

# Thinking Globally, Acting Locally about Health Reform

*Communities, RHAs, & a Health Equity Policy Agenda*

BY BOB GARDNER

*Health reform is one of the most hotly debated policy issues of the day – and of the decade. Focus ranges from widespread public concerns about waiting lists and access to services, through government worries about cost and sustainability. Planners search for the best ways to co-ordinate and integrate a vast and complex system, while practitioners strive to realize the full potential of innovations they witness every day on the front lines of health care.*

*In the midst of all this complexity and competing pressures, it is vital to keep our eye on fundamental principles. Health reform cannot just be about restraining costs or rationalizing services or relocalization of decision-making. A driving goal of reform must be to ensure that everyone has access to the services they need and that changes in the health system and in other areas of public policy result in better health for all and significantly reduce existing disparities.*

In short, health reform must be driven at least in part by an agenda of comprehensive health equity.

If enhancing health equity is indeed a goal, we have before us four critical challenges:

1. To develop a different kind of high-quality, responsive, and collaborative service delivery that puts the patient at the centre. This involves multi-disciplinary teams of physicians, nurses, and many other kinds of provider in community-based and -orientated clinics and other practice settings.
2. To ensure everyone equitable access to the full range of care and services they need. That means removing barriers of language, culture, and social disadvantage; increasing investment in spheres proven to reduce health disparity (e.g., access to primary health care); and targeting initiatives at the communities experiencing the harshest health disparities.
3. To increase the resources devoted to health promotion and prevention, so that fewer people get sick unnecessarily.
4. To understand that better and more accessible health services are only one way to reduce health disparities, and a relatively small one at that. We must get beyond the silos of the health care system and collaborate across sectors to address the roots

of ill health and health disparities in wider structures of social and economic inequality.

This article makes two connected arguments. First of all, such progressive systemic change will only occur if we build it on solid local innovation and initiatives. Good local planning and well-grounded Regional Health Authorities (RHAs) are essential to progressive reform. Second, to be effective and responsive, local and regional planning must in turn be built on a solid foundation of extensive community involvement in defining health needs and priorities.

## **The Roots of Disparity**

An enormous amount of research shows that the roots of health disparities lie in broader social and economic inequality and exclusion. The decisive impact on health outcomes of early childhood development, education, employment, good working conditions, income distribution, social inclusion, housing, and social safety nets is well established.

The real problem is differential access to these determinants. People who are homeless have far worse health. People in insecure jobs or with lower incomes have poorer health than those in better circumstances. This means that many of the policy solutions to health disparities lie *outside* the health system. The single most significant way to improve the health of Canadians overall requires a significant re-orientation of social and economic policy to reduce inequality.

One direction is to build equity into all macro social and economic policy, not just as one factor among many to be balanced, but as a core priority. Another is to develop policy collaborations across ministries to address all the determinants of health equity in a co-ordinated and comprehensive way.

Some jurisdictions have integrated checklists and other tools with their policy processes to operationalize this. For example, Québec's Ministry of Health and Social Services will now assess any change in tax or environmental policy for its impact on equity. More generally, the Canadian Index of Wellbeing is one of several efforts that challenge the capacity of GDP or stock market indexes to capture how well the country is doing, and introduce social, cultural, and other facets of well-being into the measurement process.



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## Think Big, Look Widely

There is much to learn internationally about comprehensive health equity strategies. We need to look as widely as possible for ideas and inspiration, and then adapt them to local and provincial circumstances.

The United Kingdom, New Zealand, and a number of European countries have made it a top national priority to lessen health disparities and to that end have developed cross-sectoral policy frameworks and/or action plans. International organizations have also been devoting increased attention to this issue. The World Health Organization, especially its Commission on Social Determinants of Health, is one example. Another is the European Union, with its Closing the Gap project to tackle health disparities.

Sweden is one of the most frequently cited examples. There, social welfare policy is seen to be key to reducing health disparities. It has developed a national policy framework to co-ordinate inclusive labour market, anti-discrimination, child care, and affordable housing policies, among others. The strategy also emphasizes partnerships with community service providers and organizations in both policy development and service delivery.

Equitable access to improved health care is just one part of this broader package. Sweden's national public health strategy has 12 key objectives – five of which (considered fundamental to all the others) concern improving social and economic determinants of

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(above) To get beyond “cultural awareness” to true community engagement, Winnipeg Regional Health Authority strives to make the ethno-cultural composition of clinic and hospital staff reflect the composition of the neighbourhoods which they serve. Credit: Winnipeg Regional Health Authority.

health. Other Nordic countries have taken a similar path, reflecting a political culture with a strong consensus on social solidarity.

## An Equity Strategy within the Health System

Despite their emphasis on social and economic policy, all these countries also see a transformation of the health system proper – how it is organized and how services are delivered – as indispensable to health equity. International examples also clearly indicate that action on equity cannot just come from senior governments. Many of the most innovative and insightful programs to address health disparities originate in local authorities or community providers; community residents and stakeholders make a critical contribution to planning and priority setting.

In Canada, two lines of health system reform to address health equity will be critical. To each of them community-based engagement and initiative are essential.

The first is to identify and reduce barriers to access within the system's basic architecture. User fees or clinics where people can pay for quicker services, for example, demonstrably reduce access for poorer people. Likewise, discomfort with the dominant language can prevent people from navigating our complex medical system or negotiating with professionals.

To make real progress against these barriers, it would be fruitful to invest in models that have served the most vulnerable communities well. For example, Community Health Centres (CHCs), public health, and other community-based service providers have years of experience in developing innovative programming dedicated to communities facing the harshest health disparities. (That is the reasoning behind Ontario's expansion of its CHC network over the last few years in areas with the worst disparities or poorest access to primary health care.) Initiatives such as Multicultural Health Brokers Co-operative (Edmonton), with its health education, community development, and advocacy on behalf of immigrants and refugees, need to be supported.

The second is to target resources and services to specific areas or populations facing the harshest disparities – to raise the worst off fastest, or those most in need of specific services, or where interventions will have the most impact. This requires sophisticated analyses of the bases for disparity. Is the main problem language barriers? Is it lack of co-ordination among providers? Or is it sheer lack of services in particular neighbourhoods? This requires good local research, needs assessments, and evaluation data – the sort that community-based research can richly provide.

Here in Canada, comprehensive equity strategies need to be developed at the provincial and territorial level. But their implementation and the nurturing of and building on local community-based innovations will largely take place at the local and regional levels. What then would a progressive and responsive equity strategy look like for RHAs?

## Building Equity into RHA Priorities

It is likely most RHAs mention equity as a key principle or goal. All need to develop strategies and investments to put the principle into action. Ontario is in a lucky position in this regard. Its take on RHAs, the Local Health Integration Networks (LHINs), are still relatively new. There is still a chance to build equity into their "DNA" as an underlying and driving principle.

Much like RHAs across the country, each of the 14 LHINs has identified a number of substantive priorities in their first 3-year strategic plans. Equity can be inter-woven into each priority so that implementation also acts to reduce health disparities.

For example, LHINs have prioritized mental health. Equity angles on this priority could include:

- an emphasis on the mental health needs of particular populations most in need, such as new immigrants, poor neighbourhoods, or people facing language or cultural barriers.
- enhancement of community-based programs that work with mental health needs of disadvantaged communities or populations.
- implementation of "Every Door Leads to Service" strategies, in which providers help clients receive appropriate care regardless of where they happen to access the health system, and connect them with other providers and services as needed.
- integration of mental health services into CHCs and other providers well-connected to disadvantaged communities.

## Use the Levers at Hand

RHAs need to use their power as funders and co-ordinators of service planning and delivery to drive equity as a system goal. Ontario's LHINs are currently negotiating their initial service agreements with hospitals and will be concluding agreements of this nature with all their funded providers over the coming months and years. This is a strategic opportunity for RHAs to build equity into performance management structures and expectations from the start.

The most effective indicators and expectations could take many forms. For example, each hospital in a major urban area could be expected to demonstrate that its patterns of service utilization reflect the diversity of its catchment population, or the needs of particular under-served or disadvantaged community (e.g., downtown hospitals demonstrating that they provide appropriate services to homeless people). Hospitals, CHCs, and other providers could be expected to demonstrate translation and service provision in a variety of locally-spoken languages.

A similar process could be applied to redress identified disparities in access to particular services. In Toronto, for example,

the need for hip and knee replacements is presumably either equally distributed or greater among those doing more manual types of work. Yet surgery rates are far greater in high-income neighbourhoods. The LHINs and their hospitals could develop plans to reduce these disparities and then be evaluated on progress in reducing the gaps between neighbourhoods.

In terms of policy design, building equity into performance management can be seen as expectations and incentives that cascade from the Ministry to RHAs, and then into their service agreements with hospitals and other health care providers:

- The Ministry sets equity targets for reducing health disparity in a region by a specified percentage, or for ensuring that service patterns reflect the ethno-cultural diversity and needs of local population.
- The local RHA determines how these objectives are to be achieved, preferably with significant community involvement in planning and priority setting.
- The Ministry provides the necessary financial incentives within their agreements with LHINs. It could earmark funds for pilot projects to address equity or for special initiatives targeted to poorest areas, for example.

## Pilot & Experiment

There is not going to be a magic blueprint for how to move on ideas and initiatives such as the above. The best way for RHAs to proceed will be through planned experimentation:

*RHAs' funding regimes will need to be flexible enough to support a wide range of local innovation. At the same time, they will need to be systematic in matching innovations to identified equity issues or target populations & in assessing their impact.*



(right) The Multicultural Health Brokers link immigrants to providers of health, family, law-enforcement, education, and social services. Photo credit: Multicultural Health Brokers Co-operative.

- Fund a CHC to provide chronic care management to ethno-cultural communities in their language and reflecting their cultural background.
- Fund networks of community-based service providers to develop integrated electronic records to improve access and quality of care for particular communities. The Client Access to Integrated Services and Information (CAISI) project in Toronto is developing an open source database so that homeless people can access their records from whatever shelter, hospital or other setting they happen to be in. This eliminates the need endlessly to repeat and record their medical histories, as well as the associated costs.
- Support localized and community-based research and needs assessments to identify the most promising interventions. A useful example is the 2007 survey of the health of homeless people in Toronto undertaken by Street Health. It uncovered a range of very specific barriers and problems that the local LHIN can resolve.

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RHAs' funding regimes will need to be flexible enough to support such a wide range of local innovation and experimentation. At the same time, they will need to be systematic in matching innovations to identified equity issues or target populations and in assessing their impact. A key challenge will be to ensure the best balance between local initiative and broader goals of health reform. There must be enough flexibility to allow local experiments and interventions that best respond to local needs and situations. Yet there must be a commitment to address equity seriously and consistently in every region.

We know there are many good initiatives and promising innovations all over the country. But it has been very difficult to share the lessons learned, especially across jurisdictional boundaries. This is really just a question of "knowledge management" on a large scale and can be solved. To realize the potential of local innovations and experimentation, senior governments also need to develop a framework to support experimentation and innovation:

- common data and information platforms.

- funding for pilot projects involving different practice models and community-based providers.
- dedicated funding lines to RHAs for pilots, and expectations that each RHA will undertake innovations.
- funding regimes that stress results and value, but are flexible (for example, allowing providers to adjust programs to meet emerging or shifting needs).

To build on subsequent local successes and innovations, we then need a provincial or national infrastructure to:

- trawl for and identify interesting local innovations and experiments.
- evaluate and assess potential beyond local circumstances.
- share information widely about lessons learned. At the very least this is necessary to prevent every RHA and local provider from having to "re-invent the wheel" for issues that others have already resolved.
- scale up or implement innovations widely where appropriate.
- create a permanent cycle and culture of front-line driven innovation in equity.

We also need to also share ideas across provincial boundaries. How can RHAs share what is working with counterparts in other provinces?

One excellent example of a forum was the Canadian Centre for Analysis of Regionalization and Health. Based in Saskatoon, it held annual conferences, shared information through a newsletter and website, and undertook specific analyses of specific issues or challenges in regional planning. In sum, it provided an important means of building on the insights generated by RHAs across the country and beyond. Unfortunately, this valuable resource was lost when federal funding for the Centre ended several years ago.

## **Local & Community Action Beyond Health Care**

Ministries, RHAs, and other public bodies and service providers can collaborate on the ground to deliver more co-ordinated health and social services. In Britain, Health Action Zones and other models combine community development with targeted health care access and service improvements. In Canada, some RHAs have developed operational and planning links with local social services or have emphasized community capacity building.

One approach is to deliver integrated health and social services out of the same community-based locations. For example, the Winnipeg Regional Health Authority and Manitoba Family Services and Housing have been working to develop such a model: one-stop access points in various communities to deliver a broad range of health and social services directly and to refer on to other agencies when services aren't available. New or satellite CHCs are being developed in designated high-need areas in Toronto. At some locations, CHCs will deliver primary and preventive care while other agencies provide complementary social services.

## Local Action = RHAs + Community Engagement

Responsive and effective community involvement and engagement are vital to guiding and grounding local planning and service delivery. Here are some key features of successful community engagement for RHAs to consider:

- Build on and work closely with the large number of service networks and co-ordinating bodies that already exist in every community. (For example, when the Ontario government was first creating LHINs, it found over 1000 co-ordinating or planning networks already existed.)
- Develop local and neighbourhood planning committees and systematically feed their priorities up to LHIN planners.
- Use a wide range of flexible and innovative forums and processes to tap into the full diversity of community needs, views, and perspectives, Let's think big here. Why not adapt forms of the popular budget-making developed in Brazil and other countries? Or interactive information technologies for those hooked into these media? Why not combine that with models of deliberative dialogue used so successfully in Canada and abroad to address complex policy issues?
- Pay particular attention to engaging the most vulnerable and marginalized populations whose voice is seldom heard. One of the most effective ways to do this is to work with the front-line multi-service or specialized service providers who have built up trust and long-standing relationships with these

populations. The Ontario Women's Health Network has adapted peer research approaches to create inclusive focus groups led by vulnerable and marginalized women of specific communities.

- Provide the information and tools for communities and individuals to participate meaningfully in planning and priority setting.
- Build community involvement into all key junctures of the RHA planning cycles.
- Develop clear indicators for how successful community engagement will work in practice. A good place to start is to consult with the public about what the goals and indicators should be in the first place.

Health disparities in Canada are horrible and pervasive. But action is possible. Health equity has to be addressed in a comprehensive and cross-sectoral way by provincial and other senior governments. But real on-the-ground action will also need to be driven by local planning, service delivery, and community-based innovations. To be successful, these local initiatives will need both community support and involvement and an environment of experimentation facilitated by the RHA.



BOB GARDNER is Director of Public Policy at the Wellesley Institute, a nonprofit and non-partisan research and policy institute based in Toronto that develops research and community-based policy solutions to the problems of urban health and health disparities ([www.wellesleyinstitute.com](http://www.wellesleyinstitute.com)). Contact him at [Bob@wellesleyinstitute.com](mailto:Bob@wellesleyinstitute.com) or 416-972-1010.

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