Service system	XX	X	XX
Societal / legislative	XX	X	XX

Multi-level needs: multi-level solutions System level (Hansson et al 2010)

- Health equity may have the potential to reduce disparities for IRER groups
- One way of achieving this is by population-based, flexible services based on needs
- Using local data and knowledge helps produce a better need resource curve

Multi-level needs: multi-level solutions

Clinical services

- Systems can develop equitable funding but services need to connect with their communities – structural competence
- Interventions needs to be equitably effective
- Clinicians need to practice equitably

Why I like TCLHIN Roadmap

- Equity data collection
  - Base action on evidence
- Leadership and culture change
  - this only works if we all take part, everyone should be a leader in equity
- Direct intervention
  - clinical services but also links between clinical services and organizations involved in SDOH

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But it leads to difficult questions

- If I am not helping with health equity am I part of the problem?
- If I agree with health equity, do I agree with redistribution of funding?
- If I agree health equity is quality should it be part of my quality assessment?
- If I agree with health equity am I happy to move some funding upstream?

- We are all part of the solution
- Toronto is best when we build on our history of diversity, use the knowledge available throughout the world to build a better future

An effective team has a plan.
Different players have different roles.
But everyone has to work together if we want to win

Thank you

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 @kwame_mckenzie

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