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Mississauga Halton LHIN Health Equity Plan

February, 2010

FINAL

The Mississauga Halton LHIN Health Equity Plan

The goal of this health equity plan is to reduce health disparities and differential outcomes in the Mississauga Halton (MH) LHIN with the help and shared responsibility of our health service providers and partners. The MH LHIN had a vision for health equity and diversity because of the great diversity in our LHIN. We also know that an effective way to achieve a more healthy population is by removing disparities in access to and in the quality of services people receive. This is one of the main reasons LHINs were created and made accountable for improving the local health care system. We will know we have been successful when the population's health and wellness is good and everyone, particularly those with the greatest need have access to the right care, at the right time and in the right place.

We will engage diverse communities to participate in all community engagement events, leadership and governance opportunities and policy and program planning. This health equity plan calls for action from all prospective partners to work more transparently and collaboratively in the development and implementation of a more comprehensive, consistent, equitable and inclusive approach to building health equity across the MH LHIN.

Background:

A brief description of the Mississauga Halton LHIN (MH LHIN)

The Local Health System Integration Act (LHSIA) received Royal Assent in March 2006, formally establishing LHINs. The MH LHIN is one of 14 LHINs established by the Ontario government to plan, coordinate, integrate and fund health services at a local level. The MH LHIN funds 76 health service providers that provide a variety of services in a variety of locations including a community care access centre, community support services, hospitals, long-term care homes and mental health and addictions services.

An important aspect of what we do involves working with community residents, health service providers and other partners to ensure that the health care plans and service delivery for the MH LHIN area make the best use of available resources and meets the needs of our communities.

Snapshot of our diverse population:

- By 2016, our LHIN's population is slated to grow by another 30.1% (more than double the provincial average)
- The most significant impact over the next 10 years is expected to be among 65-74 year olds, with an anticipated growth rate of 59.4%

- Currently our region has an immigrant population of 43.2% compared to the provincial average of 28.3% (2006 Census, Statistics Canada)
- Visible minorities make up 36.2% of our LHIN population
- Lowest percentage (13.3%) of family incidence of low income in the province
- Lower percentage (20.0%) than the provincial average (24.5%) of lone parent families
- Lower percentage (13.0%) than the provincial average (18.7%) of people aged 25+ without a certificate, degree, diploma

What is health? Health disparities? Health equity?

There are many definitions of health, used for many purposes, but the definition adopted by the World Health Organization (WHO) in 1978 remains a good working standard:

Health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity. It is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO, Alma Ata, 1978)

Similarly, there are many definitions of health disparities or inequities but, simply put, disparities are differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage¹. Health equity, then, works to reduce or eliminate socially structured inequalities and differential outcomes. It is linked with broader ideas about fairness, social justice, and civil society. Or, put simply, health equity means equal opportunities for good health. While people may aspire towards a healthier lifestyle, the initiation and maintenance of health behaviours result from an interaction of social, psychological, biological and environmental factors and are connected to an individuals' own responsibility.

A clear research consensus is that the roots of health disparities lie in broader social inequality and exclusion. The most effective conceptual framework for health disparities is therefore grounded in a determinants of health approach, i.e., it looks beyond the traditional definitions of health, as well as beyond the historical analyses of the causes of illness and injury, and focuses on a broad range of socio-economic influences and outcomes that affect both individual and community or population health, such as income/wealth distribution and poverty, early child development, education, employment and working conditions, housing, gender, race and ethnicity, citizenship and immigration status,

¹ Health Equity Now: A working paper on the best first steps for Ontario. June 2008. Margot Lettner. Wellesley Institute.

language, ability, sexual orientation, age, racism and discrimination, social exclusion and natural and built environments.

So, many of the most important factors producing health disparities are far beyond the health care system itself. And much of the solution to health disparities lies in macro social and economic policy – and in policy collaboration and coordination across governments that may be beyond the scope of the policymakers in a local community. But this does not mean that changes to make the health system at a local level more equitable cannot have a major impact.

Identifying and meeting the needs of priority populations is a key strategy for reducing health inequities. Diversity competent population health assessment and surveillance require the use of a new lens – health equity lens. To overcome health inequities, we need a paradigm shift. By introducing an equity lens in our health assessment, analysis and planning activities, we are more likely to understand what unique barriers and burden some populations face and what programming, social and environmental conditions need to be addressed in order to minimize those.²

According to the World Health Organization, people in less advantaged or powerful situations – whether measured by gender, socio-economic status or social class, race, immigration situation or other intersecting dimensions or inequality tend to have poorer health. At the same time, there are consistent and unequal disparities in access to care. Some of the most disadvantaged populations and communities are in very poor health and have very poor access to vital services and support. There is a vast amount of research showing that the roots of health disparities lie in broader social and economic inequality and exclusion. The impact on health of inadequate early childhood development, education, employment, working conditions, income distribution, sexism, racism, social exclusion, housing and deteriorating social safety nets is well established. The real problem is differential access to income, housing and these other key determinants of health – this underlying social inequality is the foundation of health disparities.³

It is very difficult to identify a specific root cause for disparities in health because health care interacts with the determinants of health in complicated, unpredictable ways often. But, sometimes in complex systems, small changes in the right inputs can lead to major changes in outcomes. The Ontario Health Quality Council (OHQC) identified equity as one of its nine attributes of a high-performing health care system in its first report in 2006:

² Patychuk D and Seskar-Hencic D. November 2008. First Steps to Equity. Ideas and Strategies for Health Equity in Ontario 2008-2010. Toronto.

³ World Health Organization. <http://wellesleyinstitute.com/who-health-equity-resources/who-commission-social-determinants-health>

There should be continuing efforts to reduce disparities in the health of those groups who may be disadvantaged by social or economic status, age, gender, ethnicity, geography, or language.

This definition, while providing a good starting point for shaping health care policy and delivery, can be broadened further to include health disparities related to racism and discrimination, culture, citizenship status, sexual orientation, and ability. In their second report in 2007, the OHQC identified a three pronged approach to developing a more equitable system keyed on three of the other attributes:

1. Improving the *accessibility* of the health system through outreach, location, physical design, opening hours, and other policies.
2. Improving the *patient-centredness* of the system by providing culturally competent care, interpretation services, and assisting patients and families to surmount social and economic barriers to care.
3. Cooperating with other sectors to improve *population health*.

The Ontario government has many initiatives currently in play focusing on equity in general and health equity in particular which will create an open space for community discussion and input. One is a major cross-Ministry research initiative that aims to lay the policy framework for more coordinated and integrated approaches to health equity. Its goal is to develop policy frameworks and tools that will help to minimize systematic and remedial disparities in health and social well-being along the social hierarchy. At the same time, the Ministry of Health and Long-Term Care has created a new health equity unit to lead and coordinate its efforts to address inequitable access to care and several other LHINs have identified equity and diversity as priorities.

What are some policy opportunities for those working on more health equity?

There are many opportunities to use the OHQC's framework for improving health equity and there are many examples of existing programs which could be beacons to better practices.

Improving Access

The OHQC defined accessibility as:

People should be able to get the right care at the right time by the right health care provider.

The OHQC suggested that improving accessibility could enhance equity through outreach, location, physical design, opening hours and other policies.

Improving patient-centred care

The OHQC defined patient-centred care as:

Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.

The OHQC suggested that improving patient-centred care could enhance equity through providing culturally competent care, interpretation services, and assisting patients and families surmount social and economic barriers to care.

Improving the effectiveness of the health system's work with other sectors to achieve population health goals

Intersectoral action for health has been described by the World Health Organization as⁴:

A recognized leadership between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.

People have been suggesting Intersectoral approaches to health for many years. Unfortunately, intersectoral action has proven much harder to fulfill in practice than to describe in theory⁵. After twenty-five years, there is a growing recognition in the health sector that the most complicated social problems require an intersectoral approach, one that works towards "healthy public policy". It has also been recognized that it is easier to gain the cooperation of different sectors for effective action at the local or community level than at the national or even provincial level. However, action at higher levels (e.g. federal, provincial) tends to have more impact on population health. There needs to be a two-pronged approach to promoting more effective intersectoral action for health. First, the health sector needs to engage communities to develop local projects. Second, governments, especially senior levels of government, need to be more effective at supporting effective local and regional activities.

Some other issues which are important for equity include primary health care⁶. Primary health care (PHC) is the key actor for addressing barriers to access to the health care system. PHC and local public health are also the key actors for initiating intersectoral action at the community level. There are currently

⁴ WHO International Conference on Intersectoral Action for Health 1997. Halifax.

⁵ Fortin J-P, Groleau G, Lemieux V, O'Neill M, Lamarche P. Intersectoral Action for Health. Laval University. Mimeo. 1994.

⁶ Wellesley Institute. Delivering Equity: Community-based models for access and integration in Ontario's health system. Dr. Michael Rachlis, November 2007.

considerable policy opportunities for Ontario because it is engaged in a redesign of its PHC system. There has been growth in new service models directed at solo family physicians and communities such as Family Health Networks (FHNs), Family Health Groups (FHGs), Family Health Teams (FHTs), Family Health Organizations (FHOs) and Community Health Centres (CHCs). CHCs seem especially well placed to play a major role in an equity agenda. CHCs have an explicit equity goal⁷. The Ontario government has identified CHCs as having major roles in addressing access barriers for populations with particular challenges or social conditions that affect health.

To create a high performing health system which continuously reduces disparities in health and health care, equity must become a focus for all employees of the health system from Board Members to CEOs through administrative, clinical, personal care, and support staff.

So what can the Mississauga Halton LHIN do?

Although as aforementioned, most of the root causes of health disparities lay outside of the health system, there is still a great deal that can be done within this system to move the health equity agenda forward. Governments, LHINs and health service providers can identify and reduce barriers to access. They can target investments and interventions in the most health disadvantaged communities and populations. They can build equity and diversity into all service delivery and planning.

The Mississauga Halton (MH) LHIN is committed to supporting and advancing a professional culture of shared values and behaviours, which are consistent with the mission and mandate of the organization.

THEREFORE:

The MH LHIN will strive to reduce health disparities as a shared responsibility with its health service providers and partners by integrating health equity into strategies and activities that fall within our mandate and influence.

What will this look like?

Action Plan:

1. Recruit and select the types of Board members that will ensure the MH LHIN continues to have a highly skills based Board of Directors exhibiting

⁷ Ontario Ministry of Health and Long-Term Care. Public information on Community Health Centres. Found at: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html. Accessed September 23, 2009.

diverse and independent thought in order to meet the needs of our diverse communities.

2. Adopt a framework for social inclusion that considers and integrates the needs of diverse communities and builds equity into planning and service delivery.
 - a. Monitor our Health Service Providers and ask them to share best practices around program evaluation specific to health equity.
3. Continue to engage diverse communities in all community engagement processes and any leadership and governance opportunities.
 - a. Ongoing inclusion through all community engagement events, governance to governance sessions, committee membership such as IAG, etc.
 - b. Continue to keep the Board involved in community engagement events.
 - c. Keep the community engaged with LHIN policy planning.
4. Develop strategies with our Health Service Providers and other partners to reduce health inequities.
 - a. Identify and target investments and interventions in the most disadvantaged or vulnerable populations.
5. Continue to include health equity indicators as criteria used to score proposals for new funding and used for evaluation of existing programs.
 - a. Impact on health equity is a criteria used to score Aging at Home proposals.
 - b. Health Equity is also a criteria established by the Board.
6. Develop a Community Engagement plan that involves both LHIN staff members and Board members in order to facilitate ongoing interest and recruitment of diverse cultures and individuals to our Board and staff complement.
7. Evaluate the implementation of this health equity plan after one year and develop action plans for subsequent years

These additional items will become a focus for all staff and Board members⁸:

- A. Being aware of and acknowledging the tremendous diversity within and among people.
- B. Learning about and understanding what constitutes diversity, access, and equity.

⁸ Diversity, Access and Equity Board Training Session. Mississauga Halton LHIN. Facilitator: Kwasi Kafele, May 28, 2008. Participants Resource Workbook.

- C. Understanding the importance of diversity, access, and equity (e.g. the impacts) as an integral part of excellent practice.
- D. Being aware of and acknowledging that we all have strengths and areas for growth and development, particularly in relation to diversity, access, and equity.
- E. Being aware of and recognizing that we all have pre-formed preferences, concepts and ideas which are based on our experiences, social position, level of privilege, among others, and that these shape our intentions (motivation), values, attitudes and behaviours.
- F. Being aware of and taking an active part in what is happening in relation to diversity, access and equity around us.

When the above actions and steps are taken, the following outcomes will be seen:

- More culturally competent, accessible services to clients
- Richer, more informed management/board decisions
- Improved staff morale
- Stronger relationships/enhanced reputation with community members, other agencies and funders
- Deeper, more diverse pool of information and expertise to draw from
- Staff/Board composition that reflects the communities
- Improved access and health outcomes for all members of our diverse community
- Long term resource savings
- Long term reduction in complaints

Implementation Plan:

This health equity plan will become effective once Board approval is received. Implementation steps following Board approval will include:

- Posting this plan onto the MH LHIN website
- Awareness building
 - Developing a communication strategy
- Creation of a refreshed Community Engagement Plan
- Evaluation of the implementation of this plan after one year

Some definitions:

Access: Incorporates two aspects; client access – that is, the extent, to which consumers are able to secure needed services, and organizational access – the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of those services⁹.

Cultural Competence: cultural competence is the cultural knowledge, skills and abilities required to function within a particular cultural or cross-cultural context or environment¹⁰.

Diverse Community: In general diverse means variety. So a diverse community is different people living in one community, they may be different because of their gender, social class upbringing, culture/religion etc.¹¹ According to Martin Luther King Jr., “A community can be diverse in many ways. The people could be diverse in varying ages, wealth, race, or religion.”

Diversity: the presence of a wide range of human qualities and attributes within a group, organization, or society. The dimensions of diversity include, but are not limited to, ancestry, culture, ethnicity, gender, gender identity, language, physical and intellectual ability, race, religion, sex, sexual orientation, and socio-economic status¹². Diversity in its broadest sense is inclusive of all people.

Equity: A condition or state of fair, inclusive, and respectful treatment of all people. Equity does not mean treating people the same without regard for individual differences¹³.

Holistic: relating and dealing with the whole.

⁹ Ontario Public Health Association, 1999.

¹⁰ Ibid.

¹¹ WikiAnswers. Accessed on November 4, 2009 at http://wiki.answers.com/Q/What_is_the_definition_of_a_diverse_community

¹² Ontario's Equity and Inclusive Education Strategy, 2009

¹³ Ibid.