

# Learning Essentials for Advancing Health Equity

## Module One, Part One: *Health Equity 101*



# BUILDING CAPACITY FOR EQUITY-INFORMED PLANNING AND EVALUATION



**Health Equity Project Leader**  
*Access Alliance Multicultural Health and  
Community Services*

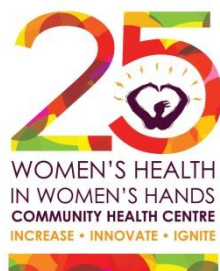


Association of Ontario Health Centres  
Community-governed primary health care  
Association des centres de santé de l'Ontario  
Soins de santé primaires gérés par la communauté



**Health Equity Project Capacity Building  
Partner**

*Association of Ontario Health Centres*



**7 Health Equity Project Champions**  
*Chigamik, Planned Parenthood; North  
Lambton; Rideau; Somerset West;  
Témiskaming; and Women's Health in  
Women's Hands Community Health Centres*



**Funder: Ministry of Citizenship and Immigration**



# Today's learning objectives are to :



- 1) Understand global, national and regional perspectives on health equity
- 2) Review key inequities that provide opportunities to impact the health system
- 3) Understand basic building blocks for achieving health equity
- 4) Gain perspective on current work around health equity.



# A global perspective on health equity



**World Health  
Organization**

The WHO focuses on

- preventable health inequalities, as distinct from biological ones, and
- human rights principles.

A 2008 report asserts the need for clear goals that lead to better policies and interventions and reduce the gap so that everyone has access to fruit on the healthcare tree.



# What about health care and health equity in Canada?

Tension exists between

- our overall commitment, and
- persistent inequities.



# National and provincial sources

- Black Health Alliance
- Well Living House
- Rainbow Health Ontario
- National Collaborating Centres
- Canadian Association for Mental Health
- Upstream: Institute for a Healthy Society
- Wellesley Institute
- Health Nexus

# Shared Model of Health and Wellbeing





# The causes of health disparities

- Data shows that Indigenous and racialized communities experience broad health disparities.
- Sexism, racism, homophobia and other types of social exclusion are linked to health care barriers and negative health outcomes.
- Race and poverty remain the strongest indicators of poor health.

# Data collection by our project champions

- Racial/ ethnic group, gender, date of arrival to Canada, sexual orientation, disabilities; francophone, fluency in official languages, spoken language/ preferred language, country of origin, education, household composition, Insurance status, household income, # of persons supported by income;
- Type of housing, employment status, food security, transportation barriers, social network, sense of belonging and rurality.

# Indigenous Health

- Over 60% of Ontario's Aboriginal population lives in urban areas. Public health assessment data for this population is almost non-existent, despite its size (150,570 persons).
- Over 90% of Toronto indigenous population lives below the before tax low income cut off. (2016)
- 52% of the First Nations population in Hamilton reported at least one visit to the emergency room over the past 2 years for acute problems compared to 22% of the Hamilton and 20% of the Ontario population.

## Socio-economic disparities

	Men	Women
All Canadian earners	40,782	28,860
Black	27,446	27,137
Latin American	31,932	23,346
South Asian	30,674	20,863

Source: Statistics Canada, 2016 Census of Canada

# Racialization of Poverty

Prevalence of low-income among visible minorities:

All Canadians	14.2%
Arab	36.2%
Black	23.9%
Chinese	23.4%
Korean	32.6%
West Asian	34.7%

Source: Statistics Canada, 2016 Census of Canada



# Rural and Remote Health Disparities

Comparing life expectancy in 3 Local Health Integration Network (LHIN) regions, 2015:

Northwest LHIN	Central West LHIN and Central LHIN
78.6 years	83.6 years

# LGBTQ+ Health Disparities



Rainbow Health Ontario  
Santé arc-en-ciel Ontario



# Disabled people face loneliness and isolation

16% of Canada's population lives with some form of disability. This affects their level of freedom, independence or quality of life.

United Kingdom research (2015):

- 23% of disabled people feel lonely most days
- 38% of young disabled people feel lonely most days
- 29% can only meet with friends once a month or less
- 6% report having no friends at all

Source: Holt-Lunstead et al. (2015)

# Interconnected Factors Impacting Access

- 1) Determinants of health,
- 2) Socio-demographics, and
- 3) Structural factors

# Access to public vs. private services

**What affects access to public healthcare?**



- immigration status (i.e. not having status or precarious status)
- being very recently arrived (3-month wait)
- being homeless and uninsured

**What affects access to private health care (dental, eye care, or prescription drugs)?**



- being the working poor/precariously employed adult
- no extended healthcare benefits
- self-employed



# Disparities in cancer screening rates

## 1. Cervical cancer screening rates (Ontario)

**Women living in  
poorest urban areas  
54.5%**

**Women living in  
wealthiest urban areas  
66.7%**

## 2. Overdue for colorectal cancer screening (Ontario)

**People living in poorest  
urban areas  
49.7%**

**People living in  
wealthiest urban areas  
34.9%**

# Screening rates for same ethnic group

East Asian and South-East Asian women

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graph TD; A[East Asian and South-East Asian women] --> B[Screening rate for breast cancer<br/>91.4%<br/>(highest among all ethnic groups tracked)]; A --> C[Screening rate for cervical cancer<br/>63.6%<br/>(lowest among all ethnic groups tracked)];
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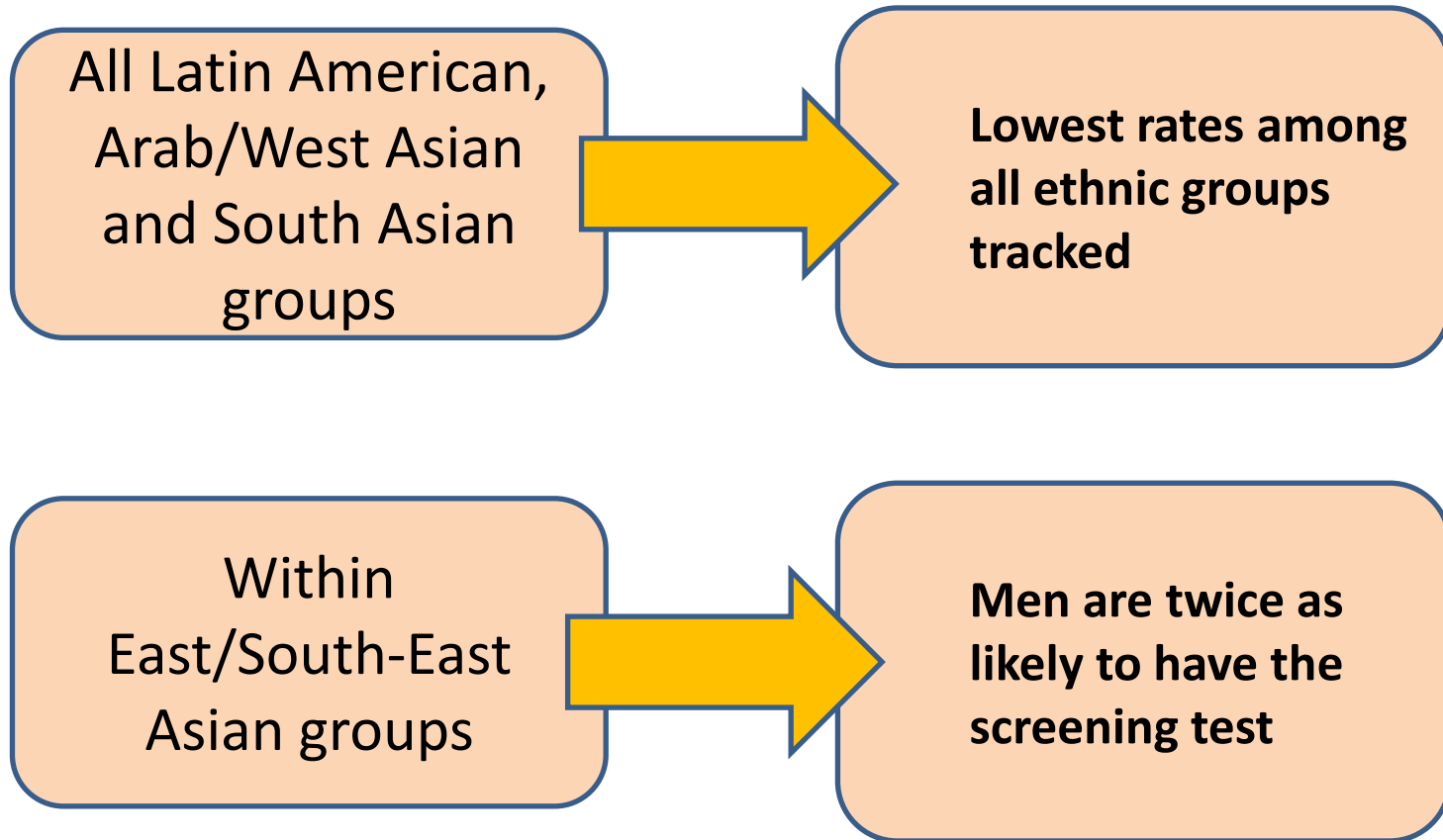
Screening rate for  
breast cancer

**91.4%**  
(highest among all  
ethnic groups tracked)

Screening rate for  
cervical cancer

**63.6%**  
(lowest among all ethnic  
groups tracked)

# Colorectal cancer screening rates



# CHCs are champions for health equity



# #1 to #4: Vital Eight Core Indicators

1. % of organizations that offer programs/initiatives to reduce: tobacco use; unhealthy eating/food insecurity; problematic substance use; obesity/healthy weight management; physical inactivity; and social isolation
2. % of clients reporting involvement in care decisions
3. % reporting self-rated physical health as excellent or very good
4. % reporting self-rated mental health as excellent or very good



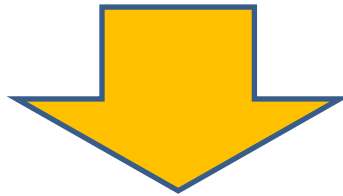
## #5 to #8: Vital Eight Core Indicators

5. % of eligible clients who received/offered colorectal/cervical cancer screening stratified by income
6. % of clients who always feel comfortable and welcome at [your CHC]
7. % of ongoing primary care clients receiving inter-professional care
8. % clients reporting very strong or somewhat strong sense of community belonging

# CHC leadership to address inequities

CHCs will be collecting data on the percentage of clients who received or were offered:

- cervical cancer screening in the previous 3 years
- colorectal cancer screening in the last 2 years



either at the CHC or outside the CHC, by  
income level

# Good News for Advancing Health Equity

- Ontario government has prioritized health equity under Bill 41, the Patients First Act (2016)
- Health Quality Ontario (HQO) is ready for Health System Performance Measurement of Health Care Equity and sees us as leaders.

# Successful advocacy with Ontario government: Patients First Act (2016)

Two pillars of the act are

- health equity, and
- health promotion

AOHC members are strong in these non-clinical factors, and we can influence the new regional model that applies to LHINs.

# Health Quality Ontario's HEALTH EQUITY PLAN



*Let's make our health system healthier*



# What does the Health Equity Plan apply to?

Health Quality Ontario's  
HEALTH EQUITY PLAN

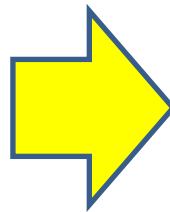


*Let's make our health system healthier*



It applies to

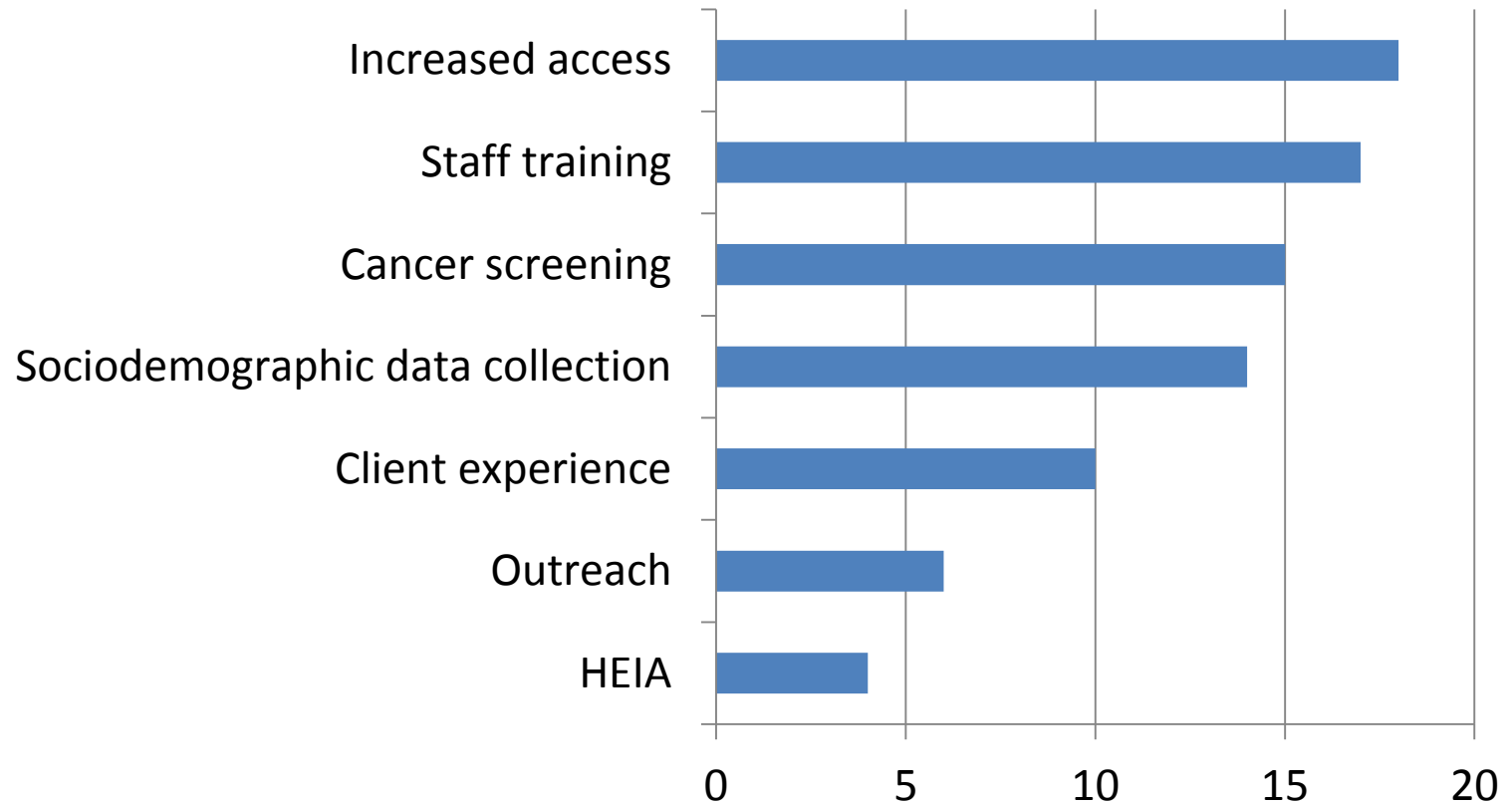
- health (status and outcomes), and
- healthcare (access and service quality)



It affects decisions related to allocation of resources.

It assigns priority to reducing health inequities.

# QIP Top Equity Themes – CHCs 2016



# HEALTH EQUITY CHARTER

“We will be bold,  
strategic and  
relentless...”

This Charter is a commitment to action by the Association of Ontario Health Centres and its members to recognize and confront barriers to equitable health.

We understand health equity to be an approach that uses policies and interventions that address discrimination and oppression with the goal of eradicating social inequality and disadvantage for the purpose of reducing disparities in health outcomes.

We recognize access to the highest attainable standard of health as a fundamental human right. We recognize health as a state of complete physical, mental, social and spiritual wellbeing.

We recognize that many health problems are not just medical or biological; they are caused by social conditions that affect access to resources and power. In our society, access to resources and power is often constrained by poverty, racism, sexism, homophobia, transphobia, ageism, ableism and other forms of social exclusion, which are often interconnected. We particularly recognize the impact that racism has had – and continues to have – on creating poverty, social exclusion and health inequity for racialized individuals and communities.

We affirm that Aboriginal and Francophone communities have distinct and specific histories, needs and constitutionally protected rights. We recognize the distinct health needs of populations living in rural, remote or isolated settings, as well as in impoverished urban neighbourhoods. We also recognize the distinct health needs and rights of people who are uninsured or without documented status. The causes of health inequity are systemic and persistent. We will be bold, strategic and relentless in challenging them.

We commit ourselves to reducing health inequities by improving our own practices and challenging other institutions and the broader community.



## In our own practices, we will identify, name and confront inequity by:

- ▶ Assigning priority to population groups who have the greatest health needs and least access to services.
- ▶ Involving the communities we serve in the design and delivery of our programs.
- ▶ Developing anti-racism/anti-oppression strategies to identify, name and confront practices that reproduce oppression within our organizations.
- ▶ Developing human resource policies and practices designed to ensure that the diversity of the communities we serve is reflected at all levels – volunteer, staff, management, and board - in our organizations.
- ▶ Ensuring our policies, procedures and staff training meet the linguistic, cultural and other needs of the diverse communities we serve.
- ▶ Developing evaluation strategies that measure health equity efforts and health equity results, and using the evaluation data to continually improve health equity practices.
- ▶ Using equity as a measure of quality in delivering people-centred care.
- ▶ Sharing best practices and lessons learned in achieving health equity results.

## In our work within the broader community, we will identify, name and confront inequity by:

- ▶ Collaborating with health partners and the broader community to ensure equity as an underlying goal of the health system.
- ▶ Supporting and collaborating with community groups who are challenging the social conditions that cause health inequities.
- ▶ Documenting the causes of, impacts of and potential solutions to health inequities.
- ▶ Advocating for public policy responses proposed by communities to reduce health inequities.
- ▶ Contributing to building an integrated, high-performing health system with health equity as one of its underlying principles.

## Reflection:

What does being  
“bold, strategic and  
relentless...”  
mean for you?

What conversations  
about equity are you  
having at your team  
level?

# Resources

**Health Equity Charter (Association of Ontario Health Centres )**

**<https://www.aohc.org/Health-Equity-Charter?lang=en>**

**Model of Health and Wellbeing (Association of Ontario Health Centres)**

**<https://www.aohc.org/model-health-and-wellbeing>**

**Health Equity Project Information on AOHC website including link to Baseline Assessment Survey**

**<https://www.aohc.org/Health-Equity-Indicators-Project>**

An illustration divided into two panels. The left panel, labeled 'EQUALITY', shows three people of different heights (tall, medium, and short) standing on a grassy field, each with a wooden crate in front of them. They are all looking over the crates towards a distant horizon. The right panel, labeled 'EQUITY', shows the same three people. The tallest person is standing on their crate, the medium person is standing on the medium crate, and the shortest person is standing on the shortest crate. They are all looking over the crates towards the horizon. The background shows a blue sky with clouds and a rainbow on the right side.

**EQUALITY**

**EQUITY**