Toronto Central LHIN

Health Equity Discussion Paper

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Ontario
Local Health Integration Network

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SUMMARY: TORONTO CENTRAL LHIN HEALTH EQUITY DISCUSSION PAPER

Health disparities in Toronto are pervasive and damaging. This discussion paper sets out twelve over-arching directions and a series of concrete recommendations that will reduce inequitable access to healthcare, target critical barriers and disadvantaged communities, and encourage innovation and system transformation to enhance equity.

Start by:

1. Creating a powerful and inspiring vision of health equity and making a clear strategic commitment to reducing health disparities.

Then build equity into service provision by:

2. Setting clear and achievable expectations, such as requiring health equity plans from service providers;
3. Building equity into all aspects of ongoing performance management – from clear targets and indicators through incorporating equity into service accountability agreements.

While strategically targeting investments and service interventions for the greatest equity impact by:

4. Reducing language, navigation and other barriers to equitable access and high-quality care for all;
5. Concentrating comprehensive and multi-disciplinary services in the most health disadvantaged populations and communities.

And build equity into system transformation by:

6. Strengthening the services and spheres that can make the most difference to reducing health disparities – such as enhanced primary healthcare;
7. Building equity into crucial directions for health reform – such as chronic disease prevention and management;
8. Driving patient-centred care through an equity lens – so that well focused program interventions take account of the more challenging circumstances and greater needs of disadvantaged populations and quality improvement is seen through an equity lens;
9. Investing up-stream in health promotion and preventive services through an equity lens - concentrating specifically designed services in areas and communities with the greatest needs;
10. Addressing the wider social determinants of health through cross-sectoral collaborations, comprehensive community-based care that reflects the lived experience of disadvantaged communities, and policy advocacy;
11. Driving continuous service and system-level innovation through an equity lens – developing better sources of equity data, relying on solid local research, enabling front-line innovation, and creating forums to share lessons learned.

And to make all this happen:

12. Implementing through careful staging, momentum building and community mobilization, and by dedicating additional resources within the Toronto Central LHIN to really be able to focus on equity and diversity.

INTRODUCTION

There are persistent and significant differences in people's health depending upon their income and wealth, where they live, the work they do, where they come from, their race and gender, and other social and economic factors. Within the Toronto Central LHIN:[1]

- 34% of people with low income reported poor or only fair health – three times as many as those with high income;
- the burden of many chronic illnesses follows a social-economic gradient: the incidence of diabetes is over twice as high in low income versus high income neighbourhoods;
- even in areas where disadvantaged populations have greater documented need, access to and utilization of healthcare services is inequitable:
  - low income people go to physicians more for arthritis;
  - yet the rates of hip replacements are far lower for people from low income neighbourhoods (age-standardized rates of 68 per 100,000 population versus 144 for high income);
- available data indicates inequitable access to key diagnostic tests:
  - despite poorer overall health and presumably greater need, the rates for MRI scans are far lower in low income neighbourhoods (age standardized rates of 2,172 per 100,000 population versus 3,495 for high income);
- and gradients in surgery and treatment for key conditions:
  - the age adjusted rate of radical prostatectomy for cancer per 100,000 men over 40 was 64 in the lowest income quintile and 123 in the highest;
- this inequitable access and outcomes are highly inefficient from a system point of view:
  - 38% of low income people reported at least one visit to emergency departments in the last year versus 25% for high income;
  - this can reflect greater healthcare needs, but to the extent that this reflects inequitable access to primary care, the result is people relying on far more expensive hospital care than is appropriate;
  - research on specific vulnerable populations – such as the 2007 Street Health Report on homeless people – shows that lack of primary care means that homeless people do have to use emergency rooms far more than is appropriate. Over half of survey respondents used emergency departments in the previous year, and 24% were hospitalized (versus 5% for the Toronto general population). Underlying this, 59% did not have a family doctor (versus 9% of the general population) and 29% had no usual source of healthcare, with a further 15% whose usual source did not provide comprehensive stable care;
  - all along the health gradient, and for almost all conditions and variables, women do worse than men.[2]

These health disparities are the problem this discussion paper seeks to solve. The paper describes what should be done within the healthcare system to reduce health disparities in Toronto. A

[1] This data was provided by epidemiological staff at Toronto Central LHIN, drawing together available information from diverse sources such as the Canadian Community Health Survey, ICES (Institute for Clinical Evaluative Sciences), InTool, etc. The problem of lack of comparable, longitudinal and comprehensive equity and diversity-relevant data is returned to later in the report.

[2] There will soon be far more comprehensive data on gender disparities, and more generally linking social determinants of health with health status, particular chronic conditions, access and utilization with the anticipated August 2008 release of the POWER reports: Project for an Ontario Women's Evidence-Based Report Card.

series of concrete recommendations are designed to reduce inequitable access to healthcare, target critical barriers and disadvantaged communities, and encourage innovation and system transformation to enhance equity. The main directions are illustrated with case studies or examples, and the paper describes how all this can be pulled together.

1. Create a Powerful Equity Vision

Most of this discussion paper is about **how** an effective health equity approach can be implemented. But **why** needs to be clear – what is intended to be achieved. A proposed Toronto Central LHIN health equity vision is offered below:
To create and sustain a healthcare system in Toronto where:

- systemic and avoidable health disparities are steadily reduced → so that the gap between the best and worst off is narrowed;
- all residents have equitable access to a full range of high-quality healthcare and support;
- all have equal opportunities for good health and well being.

All specific directions, service interventions and resource investments recommended are then judged in terms of how they contribute to achieving this vision.

Make Equity a Strategic Priority

The Toronto Central LHIN established three main service and integration priorities and a number of foundational priorities in its Integrated Health Service Plan or IHSP. But while social determinants are a fundamental planning principle, health equity is not an explicit priority.

If reducing health disparities is to be a major priority, then this needs to be reflected in the strategic plan that guides the organization. This then will drive building equity objectives and targets into all planning and into the performance accountabilities of the CEO and the organization as a whole.

At the same time, equity should remain a common theme in existing priority service and planning spheres, and in the work of all Councils.

This should not wait until the formal refreshing and revision of the strategic plan. Adopting a separate strategic statement on equity as an interim measure will send a powerful message that the Toronto Central LHIN is committed to action.

Recommended Action	Expected Outcome
1.1 Immediately adopt a strong statement of purpose identifying health equity as a fundamental priority of the Toronto Central LHIN; When the strategic plan is formally refreshed: • adopt a separate equity priority and vision; • adapt all other priorities to incorporate equity into the ways they are operationalized so that equity underlies the entire strategic plan.	This will highlight to providers, stakeholders and the public that health equity is a fundamental priority for the Toronto Central LHIN; This in turn will positively influence and guide service providers to emphasize equity in their own priorities; It will provide a standard to which the community can hold the Toronto Central LHIN accountable.

STARTING POINTS

Defining Health Equity

People in less advantaged or powerful situations – whether measured by gender, socio-economic status or social class, race, immigration situation or other intersecting dimensions of inequality - tend to have poorer health. At the same time, there are consistent and unequal disparities in access to care along the health gradient. Some of the most disadvantaged populations and communities are in very poor health and have very poor access to vital services and support.

Health disparities or inequities are differences in health outcomes that are **avoidable, unfair and systematically** related to social inequality and disadvantage. This definition is:
- clear, understandable and actionable;
- identifies the problem that activities will try to solve;
- tied to widely accepted notions of fairness and social justice.[3]

The proposed goal of this health equity discussion paper is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes.[4]

In addition, a forward-looking vision of health equity is ensuring equal opportunities for good health for all. The impact of achieving this goal would extend far beyond enhancing individual and collective well being, but would also contribute to overall social cohesion, shared values of fairness and equality, economic productivity, and community strength and resilience.

Roots of Disparities Lie in Social Determinants of Health

There is an enormous body 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. Gender is not simply one among this long list, but intersects with all other determinants.[5] The

[3] It is also meant to be comprehensive. One of the critical trends – and challenges to service providers and policy makers - in contemporary Toronto and Ontario is the tremendous diversity of the population. Taking diversity into account means ensuring that the different needs and preferences of diverse communities are always analyzed in health care planning and delivery, and that inequitable access, treatment and outcomes by race, country of origin, sexual orientation or any other line of discrimination and oppression is challenged and eliminated. Diversity issues are always an essential component of equity analysis and action.

[4] The focus of this discussion paper is on how inequitable access to care and differential quality are shaped by social inequalities and institutional barriers, and how the damaging impact of this structured inequality can be reduced within priorities identified in the IHSP. It does not address the tricky question of the distribution of resources among different health conditions. For example: do people with disabilities have enough access to sufficient specialized care and support to live a comparable quality of life? Should more resources be allocated to chronic disease prevention and management (and for which conditions) versus cancer treatment? These are all profound practical, ethical and fairness questions, but they are beyond the scope of this paper. Nonetheless, Toronto Central LHIN will need to be aware of particular conditions that affect less advantaged individuals and communities disproportionately. For example, sickle cell anaemia is more prevalent among less advantaged racial groups, and work place injuries and illnesses, chronic diseases and many other health problems have a clear social gradient.

[5] Gender analysis is an essential element of equity-driven health analysis and reform. Whenever equity is mentioned in this report, it also means gender.

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.[6]

This means that the many of the most important forces producing health disparities are far beyond the healthcare system, and that much of the solution to health disparities lies in macro social and economic policy and in policy collaboration and coordination across governments. All of this is beyond the formal mandate and powers of the LHINs.[7] The LHIN cannot raise the minimum wage, build affordable housing or initiate other social and economic policy changes that would reduce health disparities.

Addressing Health Disparities Through the Healthcare System

Nonetheless, it is in poor and unequal health – and ending up sicker in the healthcare system needing care - that the effects of this wider social and economic inequality are felt. A great deal can be done within the healthcare system to address the harsh impact of overall disparities and enhance the well being of even the most disadvantaged.[8] The main directions in which the healthcare system can address health disparities are by:

- identifying and reducing barriers to access to services;
- ensuring all receive the high-quality and responsive care they need, regardless of their social position and conditions;
- targeting investments and interventions towards the most health disadvantaged communities and populations;
- building equity, diversity and gender analysis into all service delivery and planning;
- enhancing equity-focused primary, chronic and preventive care, and other healthcare investments that will have the most impact in reducing disparities;
- building cross-sectoral collaborations beyond the healthcare system to address the wider determinants of health.

Methodology

This analysis is based upon:

- an extensive review of academic, professional, practice and other specialized expert literature on the causes of health disparities and on services or interventions to address the impact of disparities;
- detailed analyses of policy frameworks, programs and initiatives from leading European and other countries and from the WHO, EU and other international organizations that have developed comprehensive policies addressing social determinants of health and health disparities;
- research specially commissioned by the Toronto Central LHIN and the Wellesley Institute on health equity strategies and practices of leading Regional Health Authorities across the country;[9]

[6] One window into this literature is the work of the World Health Organization's Commission on Social Determinants of Health – its various knowledge networks, reports and research can be accessed at http://wellesleyinstitute.com/who-health-equity-resources/who-commission-social-determinants-health

[7] But the plan will nevertheless return to how the LHIN can facilitate cross-sectoral planning and collaboration to address the impact of social determinants of health.

[8] It is generally estimated that about 25% of health disparities are due to the health system and health care.

[9] Denise Kouri *Addressing Health Disparities in Regional Health Authorities* May 2008 http://www.wellesleyinstitute.com/files/addressinghealthdisparities.pdf

- analysis of a wide range of guidelines, tool kits, checklists and other resources for equity and diversity planning;
- extensive formal consultations with some twenty-five provider or sector networks; hospital tasks forces and officials; CHCs and the GTA network; research centres; provincial agencies, foundations and officials; community organizations; and many individual experts or practitioners;
- review of research, backgrounders, briefs and policy statements submitted by these and other stakeholders;
- informal discussions with dozens more consumers, providers, collaborations, networks and interested individuals;
- drawing upon health equity roundtables of researchers, experts, service providers and community-based organizations organized by the Wellesley Institute;
- intensive internal discussions with the Toronto Central LHIN planning, community engagement and accountability management and staff, and review of strategic and operational planning documents.[10]

LHIN Scope of Action

To start, a clear recognition of the LHIN's mandate and powers is needed – to identify what it can do and where it should concentrate. The focus of this report is on the geographic boundaries of the Toronto Central LHIN – although cross-LHIN collaboration is crucial – and on the healthcare system.

Key constraints are that:

- the Province maintains an overall strategic leadership and stewardship role.
  - how this translates into an effective working relationship between MOHLTC and LHINs is still evolving;
  - however, equity is a major priority of the provincial healthcare strategy, and the Toronto Central LHIN approach will need to align well with provincial objectives;
  - areas where provincial policy and resources will be critical to enable and support LHIN innovation and action on health equity are identified throughout the discussion paper;
- the LHINs do not control crucial parts of the healthcare system that affect equity:
  - lead responsibility for Aboriginal health, HIV/AIDS and other specific spheres remains with senior levels of government – how to link innovations underway in such sectors into LHIN initiatives is discussed;
  - physicians and most primary care are outside their mandate;
  - so too is public health – with its long tradition and considerable expertise in equity-driven planning and delivery;
  - how to work around these constraints to still address primary care and public health as key areas of equity-driven intervention is also discussed below;
- the fact that the GTA is divided among five LHINs is a complication – and the five already meet regularly to coordinate.

But the LHIN does have very significant powers, resources and levers it controls – this discussion paper sets out how these resources can be mobilized to enhance health equity within Toronto.

[10] Because this is a discussion paper, these specific sources will not be cited throughout.

The Toronto Central LHIN identified key strategic priorities in its Integrated Health Service Plan (IHSP). An equity lens can be applied to all these priorities. For example, what specific access barriers face seniors of different socio-economic circumstances, ethno-cultural backgrounds and neighbourhoods? Action recommendations are designed to build upon and complement established IHSP priorities.

Starting From Strengths[11]

One problem is that health disparities can seem so overwhelming and the necessary policy solutions so daunting, that it can be paralyzing – where to start? everything can't be tackled at once? how can these deep-seated disparities ever be changed?

Luckily, the Toronto Central LHIN has not suffered from this paralysis. It has emphasized social determinants of health, equity and diversity from its inception. Many of the key recommendations and priorities emphasized in this report have already been begun. Health equity and diversity is routinely considered in planning and resource allocation decisions, and grounds a comprehensive community engagement, in which the LHIN has tried to reach out to the most disadvantaged. Significant pilot projects, service integration initiatives and innovative investments directly addressing access barriers, disadvantaged populations and making the system more equitable are underway.

Luckily also, there is a great deal of innovative front-line service delivery underway addressing health disparities and the needs of disadvantaged populations across the LHIN, and beyond. How to most effectively build on this commitment, experience and community and provider strength is discussed throughout.

Take the Long View, But Get Going

This proposed discussion paper tries to be both ambitious and realistic. While the LHIN wants to be steadily moving forward on addressing health disparities, it also has to realize that fundamental change does take time. Addressing pervasive social problems and shaping system change in spheres as massive as healthcare is a complex challenge. In practical terms, this means that the LHIN could break the various problems, initiatives and lines of action up into achievable projects and programs. That is, the LHIN needs to 'chunk' out the overall equity objective into initiatives that can be effectively phased in, and will complement and build on each other over the long-term.

There is a second reason why heath equity reforms are bound to be incremental and iterative. The nature and basis of heath disparities and the most promising strategic directions and types of service interventions needed to address them are broadly "known". But there is not enough research and evaluation data on which particular types of programs or which particular interventions work best in reducing disparities on the ground. This means that the LHIN will need to continually and systematically pilot and experiment. On the basis of available knowledge and research, the best estimate of potentially significant initiatives is made; a range of promising experimentation is funded and resourced; evaluation indicators and mechanisms to all projects are built in; all interventions for their impact on health disparities are monitored; and programs and services are adapted as needed. The goal is to create a continuous cycle of equity-

[11] Strategic planning starts from an assessment of community and institutional strengths, resources and opportunities, as well as problems and challenges.

driven innovation, building on what has been learned about successful and effective interventions.

Targets and Indicators

A clear conclusion from all jurisdictions with comprehensive health equity strategies and from other leading Regional Health Authorities is the need for concrete targets to drive action. More precisely, a coordinated system is needed of:

- concrete targets to enhance services, reduce barriers, develop programs or interventions for particular populations; plus
- effective indicators and means to measure progress against the targets; plus
- dedicated resources for research and evaluation; plus
- funding and other incentives to support and encourage achieving the targets; plus
- monitoring, evaluation and performance mechanisms that hold providers to account for how well they achieve the targets.

A series of cascading and inter-connected targets and indicators will be set out throughout the report that will drive change, measure and evaluate progress, and enable programs to be continually improved and flexibly adjusted. Where appropriate indicators are not currently available, the discussion paper recommends how they can be developed.

- some targets are ambitious and broad = the overall goal recommended in this paper is to steadily reduce differentials between high and low income neighbourhoods in self-reported health and adjusted life expectancy rates;
- some are specific by condition = reduce the differential in diabetes incidence between high and low income neighbourhoods by 5% over three years;
- some specific by service = increase the availability of interpretation services in hospitals by (% determined by needs in particular hospitals).

Action Plans

This discussion paper recommends a combination of short, medium and longer-term directions and interventions that will both show progress and build momentum quickly, and lay the foundation for fundamental and sustained change.

These action recommendations are grouped into three major themes.

THEME I: BUILD EQUITY INTO ALL SERVICE DELIVERY AND PLANNING

The first of these themes is that the Toronto Central LHIN should use the levers and resources it controls in a systematic way to enable, encourage and ensure equity is built into all service delivery and into the very fabric of health service providers (HSPs).

Health reform is never just a case of broad system changes. For priorities such as enhanced efficiency, sustainability, quality and equity to have impact they need to be reflected in the way actual healthcare services are planned, organized and delivered. Building equity and diversity into service provision can mean:

- people and communities with different and more challenging needs are provided with the specific, and sometimes greater, care they need;

- population health considerations – living conditions, resources and opportunities – are taken into account in service delivery and planning;
- similarly, the diversity of the population is always taken into account – and culturally competent care becomes the norm throughout the system;
- language, literacy, accessibility and other barriers to care are systematically addressed so that all have equitable access to the services they need.

Considerable equity and diversity-based care and planning are currently underway across the system and there are many innovative networks and providers to build on. The challenge for the Toronto Central LHIN and its partner providers is to ensure that **all** services are delivered in the most equitable fashion, and that equity is a driving priority across the system.

2. Set Equity Requirements

LHINs have significant powers to require the health service providers (HSPs) they fund to act in defined ways. These powers need to be effectively and judiciously used to influence providers to address health equity in their planning, services and organization. The first equity geared requirement is already underway.

Require Health Equity Plans

The Toronto Central LHIN will require all health service providers to have effective health equity plans. The goal of requiring these plans is to:

- act as a catalyst to initiate the deep organizational changes needed to build equity and diversity into service planning and delivery in all provider institutions;
- lay the foundations for building equity into ongoing accountability, resource allocation and performance management relationships between the Toronto Central LHIN and the providers;
- provide a visible and concrete context for widespread discussion of health equity – within individual organizations, within particular sectors, across sectors, and in the wider community.

Hospital Equity Plans

The Toronto Central LHIN began with hospitals, whose plans are required in October 2008. Hospitals are by far the largest providers of acute healthcare services. It is therefore crucial to ensure that the way in which their services are provided supports overall goals of reducing health disparities and ensuring appropriate high-quality care for even the most disadvantaged and challenging.

An effective and comprehensive hospital equity plan would include elements such as:

- a broad overall vision or commitment to reducing health disparities through their service delivery;

- demonstrating that the hospital has analyzed health status and disparities in the area in which they are located or their broader catchment area[12] - or if they haven't done the necessary local analysis, how they will;
- indicating how they have or will incorporate this data and analysis into program planning;
- analysing how closely hospital utilization patterns and service mixes reflect the demography and meet the needs of their catchment areas – and if they don't, indicating critical unmet needs;
- describing what current programs, outreach and resources are targeted to addressing health disparities in their area, and what additional expanded or new services are needed;
- operationalizing a comprehensive commitment to women's health – not simply sexual and reproductive healthcare – but ensuring all research, diagnoses and treatment take gender differences into account;
- clear standards for culturally competent care – and consumer satisfaction, evaluation and performance management mechanisms to ensure these standards are consistently achieved;
- describing how the hospital is reducing physical and other access barriers;
- human resources, recruitment, training and other diversity practices to ensure the 'face' of hospitals reflects their communities;
- setting out how internal organizational structures and working cultures such as governance, performance management and communications have been or will be changed to prioritize equity and diversity;
- indicating how the hospital does or will systemically collect appropriate equity and diversity-relevant data on services and patients, and build this into their monitoring and accountability processes;
- assessing how the hospital has built solid relationships with community-based service providers in their area, and developed networks and partnerships to deliver innovative services to disadvantaged populations; and
- community engagement processes and advisory forums to guide and evaluate equity plans and delivery.

This list is not meant to be prescriptive: the hospitals are far better placed to determine what specific plans and directions fit their situations. But it does highlight the overall elements of what a plan that could effectively support equity-related planning and delivery would look like, and what the LHIN could expect individual plans to cover.

[12] This expectation recognizes that assessing catchment areas and priority communities is particularly complex for the large academic hospitals that provide specialized care for people from wide areas, including far outside Toronto Central LHIN.

Recommended Action	Expected Outcome
2.1 Define expectations for the hospital equity plans, how the plans relate to the Toronto Central LHIN's overall equity vision and approach, and the process to be followed; Pull hospital leaders together early in the summer to begin to elaborate requirements and directions expected in the plans; Enable or convene ongoing working roundtables through the summer to develop the various components of the plans; As part of these roundtables, or in a parallel process with epidemiologists and data specialists, identify the kinds of equity-relevant data to be collected by hospitals and the most cost-effective means to do so. (see 11.1)	Hospitals will understand what is expected and will develop the most effective equity plans possible; Hospitals will develop these plans in a collaborative manner – both contributing to enhanced effectiveness, and laying the foundations for future collaborative planning.

Other Sectors

How the purposes set out at the start of this section can most effectively be fulfilled – and the resulting nature of equity plans to be developed - will vary by sector. For example, given their mandate and history, many Community Health Centres (CHCs) already have well developed policies and priorities for addressing disadvantaged populations and health equity in their areas. But they may not have formal explicit plans. CHCs should certainly demonstrate they have or can meet the general expectations set out above for hospitals. Whether that means additional specific documents remains to be negotiated; it is quite possible that existing plans are clear enough. Whatever the form, CHCs should provide their equity plans in the next 24 months.

The Toronto Central LHIN could flexibly adapt requirements for other sectors, and it may need to provide some planning, analysis and other enabling support, especially for smaller agencies. It may be wise, depending upon sector and agency capacity, to not require equity plans for other sectors until after 2009.

3. Build Equity Into Performance Management

Specific requirements such as equity plans can be set. But the real way in which equity will be operationalized in service delivery and planning will be by incorporating equity expectations and targets into routine performance management and accountability processes, and into the dense web of financial incentives that drive day-to-day work.

Build Equity into Working Relationships with HSPs

Equity should be one factor that is considered in request for proposals (RFPs), business case guidelines, deliverables in research and consultancy contracts, decision-making criteria for assessing proposals and allocating funds, and all other key facets of the working relationships between the Toronto Central LHIN and the health service providers.

For example, it could be expected that a minimum requirement of every proposal for a new service initiative would be to assess language needs, cultural and other access barriers, and

overall social and economic conditions of the target populations or community, and that the proposal would indicate how planned services would take account of the diversity of the community. Similar factors can be used for internal decision-making: how a proposal has incorporated diversity and equity considerations and how effectively its services will reduce access barriers or enhance the health of disadvantaged populations can be one criterion for deciding which proposals to support.

Service Accountability Agreements

Possibly the most important lever the Toronto Central LHIN has to influence service provision and organization is in its service accountability agreements. The fundamental goal should be to incorporate equity into these agreements in a systematic and sustainable way, meaning that:

- agreements would include equity-relevant targets and indicators the institutions must meet;
- the specific indicators would vary by provider and identified need – for example, they could range from an increasing % of low-income people using specific programs, to increased provision of interpretation services, to increased satisfaction among people with disabilities with the institution's services;
- financial and other incentives would be attached to meeting equity objectives.

A theme of this discussion paper is to design its various components so they reinforce each other. In this case, incorporating equity into service accountability agreements can build upon the equity plans being required of all provider institutions:

- the equity plans must not be seen simply as a one-off report, but as the first base-line stage of creating a systematic way of building equity into provider and system-wide accountability and planning;
- the first equity plans will need to include specific program objectives, timelines and success indicators;
- providers would then regularly report to the Toronto Central LHIN on progress against these objectives;
- at one level, this can be seen as routine refreshing of the equity plans, in which progress is assessed and programs adjusted as necessary;
- but to give this process force, assessing progress on equity objectives, and adapting resources and programs as necessary to better meet the objectives, needs to be part of monitoring and re-negotiating the service accountability agreements;
- this will solidly incorporate delivering on equity objectives into performance management and resource allocation processes.

All of this should be carefully planned and phased in. It was not possible to consider equity and diversity objectives in the first negotiation of agreements with the hospitals. And the need to negotiate with the far larger numbers of community-based providers is a daunting prospect. Nonetheless, building equity into these service accountability agreements as early as possible is an opportunity that should not be missed.

Recommended Action	Expected Outcome
3.1 The Toronto Central LHIN Senior management assess the full range of guidelines, contracts, service accountability agreements and other business relationships with service providers, and make recommendations on where equity objectives and incentives could most effectively be incorporated - report to Board within twelve months.	This assessment will allow the most effective identification of opportunities and means for building equity into ongoing performance management and provider relationships; Doing this preliminary work before the hospital equity plans are due will allow the Toronto Central LHIN to more effectively negotiate with the hospitals on building equity into ongoing accountability relationships.
3.2 Incorporate equity expectations and deliverables into the second round of service accountability agreements as they are being developed sector by sector – with a goal of all service accountability agreements having effective equity requirements and objectives at the end of this second generation of agreements.	Equity objectives will be phased into performance management in the most effective ways; Equity will be solidly built into ongoing working relationships with providers from then on.

Clear Equity Expectations, But Not Prescriptive

Developing clear requirements, targets and incentives will be crucial. But implementation cannot be precisely scripted, and can be flexible enough to meet the specific access challenges or community needs individual HSPs face. For example, all hospitals will need to be able to provide good follow-up care and effectively link to community support for isolated immigrant seniors, but the languages and cultures within which that care needs to be centred will vary from hospital to hospital and area to area.

THEME II: STRATEGICALLY TARGET INTERVENTIONS TO MAXIMIZE IMPACT

In addition to ensuring that equity and diversity are built into service provision and planning, a second major theme is to target resources and services to specific access barriers, challenges or populations:

- those facing the harshest disparities – to raise the health of the worst off fastest;
- those most in need of specific services to compensate for greater health challenges or more restricted health opportunities;
- access barriers that have the greatest adverse effect; and/or
- where interventions will have the most impact.

This requires good local research and information to be able to analyze which populations are most in need and will benefit most from targeted interventions, and what barriers and problems are creating the worst disparities. For example, are the main problems language barriers, lack of coordination among providers, sheer lack of services in particular neighbourhoods, etc.? Involving local communities and stakeholders is also critical to understanding the real local problems.

Which Barriers and Populations?

Potential criteria, or axes, upon which the Toronto Central LHIN can identify priority barriers or populations, and assess where to invest resources most effectively include:

- where the impact will be greatest in terms of affecting the largest number of people, ameliorating the harshest impact of health disparities or reducing costs or avoidable illnesses. Populations that would meet these criteria are immigrants or people who face language and cultural barriers to access to care, homeless people, people with diabetes and other chronic conditions from less advantaged social and economic positions, etc.;
- where addressing particular barriers and enhancing services to particular populations will act as catalysts for wider system change. For example, enhancing language capacities, navigation and culturally competent care will have a positive and disproportionate benefit for particular disadvantaged populations, and at the same time could improve patient-centred care throughout the system;
- where addressing inequities will build momentum for wider system and social changes. An example of a population facing desperate health challenges is non-insured people; providing services regardless of status prioritizes social fairness and equity over more narrow legal interpretations or cost implications;
- where impact has long-term implications, such as improving chronic disease prevention and management in those disadvantaged populations where the burden of illness is greatest; and
- where the cost-benefit ratio of service interventions is most promising.

Involve Communities in Complex Priority Setting

This process of assessing need and cost-benefits is never purely technical, but is always ethical and political. Who gets to say whose needs are greater than others? A pre-condition for both good planning, and decisions that are seen to be legitimate, is that the process of identifying barriers and populations to be targeted is based upon solid evidence, clear and rigorous criteria and a transparent process. This will certainly need to rely on the best available epidemiological data, expert program evaluation, cost-benefit analysis and health ethics advice. But, just as importantly, significant community and consumer involvement in determining what matters most to them will be crucial. The methodological assumptions and criteria built into even the most rigorous assessment tools are based on values, and it is absolutely critical to involve the local community, especially those people most affected by health disparities, in identifying what those underlying values and goals should be.

Building on the Toronto Central LHIN's tradition of community engagement, there will need to be intensive community involvement in identifying the key criteria, methods and mechanisms to guide the inevitable trade-offs in determining where to allocate targeted interventions and investments. This exercise would not be just one more round of consultations, but would specifically focus on developing equity-driven decision-making and resource allocation processes. There has been considerable international and Canadian experience in using citizen juries or panels and other forms of deliberative dialogue to make exactly this kind of complex input to healthcare decision-making.

Recommended Action	Expected Outcome
4.1 Working with its Councils, Panels and community partners, the Toronto Central LHIN should: • initiate effective deliberative dialogue processes in the next 12 months; and • building on their findings, convene a consensus conference in the in the next 24 months; The goals of both would be to: • identify criteria and processes to be used to determine where and how to target funds and resources to specific access barriers, issues or populations; • identify priority access barriers, issues or populations; • identify criteria for assessing the impact of interventions and programs targeted to particular access barriers, issues or populations.	Strategic decisions on targeting resources to access barriers or disadvantaged populations are more effective and solidly grounded, and have greater community involvement and support

4. Target Barriers

Focusing service interventions and resources to reduce institutional barriers will improve equitable access to care. There are a huge number of barriers that prevent or limit access to services, and their impact varies by specific population. All cannot be addressed at once.

Barriers such as language, navigation and accessibility of services have been identified in the Toronto Central LHIN community engagement. Reducing their impact has great potential to improve access to services and quality of care for disadvantaged populations and communities.

Language

There is considerable research evidence, clinical practice and provider consensus that language is a crucial barrier to equitable access and to good quality care for many patients who are unable or uncomfortable in speaking English. There is also enough experience within Toronto and beyond on the kinds of policy and program solutions needed to address this barrier.

The fundamental principle is to have trained interpretation services available to all consumers who need it, where they need it. While there is no one single blueprint or model that will work in every institution, practitioners and experts argue for a flexible combination of:

- in-house interpretation and translation services provided by professional healthcare interpreters – normally in the predominant languages of the institutions' service users;
- appropriate in-house staff who are able to interpret in addition to other jobs – this highlights the value of a diverse workforce that reflects HSPs' communities;[13]

[13] But training, quality and medical literacy are vital, so this does not mean simply any employee who speaks a particular language.

- some jurisdictions have been very innovative in involving internationally trained healthcare providers who are not yet able to practice their profession in navigation, brokering and interpretation;
- well-organized programs that draw upon volunteers from particular language communities;[14]
- supplemented by commercial or non-profit services that are able to provide interpretation services on demand.

Whatever the model and combination of services, interpreters have to be well trained and there needs to be very strong quality control. Trained means more than technical proficiency; sufficient health literacy is needed to understand medical concepts within both languages. Quality means having an understanding of the culture and traditions of patient populations to be able to help them understand the medical information and options in their own context.

Build Into Performance Management

Returning to the theme of using available levers and resources to drive change: addressing language barriers needs to be built into the provider requirements and incentives discussed earlier:

- The Toronto Central LHIN will be expecting hospitals to address interpretation services in their equity plans due in October 2008, including;
  - what languages are needed?
  - how well do existing services meet needs?
  - what new forms of delivery will best support local needs?
- all of this will vary from provider to provider, so specific expectations and planning will also vary. But every HSP will need to be able to demonstrate that language needs are being met and that appropriate culturally competent high-quality interpretation is being delivered;
- indicators for appropriate interpretation service levels and standards would be built into subsequent service accountability agreements;
- to facilitate innovation and quick movement on this issue, the Toronto Central LHIN should provide special funding for community profiles, language needs assessments, volunteer training and piloting innovative delivery models;
- incentives could take the form of lines in approved budgets available to deliver interpretation services – if services are not developed and delivered, then the funds cannot be spent;
- if necessary, there could also be penalties – if quality standards and expected levels of interpretation are not met, then the overall budget to a hospital could be reduced by a defined amount until those standards are achieved.

A second means for ensuring high standards and high quality could be accreditation – either incorporating standards of interpretation services within the basic accreditation processes for hospitals and other providers, and/or specific accreditation or standard setting processes for interpretation programs.

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[14] In addition to volunteers from specific ethno-cultural communities being better able to provide culturally sensitive support, there is an additional critical advantage. No matter how seriously diversity is prioritized within HSP recruitment and human resources strategies, it takes considerable time to shift the composition of providers' labour forces. Drawing on volunteers can be used to more quickly develop services that reflect the full range of ethno-cultural communities living in the city.

Measure and Monitor

Targets and indicators for enhancing interpretation services and reducing the impact of language as a barrier to access and quality care could include:

- all HSPs have appropriate and effective plans for interpretation services within two years;
- the volume of interpretation services increases across the system, and specific negotiated service volume targets for individual HSPs are met;
- the proportion of patients who report language barriers and poor quality interpretation steadily decreases;
- positive consumer feedback increases over the next three years.

Build on Existing Strengths

A major advantage the Toronto Central LHIN has in addressing language barriers is that it can build on strong community and institutional networks and experience. There is a well established Health Interpreters Network, and many of the major hospitals provide interpretation and translation services. Considerable work has already been done within this network on identifying service mix and other solutions to language barriers.

This is an area where quick action is possible.

Recommended Action	Expected Outcome
4.2 Establish an expert/community task force to develop an action plan for enhancing interpretation services within local service providers - to report in within the next 12 months; Allocate specific funds to implement the action plan and to build interpretation services beginning in the next 12 months.	A comprehensive plan to reduce the inequitable impact of language barriers; Which will guide investments and service improvements to ensure comprehensive interpretation services.

Navigation

There is considerable research showing that people from more disadvantaged or vulnerable communities have a harder time navigating the healthcare system. These difficulties reflect their wider social circumstances:

- jobs that are precarious or less flexible where people cannot take off time to go to medical appointments, or in which they do not have access to a phone to make appointments;
- for those without a car, inadequate public transportation to get to facilities;
- language barriers, cultural norms and a lack of confidence in dealing with healthcare professionals.

What this means in practice is that navigation models will need to take language, accessibility, literacy and other barriers into account in their planning and delivery. Here again, these issues have been extensively discussed in planning navigation initiatives within the LHIN. It will be important to involve specific communities in designing the navigation services and in an ongoing advisory capacity to ensure the services are meeting their needs.

Because the least advantaged have a harder time navigating the system, improving navigation will have a disproportionately greater beneficial impact on the most disadvantaged populations. This is a win-win situation: these improvements would not come at the expense of those who are

usually better able to navigate the system on their own, and all would be able to use the navigation services should they need them.

Measure and Monitor

Success indicators or targets for effective equity-driven navigation programs could include:

- a higher and increasing percentage of the designated population use the navigation services;
- high satisfaction and positive feedback on the usefulness of the services;
- access to specialized services increases for this population;
- HSPs report that cross referrals and coordination have become more effective.

At a system level, the goal would be that wait times and other symptoms of inadequate and inequitable access improve.

This will mean that the new navigation programs will need to collect information on how the referrals that they organize for patients actually worked out: did the patients get to see the specialist, did the procedures then take place, was rehabilitation effective, and so on? The LHIN and HSPs will want to ensure that there is no differential treatment in navigation (or any other) services by gender, race, ethnicity or income, so the services will need to collect appropriate data to monitor and evaluate.

Address Inter-Connected Barriers in Integrated Ways

These specific problems never work in isolation and particular programs or innovations need to address inter-connected barriers in complementary ways. If the goal is to enhance navigation systems for seniors or other specific populations, and if language is one of the key barriers to working their way through the system, then culturally sensitive and language capable navigation programs are key. One option would be to locate some of these navigation programs in agencies able to provide services in particular languages. For example, if one community needing support is Portuguese seniors, then the navigation services could be located in Portuguese speaking agencies. There is no down-side to using language as the first criteria for location - any agency must also be able to provide navigation support in English.

In these ways, the LHIN should always try to build on the wider potential of innovations designed for particular populations or barriers. For example, peer navigation models that arose out of particular ethno-cultural communities can be adapted by other communities. And these benefits are by no means confined to disadvantaged populations: while it is absolutely crucial for new immigrants from Francophone countries who do not speak English to have services in French, these same services will make the quality and cultural relevance of care better for bi-lingual Francophones as well. While Aging At Home supports should be available in their own languages to seniors who do not speak English, many others who can get by in English will have greater quality of care if available in their mother tongues and cultures.

Recommended Action	**Expected Outcome**
4.3 Fund at least two pilot initiatives to provide specialized navigation services to identified disadvantaged populations in the next 24 months, with an emphasis on meeting language needs of diverse communities and culturally competent services.	Navigation is improved for priority population; More is learned, and can be applied, about effective navigation to reduce access barriers.

Accessibility of Services

As with navigation, being able to get to healthcare settings can be a greater barrier for the most disadvantaged. Services can be made more accessible by:

- keeping longer hours - most CHCs and many other community-based agencies have extended hours;
- taking primary care to where people are – there are many existing local examples of mobile services to build on:
  - the Sherbourne Health Centre and Immigrant Women's Health Centre buses;
  - CHCs sending nurses and social workers into seniors' homes
  - primary and other care being provided in homeless shelters and other meeting places.

The Toronto Central LHIN can fund such innovations where services are taken out into local communities, especially to the most isolated and marginalized.

Improving accessibility is also an opportunity to be flexible and innovative around how services are bundled and located. For example, if child care and parental support are available in healthcare settings, it will make it much easier for parents to come in; and once in, there is a greater chance the families will return to receive regular primary and preventive care.

5. Target Disadvantaged Populations

The premise of targeting scare resources and well-focused programs to the most disadvantaged populations is well established in health research and practice. Critical populations identified in the Toronto Central LHIN community engagement and planning work, and in consultations for this report, have included:

- immigrant populations - people tend to arrive with better than average health, but it then deteriorates;
- racialized and other communities facing discrimination, language, cultural and other barriers to healthcare and wider social and economic inequality;
- low income people more generally;
- homeless people;
- people without health insurance.

Intersecting Inequalities

And, of course, these various lines of health disparities and discrimination intersect.[15] For example, recent community-based research from the Ontario Women's Health Network, CHCs and other partners documented the 'triple jeopardy' of access barriers and unmet needs faced by older immigrant women. Similarly, a common challenge identified by providers is the lack of culturally appropriate mental health services available in the languages of diverse communities.

[15] Which is why a comprehensive anti-oppression framework that analyzes the interdependent and reinforcing nature of key social determinants of health and power differentials is so important to understanding the forces that produce health disparities and the circumstances of disadvantaged individuals and communities. An anti-oppression framework is also emphasized by diversity practitioners to guide the kinds of equity-driven organizational change discussed in later sections.

The Toronto Central LHIN programs and planning are addressing this inter-connection. For example, planning for seniors' services included:

- commissioning research on barriers facing marginalized seniors;
- developing a marginalization tool to help guide planning and resource allocation;
- working intensively with community agencies and networks well connected to diverse communities and with considerable experience in delivering services to the most vulnerable seniors;
- considering equity, diversity and marginalization in planning and decision-making around the Aging at Home Strategy;
- building equity considerations into planning new navigation models and initiatives.

Issues discussed above in addressing language and accessibility barriers and ensuring culturally competent care will be especially important for immigrants and racialized communities.

Low Income

The connections between poverty and low income and ill health have been well documented, and an overall unequal distribution of income is one crucial foundation of health disparities. While low income people tend to have greater and more challenging healthcare needs, they have less access to necessary healthcare services. Low income overlaps and intersects with other key determinants of health such as racism, gender and immigration situation.

Two key directions for the Toronto Central LHIN to address the impact of low income on health disparities are to:

- enhance those models or services that most effectively provide care to the most disadvantaged communities and individuals, especially by expanding access to primary healthcare. The key role of Community Health Centres and the potential of their multi-disciplinary model are discussed in a later section.
- locate new or expanded services in poor or under-served neighbourhoods where possible and appropriate. For example, this principle could shape decisions about where to pilot new models of navigation services, because the most disadvantaged tend to have greatest difficulty in navigating the system and would benefit significantly from improvement.

More generally, the Toronto Central LHIN focus on the healthcare needs of low income and disadvantaged communities will align with the provincial poverty reduction.

This section addresses four further specific populations as case studies.[16] As with the discussion of barriers above, this is not an argument that these populations are the most disadvantaged or should be the sole focus of LHIN attention. Rather, these are illustrative examples of the impact of health disparities on particular populations, and of innovative ways in which this harsh impact can be reduced.

[16] These examples are meant to be illustrative not comprehensive; considerably more consultation and analysis would be needed to develop systematic action plans in these areas, and next steps are indicated for how this could be done.

Homeless People

The desperate health situation of homeless people has been identified as a priority by the Toronto Central LHIN. Comprehensive research from Street Health has been presented and the Board is committed to taking action, building on a solid base of long-standing community agencies supporting homeless people.

Action to improve the health of homeless people would:

- increase funding for multi-disciplinary primary care for homeless people in a variety of settings:
    - expanding CHC services and outreach;
    - creative partnerships of community providers, homeless people and other stakeholders to plan ways to take services to homeless people in community settings, especially follow-up care;
    - partnering with Family Health Teams and other agencies who are concentrating on the care of the homeless;
- work with the Ministry, FHTs and others to increase the awareness and ability of local physicians to provide appropriate primary care for homeless people;
- pilot case management workers to support homeless people working their way through the healthcare and other service systems:
    - locate some in hospital emergency departments available 24 X 7;
    - others out of well-connected and respected community agencies;
- increase funding and support for mental health and addictions services, where improving access is especially important for homeless people;
- work with stakeholders to increase the availability of supportive housing.

Measure and Monitor

Targets and indicators for the action plan could include:

- reduced re-admission rates to hospitals for homeless people;
- increased numbers and proportions of homeless people with regular access to primary care;
- improved satisfaction with healthcare services received;
- improved health status.

Address Inter-Connected Barriers in Integrated Ways

As in other areas, this activity would be reinforced through a series of inter-connected actions:

- specific expectations in provider equity plans and accountability agreements:
    - e.g., all downtown hospitals could be expected to have a plan to provide appropriate services and support for homeless people;
    - these plans would explicitly address how they will reduce discrimination, violence from security guards and other documented quality and treatment problems homeless people face at their institutions;
    - all plans would address how appropriate post-discharge follow-up care in the community will be ensured;
- flexible innovation funding could support experienced agencies providing or partnering to deliver community-based follow-up and support.

The Toronto Central LHIN should play an ongoing coordinating and enabling role.

Recommended Action	Expected Outcome
5.1 In partnership with Street Health, other key agencies and homeless people, establish and resource a working group to create an action plan to improve homeless peoples' health – report in the next 12 months.	Comprehensive and cross-sectoral action to increase access to services for homeless people; Improved access to primary care and overall health.

Non-Insured People

People without health insurance have tremendous difficulties getting access to care and face serious health dangers as a result. To date, CHCs have been provided with funds by the Ministry of Health and Long-Term Care to pay for services for non-insured clients, but the funds are not enough, can be exhausted with several high-needs patients, and rely on the goodwill of hospitals to actually provide care.

The Women's College Task Force reports considerable anecdotal information on adverse health impacts: women arriving at hospital in labour without receiving any pre-natal care, injuries left untreated, chronic conditions unattended to, and of poor and differential treatment for non-insured by providers. More needs to be known about the specific nature of the non-insured population in terms of overall numbers, their different reasons for being uninsured (e.g., the three month waiting period, non-documented, eligible but lost ID → all of which require different policy and organizational solutions) or of the many ways some providers have been trying to work around these barriers. But enough is known to identify this is a serious equity issue, largely affecting the most vulnerable such as immigrants, refugees, racialized populations, and people in the most precarious segments of the labour market.

Some of the solutions to the problems the non-insured populations face are beyond LHIN mandate. For example, many practitioners and advocates argue that the three month waiting period for eligibility for OHIP should be waived. While the Toronto Central LHIN can urge action, this is a matter of provincial policy. Similarly, settlement and other policies to allow people various categories of immigrants and refugees to have access to health insurance is a federal issue.

Nonetheless, there are still important initiatives that the Toronto Central LHIN can take. Overall, there should be consistent policies and procedures amongst healthcare providers across the LHIN to ensure that non-insured people receive adequate and non-discriminatory care. Barriers that prevent people without insurance from accessing vitally needed care can be reduced by:

- systematizing and extending existing ad hoc arrangements through a centralized pool of money run by the Toronto Central LHIN from which hospitals and CHCs can then draw;
- as well as being more efficient and equitable, a centralized pool could be accompanied by very clear procedural guidelines and quality expectations;
- hospitals could be expected to ensure that their providers and specialists never discriminate against non-insured patients;
  - some hospitals are very creative in finding ways around bottlenecks such as this by attaching conditions to granting privileges – e.g., one expects its physicians to sign a waiver that they will treat anyone within the hospital, including people without insurance;
  - the Toronto Central LHIN could encourage all hospitals to follow such principles;

- the Toronto Central LHIN could prohibit financial discrimination against non-insured people such as bringing in collections agencies when people clearly cannot afford to pay.

Recommended Action	Expected Outcome
5.2 Work collaboratively with the Women's College Task Force on the Non-Insured on: • research needed to understand the nature of the non-insured population and their particular healthcare needs; • identifying concrete solutions to the access barriers that non-insured people face; • how to systematize and centralize funding for services for non-insured; and • developing evaluative mechanisms for any solutions implemented.	Better access to healthcare is secured for a very disadvantaged population; This plan is developed in a systematic and coordinated way, replacing current ad hoc, inconsistent and unfair arrangements.

Aboriginal People

Aboriginal residents face particularly striking disparities in health conditions and inequitable access to healthcare services. Province-wide planning mechanisms for Aboriginal health are in place and the Ministry of Health and Long-Term Care has recently provided funding for Aboriginal community engagement. The Aboriginal communities of Toronto have well organized networks of community based providers and considerable needs assessment and planning analysis has been done. It will be crucial to build on these community strengths and experience.

Particular needs of Aboriginal people and communities will need to be taken into account in planning all equity initiatives such as enhanced navigation, culturally competent care, expanding community-based delivery in disadvantaged neighbourhoods, enhanced primary care and health promotion. How all of this can be planned can only be determined with Aboriginal community partnership and leadership.

While Aboriginal people may be more concentrated in certain neighbourhoods, the structural barriers they face to equitable care extend across the GTA and beyond. This speaks again to the value of population specific GTA-wide urban planning and coordination. Francophone providers have led the way in identifying unmet needs and coordinating services through the Toronto Regional French Language Services Planning and Support Committee, and this model could be developed for other communities.

Recommended Action	Expected Outcome
5.3 Partner with Aboriginal organizations in the next 12 months to: • synthesize existing needs assessments, planning reports and data on the healthcare situation of Aboriginal residents; • recommend how key conclusions and directions from these analyses can be incorporated into the Toronto Central LHIN planning; • consult with Aboriginal communities and providers to determine if a GTA wide coordination mechanism is needed; • conduct a pilot of how such a GTA LHIN wide Aboriginal community engagement and planning process could work.	An action plan for addressing Aboriginal health disparities that builds on past analyses and rich community expertise; Local strategies that are well aligned with provincial and overall Aboriginal health priorities.

People with Disabilities

People with disabilities face significant barriers in accessing the healthcare services they need. Ensuring equitable access for people with disabilities will necessarily be multi-faceted. First to all, it is crucial to not lump all people with disabilities together: the nature and severity of their disability and the services they need to ensure quality of life vary greatly. Nor should people be seen in purely medical terms, but in the social context in which they live. This means that it is crucial to understand how access to services, quality of care and overall lived experience may vary by gender, ethno-cultural background, facility with English, income level and other determinants of health for people with disabilities. For example, culturally competent care can be especially important for personal intimate support. People with higher incomes may be able to privately purchase a wider range of services. That others may not be able to get the services they need because they cannot afford them is fundamentally unfair.

One key direction will be ensuring that barriers to physical accessibility to services are steadily reduced. HSPs will be working to comply with the requirements of the Ontarians With Disabilities Act and the Toronto Central LHIN can play a key coordinating role in supporting individual provider efforts and pulling them together into a coherent overall drive to reduce barriers throughout the system. Barrier-free facilities, of course, are a benefit to many people with mobility challenges, not just those with physical disabilities. For example, two thirds of people in the Toronto Central LHIN over 75 have an activity limitation.

A second major issue is availability of specialized services, some of which can be very intensive. The key equity question here as always is whether people with disabilities have equitable access to available services regardless of gender, socio-economic status, language, etc. More concrete information is needed before developing an action plan to address service gaps and needs.

Recommended Action	Expected Outcome
5.4 Within the next 12 months: • Sponsor or convene a consensus conference of people with different disabilities, family and personal care providers, community service providers, healthcare professionals, researchers and other experts to define problems and challenges in ensuring adequate supply of specialized services; • Conduct or commission research – guided by the consensus conference – on unmet needs, service gaps and implementation challenges. This can build on the considerable work already done by community providers and advocates in these areas.	Needs and healthcare service gaps for people with disabilities are identified; An action plan to ensure necessary services are available is developed in the next 24 months.

There are many expert researchers, providers, networks, professional associations and consumer or advocacy organizations that the Toronto Central LHIN could partner with to organize such a conference.

Community-Based Case Management and Support

Street Health 2006 research identified a very high percentage of homeless people who had disabilities. These people met eligibility criteria for the Ontario Disability Support Program (ODSP) but very many had not been able to get onto it. The research found an incredibly complicated maze of eligibility restrictions, far too complex application procedures, and many other practical barriers that almost all homeless people with disabilities were simply unable to overcome. Street Health made a range of specific recommendations for administrative and procedural changes and has been working with the relevant authorities to address these barriers. This demonstrates the potential of community-based research to identify specific program and administrative barriers and to develop practical solutions. But it also highlights an innovation with broad potential.

The Street Health research piloted what proved to be a very successful model of intensive support or case management to help people work through the application process. A very high proportion of homeless people were able to secure eligibility to ODSP with this support, and a very high proportion were subsequently able to obtain housing.

This community support worker model could be valuable not only for the homeless, but for many vulnerable and marginalized people facing organizational and capacity barriers in getting onto assistance programs for which they are eligible. And, beyond ODSP, this model could support vulnerable people working their way through the services system wherever they need to go – in effect, this would be another form of navigation support. It links into earlier recommendations for case management workers in hospitals to support homeless and other vulnerable people.

Recommended Action	Expected Outcome
5.5 Pilot community-based case management and support workers programs in 2009; Locate them in disability experienced agencies, neighbourhood centres, community health centres and other community places conveniently accessible for people with disabilities.	People with disabilities will be supported in getting access to eligible programs; More broadly, this can be seen as one essential building block for ensuring responsive and effective system navigation for vulnerable people.

THEME III: BUILD EQUITY INTO SYSTEM TRANSFORMATION

Massive transformation in the healthcare system is well underway and the pace of reform will not slacken in the immediate future. The challenge is to build equity into fundamental reforms, so that system changes result not just in improved efficiency, sustainability and quality of care, but also serve to reduce health disparities. The Province will continue to lead overall transformation. But LHINs have a key role to play, first of all by enhancing those directions that will have the greatest impact on health equity.

6. ENHANCE SERVICES WITH HIGH EQUITY POTENTIAL

Areas emphasized above that can have a high impact on the most disadvantaged populations have been reducing language and other access barriers and enhancing navigability of the system.

Equity-Driven Primary Health Care

There is also considerable international evidence that expanding primary healthcare for disadvantaged populations is one of the most important healthcare system means of reducing health disparities.

Make Primary Healthcare a Strategic Priority

Primary care is not currently one of the main priorities in the IHSP. However, it was prioritized in the first planning exercise as the LHINs were being established and the need for better access to family physicians and other primary care was much emphasized in recent community engagement.

Recommended Action	Expected Outcome
6.1 Include increased access to primary healthcare as one of the major priorities for subsequent adjustments of the IHSP; In the interim, prioritize primary care in operational planning.	Increased access to primary care, especially in health disadvantaged communities and populations; Reduced differential in access to primary care between high and low income neighbourhoods.

Measure and Monitor

The overall target should be increasing the number of people who have regular access to primary care by 1% a year in identified under-served areas to start, and LHIN-wide as soon as possible. A more specific target could be to reduce the differential between high and low income neighbourhoods in the proportion of residents who have a regular primary care provider.

Build On Existing Strengths: CHCs

The most important primary healthcare sector within the LHIN's mandate is Community Health Centres. CHCs have long had a mandate and solid record of providing primary and preventive care to disadvantaged populations. Key features of the CHC model – salaried staff so that payment incentives do not restrict the care people with complex needs receive, multi-disciplinary teams, community engagement and partnerships, etc., – are especially important in providing primary healthcare to disadvantaged communities.

The Province has been undertaking a major expansion of CHCs and this should continue. However, the ratio of CHCs to populations is below other jurisdictions and what is considered ideal, and many CHCs are full or have waiting lists. The Toronto Central LHIN should consider how to continue to expand the number of CHCs and the scope and reach of their programs, especially concentrating expansion in under-served and disadvantaged neighbourhoods.

Recommended Action	Expected Outcome
6.2 If organizational capacity allows, increase funding so CHCs can expand their primary healthcare programs.	Increased access to primary care, especially in health disadvantaged communities and populations.

Support Innovative Delivery

There is no reason that hospitals could not experiment with increasing primary healthcare as part of their community outreach and services:

- one hospital was exploring the idea of developing mobile multi-disciplinary teams that would regularly go to family physicians' offices to provide more comprehensive care than the individual doctors could;
- hospitals have family health practices that could be enhanced, capacity allowing:
  - e.g., if hospital family practice physicians each were able to take on a small number of people being discharged without a regular doctor every year, then the overall numbers of people with access to primary healthcare could be significantly increased;
  - a stronger version of this goal would be an expectation on hospitals that it is their responsibility to sharply reduce the number of people discharged who do not have primary healthcare;
- The Toronto Central LHIN could ask hospitals to develop proposals for ways to expand primary healthcare in clinics or other community settings to priority populations or neighbourhoods in their equity plans.

The Toronto Central LHIN can encourage such innovation through special funding for hospital projects to increase primary healthcare; and including expectations such as the above in performance management agreements.

Recommended Action	Expected Outcome
6.3 Encourage hospitals to deliver an appropriate and increasing amount of primary healthcare, especially to high-need populations and in community settings.	Increased levels of primary healthcare in community settings; New innovative models of community-delivered care and better relationships between hospitals and communities.

In addition:

- nurse practitioner and nurse-based clinics have been very effective in delivering primary healthcare and managing chronic conditions in other jurisdictions;
- The Toronto Central LHIN could support healthcare providers partnering with non-healthcare ethno-cultural social service organizations to provide culturally appropriate primary healthcare and health promotion in their locations.

To enhance the equity impact of such initiatives, the Toronto Central LHIN should concentrate on those populations who have the greatest disparities in access to primary healthcare and concentrate new initiatives and pilot projects in disadvantaged neighbourhoods.

Addressing Inter-Connected Issues in Integrated Ways

Primary healthcare innovations can support other priorities as well. For example, addressing homeless priorities by expanding Street Health and other agencies' capacities to provide primary healthcare, support in shelters and other gathering places for homeless people. There has been considerable media attention to a family physician that provides house calls to isolated seniors. Healthcare in the home is certainly one part of the continuum of care needed for seniors to remain living as independently as possible. The LHIN could develop creative means of ensuring home-based services are available:

- funding CHCs, hospitals or other agencies to provide physicians or nurse practitioners for house calls and follow-up;
- building on the practice of many CHCs and other agencies who provide services in seniors' apartment buildings and residences;
- hiring physicians in private practice to devote some proportion of their time to house calls; and
- concentrating these initiatives in the most under-served neighbourhoods.

Recommended Action	**Expected Outcome**
6.4 Fund at least two outreach, partnership, service expansion or other demonstration projects designed to enhance access to primary healthcare in disadvantaged populations or areas in the next 12 months; Look for opportunities to enhance home-based primary care.	This would immediately increase access to primary healthcare; At the same time, it would build knowledge of what types of primary care programs for disadvantaged populations work best; Enhance the continuum of care available to vulnerable populations, and specifically support the Aging at Home Strategy.

Working Beyond Mandate on Primary Healthcare Initiatives

One constraint is that key drivers for increased primary care – family physicians, new practice models such as Family Health Teams, etc., – are outside of the LHIN mandate. The innovations and opportunities available within LHIN scope and powers outlined above need to be effectively linked to these other initiatives. The Toronto Central LHIN should lead collaboration of all primary healthcare providers within its area, with the goal of increasing primary care in poorer and higher need populations.

The Toronto Central LHIN should also link into provincial primary care initiatives. One potential problem is that by developing new incentives for doctors through FHTs and other

mechanisms, the gap between their income and salaried doctors in CHCs could be increased. This is part of a much larger system-wide problem that those sectors and agencies serving disadvantaged populations tend to themselves be under-resourced relative to other sectors. A second problem is 'perverse incentives' built into capitation models: while far more geared to patient-centred care than fee-for-service payment, capitation systems create disincentives to taking on patients with complex needs or locating in poorer areas where needs will be more intensive and outcomes poorer. The Ministry will need to be very careful that the incentives it creates here do not harm CHCs and other providers concentrating on serving the most vulnerable. The unintended impact could be widening access disparities.

The opportunity is to build equity into primary care reform from the start. However the FHTs and other initiatives evolve, the goal must not simply be increasing overall availability and utilization, but improving equitable access and increasing care for the most under-served. Can the Ministry encourage new FHTs or other practices to locate in areas with the poorest access or health status?

The Toronto Central LHIN needs to ensure its CHC and hospital-based initiatives are well coordinated with FHTs and other primary care practices locally, especially in neighbourhoods with concentrated disadvantaged populations.

Recommended Action	Expected Outcome
6.5 Establish and resource a cross-sectoral planning table on primary healthcare in the next 12 months.	Increase availability of primary healthcare in defined areas.
6.6 Explore and pilot at least two cross-sectoral initiatives in the next 24 months in which LHIN funded agencies partners with FHTs or other non-LHIN practices to delivery primary healthcare for priority populations.	Effective new models of cross-sectoral collaboration.

7. Build Equity Into Key Directions for Health Reform

Chronic Disease Prevention and Management

Understanding how to prevent and manage chronic conditions will be one of the crucial challenges for health reform over the coming decades, not simply to improve the health of many, but to control demands predicted to be a major burden on the system.

Chronic conditions clearly reflect wider social and health inequities:

- the POWER study is documenting the inequitable burden of illness, with more disadvantaged populations having higher incidences of key chronic conditions;
- at the same time, they have less access to specialized health promotion and preventive services and to chronic care management support;
- in addition, the cost of drugs, exercise, alternative therapies and other means to manage chronic conditions are a larger barrier for poorer people.

Designing and delivering chronic care prevention and management in ways that target the complex and deep-seated problems facing the most disadvantaged can contribute to reducing overall health disparities. In addition, innovations to better manage and prevent chronic conditions in these most challenging circumstances can be adapted throughout the system.

Equity-Driven Planning: Diabetes

Diabetes illustrates the potential of good local planning through an equity lens:

- it is over-concentrated in less advantaged communities and populations;
- it is a major driver of ill health and expenditure, and this and other chronic conditions are a major provincial priority;
- how to manage treatment and reduce the impact of diabetes is broadly known;
- good groundwork has been done, both in terms of planning frameworks and innovative delivery:
    - the Urban Health Framework developed by GTA CHCs has been workshopped on diabetes;
    - this exercise revealed solid networks and sophisticated cooperation already underway → modest investment for coordination, outreach and expansion is needed;
- good data to identify problem areas and monitor results is available, especially the Diabetes Atlas.

Comprehensive and community-based programs for diabetes prevention and management would need to be:

- integrated – with multi-disciplinary teams providing intensive support and long-term follow-up;
- community-based – providing barrier-free services and support where people are, and in the languages and cultures of people needing services;
- collaborations of many agencies, well coordinated through neighbourhood and area networks;
- built on well established programs such as the London Intercommunity Health Centre Latin American Diabetes Program, which arose out of the local Hispanic community and CHC, and is now being developed LHIN wide there;
- also addressing the social inequalities that shape diabetes – e.g., working with the City and others on nutrition, food security, exercise, employment security, etc.

Measure and Monitor

There would need to be clear targets for reducing incidence and complications, possibly specific to small areas or particular communities. Like many areas, it is best to develop concrete indicators and targets through consultations with consumers and providers, but possible targets include:

- declining incidence in identified priority populations or neighbourhoods;
- increased proportions of people with diabetes in identified priority populations or neighbourhoods who are able to effectively self-manage their condition;
- reducing the differential in diabetes incidence between the richest and poorest neighbourhoods by 5% over three years.

Recommended Action	Expected Outcome
7.1 Pilot at least two initiatives to increase diabetes care and prevention for designated populations or at-risk neighbourhoods in the next 24 months;	Valuable knowledge on planning and best practices that can be applied to other chronic conditions; Reduced differential in diabetes incidence between the richest and poorest neighbourhoods.
7.2 Fund the GTA CHCs, with extended partners, to develop the Urban Planning Framework as applied to diabetes into a comprehensive regional planning framework.	More comprehensive and coordinated care and support for diabetes.

There is no reason that the same kind of equity planning and comprehensive care model could not be applied to other chronic conditions as well.

8. Patient-Centred Care Through an Equity Lens

Earlier sections stressed the importance of targeting resources to systemic access barriers and particular health disadvantaged populations. But an equitable healthcare system will not simply eliminate structural access barriers and ensure a full continuum of care is available to all. It will also recognize that new responsive approaches are needed to take account of the worse health, adverse live circumstances and more limited health opportunities of those lower down the health gradient.

Patient-centred care is one of the key characteristics of a well-performing healthcare system and a key priority for the Toronto Central LHIN. Through an equity lens, this recognizes that not all patients are in equal positions or have the same needs; so patient-centred care cannot mean the same care for all. Progressive or equity-based approaches recognize that care for disadvantaged populations has to be designed to:

- soften the harsh impact of wider social exclusion and inequality;
- take account of the long-standing and deep-seated nature of social and economic inequalities experienced by many marginalized communities and individuals;
- meet their resulting greater health needs and challenges.

Equity-Driven Delivery

In effect, this means proactively providing care that compensates for and ameliorates far more limited health opportunities. Care designed for disadvantaged communities is:

- more multi-disciplinary and intensive to address multiple and complex health challenges;
- more holistic and comprehensive to ground care in the lived realties of the more marginalized and vulnerable;
- also designed to build individual and community resilience to cope with greater health and other inequality;
- and finally, geared to supporting individuals and communities to be able to take more control over their health and well being.[17]

[17] In public policy terms, this parallels redistributive objectives of fiscal or social policy and employment equity type remediation.

Here again, there are many examples of equity-driven care that can be built upon. A defining feature of the CHC model is exactly this kind of multi-disciplinary and equity-driven care. Similarly, there is much to be learned from the principles of feminist or women's health.

Particular examples and challenges have been discussed throughout this report:

- home provider visits for the most isolated – and expanding this principle to 'friendly visitor' type volunteer programs, meals, transportation and the other services that may be more needed by more marginalized seniors and others;
- follow-up care for the most marginalized will need to be different – often going to people rather than having them come in to the provider;
- the mix of services available to the most disadvantaged populations and neighbourhoods will need to be different, taking account of their more complex needs and challenging circumstances
- in other words, the continuum of care will need to be designed and delivered differently for different populations:
  - at the minimum, the continuum of care should never be narrower for the more under-served or disadvantaged neighbourhoods;
  - more generally, there will need to be a different and enhanced mix of services available to address the greater and more challenging health needs of the worse off;
  - in fact, identifying what a good continuum of care consists of for the most health disadvantaged could be a useful community-based research project.

These defining features of equitable patient-centred care will need to be built into the kinds of pilot projects and innovation discussed earlier. The goal of equity-driven innovation is not simply to fix structural access barriers, but to develop the best mix of services and approaches to meet the challenging needs of patients with more restricted health opportunities. The vital concept of culturally competent care captures this dual emphasis on care that transcends language and cultural barriers, and responds to particular needs of individuals and communities.

Build Equity into Quality Improvement

Continuous service and quality improvement is also a key feature of a well performing healthcare system. Quality improvement methods and objectives will need to take equity and heath disparities firmly into account.

Underlying all this, it will be particularly crucial to involve the most disadvantaged populations in defining what quality care means to them and in developing methods and indicators that would be able to effectively assess and monitor that good care. Community advisory panels can also be actively involved in assessing equity and diversity relevant service delivery in their institutions.

Service providers have many established means of quality control and improvement that can be adapted through equity and diversity lenses. Patient satisfaction and complaints data could be analysed to watch for systemic barriers: e.g., are a high proportion of complaints about lack of interpretation? if so, from what language groups? Rates of re-admission or follow-up care could be analyzed by neighbourhood to assess if there are inequitable patterns or particular risks/needs by socio-economic status.

Providers can also be encouraged to be creative in developing new equity-driven means of quality assessment. For example, adapting a 'mystery shopper' model to quality monitoring has been discussed within the Toronto Central LHIN. Through an equity lens, this could rely on peer 'shoppers' such as homeless people going into emergency rooms and other healthcare settings to assess their treatment. Discriminatory treatment was identified as a crucial problem in Street Health research and means such as this will be needed to monitor improvements.

Community-based research principles can be effectively adapted to support equity-driven quality assessment. For example, trained peer researchers who are homeless, IV drug users or facing language or literacy challenges will be able to elicit more open and nuanced responses from those communities in post-treatment follow-up research. Similarly, inclusion research style focus groups led by homeless people, marginalized women and members of particular ethno-cultural communities to assess client satisfaction have proven effective amongst groups that may not fill in traditional questionnaires. There are a substantial number of experienced peer researchers in Toronto from community-based research projects, and their training in research techniques could be quite easily adapted to quality and program evaluation.

Recommended Action	Expected Outcome
8.1 Initiate at least two pilot projects in the next 24 months to develop equity-based quality improvement and consumer satisfaction methods.	Quality improvement is enhanced by building equity in.

In addition to traditional accreditation, the Toronto Central LHIN could experiment with more community-based methods for identifying good equity practice. An interesting idea could be a mark or certificate of approval to indicate providers have satisfactorily built equity into their service delivery. The Councils or Panels could be involved in developing the concept, assessing institutions and granting the approvals. The idea would be to showcase best practices to encourage others – with the hope that the mark of approval would come to be seen as an essential part of good service provision that all institutions would strive to acquire.

9. Up Stream Through an Equity Lens

One of the most critical challenges facing the overall healthcare system is how to shift the focus from treating people when they get ill to preventing illness and promoting good health. How that is to be done is beyond the scope of this report. But, however this transformation is made, health promotion should be planned and implemented through equity and diversity lenses.

This is crucial for very concrete reasons. Some health promotion campaigns (put crudely, eat your green vegetables and get exercise) do not take account of the challenging material and other circumstances of vulnerable populations – such as poorer single mothers isolated in high-rise buildings a long bus ride from parks and decent grocery stores. There is some evidence that general or universal health promotion programs can widen disparities as their messages tend to be taken up more by the more affluent and educated.

While health promotion may not be a designated high priority of the Toronto Central LHIN at the moment, it is certain to be more important in the future, and it was a consistent message in

recent community engagement.[18] Any Toronto Central LHIN health promotion should build on the basic principles outlined in this report.

First of all, the LHIN can influence health promotion programs within its mandate to take a more equity and social determinants based approach. For example, it should build into any funding and service agreements that health promotion programs need to explicitly address the social, cultural and economic factors that shape risky behaviour in poorer communities, not just the usual focus on individual behaviours and lifestyle. Programs should recognize the constraints on good nutrition, exercise and other healthy lifestyles imposed by poverty and disadvantaged environments.

Secondly, these programs would need to be adapted and targeted to be effective for disadvantaged populations. The Toronto Central LHIN heath promotion should build on the many innovative examples of focused community-based health promotion and preventative programs:

- the Ontario Women's Health Network and other partners extended their inclusion research model to develop specific tools and methods of stroke prevention for marginalized women – this will be piloted in south-east Toronto;
- Access Alliance has trained members of particular ethno-cultural communities to deliver health promotion in their own languages and cultures;
- South Riverdale CHC's Health Ambassadors program had a similar peer community focus.

Thirdly, a progressive planning approach to preventive services recognizes that the risk and prevalence of many preventable conditions is higher in disadvantaged neighbourhoods and populations. Health promotion such as preventive dental, sexual and reproductive health, well baby care, immunization and related public health services should be concentrated in disadvantaged communities that need them most.

This speaks to the potential of cross-sectoral collaboration (to be developed below). For example, the Toronto Central LHIN and health service providers could work with public health to concentrate infant and maternal care in the poorest and under-served neighbourhoods; with the City to develop and extend comprehensive drug and harm reduction strategies or develop food security initiatives; or with the Board of Education to locate health promotion services in schools, especially in the poorest neighbourhoods.

Recommended Action	**Expected Outcome**
9.1 Establish a cross-sectoral planning table or task force in the next 24 months to coordinate health promotion programs within the Toronto Central LHIN area.	Health promotion that takes social determinants of health into account and targets services to lessen health disparities.
9.2 Initiate at least two pilot projects in the next 24 months to develop and deliver equity-based health promotion programs.	Increased knowledge of and access to health promotion that takes social determinants of health into account.

[18] The complication here, as in other spheres, is that much health promotion is beyond LHIN mandate: many programs are funded through the Ministry of Health Promotion or public health.

10. Address the Wider Social Determinants of Health

An important message from the Toronto Central LHIN's community engagement has been the need to understand the wider social and economic inequalities that affect health disparities and to build action on these social determinants into health planning and delivery. This section sets out how this can be done.

Cross-Sectoral Collaboration

Those Regional Health Authorities that most systematically address health equity also tend to emphasize cross-sectoral collaborations and partnerships focusing on wider determinants and issues. For example, RHAs surveyed participate in regional or planning collaborations around such issues as child poverty, homelessness and food security, and work with school boards, social service departments and others towards more seamless services for more vulnerable populations. The Toronto Central LHIN should:

- directly bring together planning tables of local housing, education, social service and other providers to identify areas where joint service planning and coordination could be most effective, or around particular issues such as homelessness, settlement and other support for immigrants, addressing language barriers in all services, etc.
- encourage and fund health service providers to initiate and engage in cross-sector planning and programming.

Innovative equity programs and strategies in other RHAs almost invariably involve public health. Locally, Toronto Public Health is a rich resource of research, planning, expertise and long standing experience in delivering services to disadvantaged populations and neighbourhoods. The fact that public health is not within LHIN's formal mandates and that Toronto Public Health deals with five LHINs complicates, but does not make the need for collaboration any less important.

- Toronto Public Health is already linked into the GTA LHIN CEOs planning table, and this will be very useful for broad issues such as pandemic planning;
- but strategic partnerships, joint ventures or inviting TPH representatives to planning tables where they will make the most difference will be also be essential. Controlling bedbugs is one current issue that public health and partners are concentrating on that affects the most disadvantaged far more, and poses a real danger of eviction and housing-related problems, and the consequent health impact;
- one valuable historical practice was having Public Health nurses in schools. While that may not be precisely replicable in the current age, the principle of having a liaison or triage healthcare professional that would identify health issues in children well before they became pressing, that could help organize early intervention as appropriate and that would work out of a place where all children attend has significant potential. A promising idea could be for the Toronto Central LHIN to partner with the Toronto District Board of Education, Public Health and other providers to locate such staff in schools in the most disadvantaged areas.

The best way to determine what cross-sectoral initiatives could have the most impact will be to experiment and evaluate.

Recommended Action	Expected Outcome
10.1 Establish at least one cross-sectoral planning table in the next 24 months to focus on a priority social determinant of health issue; Support up to two network or provider cross-sectoral planning initiatives in the next 24 months.	The potential of cross-sectoral planning in developing effective coordinated action addressing health disparities is demonstrated.

The Toronto Central LHIN Councils could play a key role in identifying promising projects and opportunities.

Beyond Healthcare Boundaries

A clear lesson from the experience of RHAs across the country is that cross-sectoral planning and partnering on service delivery beyond traditional healthcare system boundaries are effective ways to address wider determinants of health. Many CHCs and other community providers already work with social service and other providers well beyond the healthcare system. The LHIN can encourage and fund these kinds of initiatives.

A striking local example has been *Pathways to Education*. The project originated out of the Regent Park CHC, where its local community identified lack of educational opportunities as the most important health and social problem they were facing. Scaled up across the province and country, the model provides intensive support so that young people in disadvantaged communities are able to continue their education. It is a good example of an initiative that arose out of immediate concerns around health disparities, but quickly became a broadly-based partnership and comprehensive service collaboration. It highlights that a great deal of innovation can originate in healthcare providers' relationships with their immediate communities and in their tackling pressing local problems. It will be crucial for the Toronto Central LHIN to provide flexible funding so that HSPs can experiment in addressing local healthcare challenges in this kind of way, including working beyond the healthcare system's boundaries.

This type of innovation need not be confined to community-based providers. A number of hospitals have identified inadequate access to supportive housing as a crucial problem for their patients with mental health and other challenges being discharged without sufficient support. From the hospital and system point of view, lack of supportive housing contributes to preventable re-admissions and poorer health outcomes among vulnerable populations. This does not mean that hospitals should get into the business of building supportive housing, but it could involve hospitals collaborating with supportive housing and other agencies to ensure a much more seamless transition and coordinated network of support for people in the community. This example highlights the potential of the LHIN being flexible in the kinds of initiatives that it is willing to fund, of healthcare providers thinking beyond their boundaries and of everyone working together to put a social determinants of health approach into practice.

Integrated Multi-Disciplinary Care

Many jurisdictions have clinics or centres that provide both healthcare and wider social services in one accessible location:

- many CHCs have developed partnerships and working relationships with non-healthcare providers so that social, employment, skills, literacy and other support services are provided out of the CHC;
- a number of existing CHCs and several of the new satellites in designated high-need areas in Toronto will combine their primary and preventive care and other agencies providing complementary social services out of the same location;
- CHCs and other healthcare agencies also partner with non-healthcare social services around particular neighbourhood projects or issues.

However, with limited or unpredictable project funding these initiatives are always vulnerable. The Toronto Central LHIN could dedicate explicit funding to providers to engage and sustain such cross-sectoral collaborations geared to health disparities.

The Toronto Central LHIN could also experiment with funding non-healthcare services that have a direct impact on reducing health disparities:

- health promotion or outreach staff could be located in the dense network of multi-service neighbourhood service agencies across the city;
- non-healthcare community-based agencies could be funded to provide referrals or interpretation services for non-English speaking seniors.

Hub Models

One proven approach that has been applied on many jurisdictions and has been developed by Toronto Neighbourhood Centres, the United Way and other agencies here is the hub model of community services. It takes the broader social determinants of health into account in service delivery, gets beyond funding and sectoral silos in delivering and planning services, and includes:

- a range of multi-disciplinary services;
- all provided through one accessible and convenient hub location;
- cross sectoral coordination of these different services and cross referrals from agency to agency;
- horizontal coordination at a community level;
- community engagement as crucial to shaping the mix of services offered;
- local governance to ensure services are responsive to local needs;
- administrative integration and efficiencies through a single back office.

Providing comprehensive services addressing local community needs out of single accessible locations is especially important for those disadvantaged and vulnerable individuals and communities that have the most difficulty securing access through traditional services.

Recommended Action	Expected Outcome
10.2 Initiate at least two pilot projects in the next 24 months to: • develop cross-sectoral service collaborations or partnerships addressing priority health disparity issues; and/or • provide healthcare and relevant social services out of a single location in health disadvantaged neighbourhoods.	The potential of cross-sectoral action to address underlying social determinants of health disparities is demonstrated

Policy Advocacy

The Toronto Central LHIN coordinates a huge healthcare system in the province's capital city. This gives its views – if carefully considered and solidly researched – considerable potential influence. The Toronto Central LHIN could use this potential to discuss with appropriate levels of government policy responses to the social and economic problems and inequalities that underlie health disparities.

For example, given the impact of poverty and income inequality on health and health disparities, the Toronto Central LHIN could join existing broad partnerships of the City, community agencies and many others working to develop poverty reduction strategies. This issue is very much on the provincial agenda at the moment and a strong voice demonstrating the health impact of pervasive poverty could add significant influence.

At a local level, there has been considerable attention to addressing poor infrastructure and social conditions in high-risk neighbourhoods. Healthcare services have been an important part of these efforts, especially with the location of CHC satellites in designated neighbourhoods. This report has emphasized the potential of concentrating primary healthcare and other healthcare services in the most disadvantaged neighbourhoods and populations; and it has highlighted the potential of co-locating healthcare and social services out of CHCs and other community centres, as is planned in designated neighbourhoods. The Toronto Central LHIN staff could participate in neighbourhood planning tables to most effectively link healthcare planning and delivery to ongoing community development and capacity building efforts.

Recommended Action	Expected Outcome
10.3 Undertake advocacy with senior levels of government around at least one social determinant of health policy issue in the next 24 months.	The potential influence and role of the LHN in wider policy advocacy can be tested and demonstrated.

As Always, Focus

There are a wide range of social determinants, all with a powerful impact on health and health disparities. But effective collaboration and advocacy efforts cannot address them all at once. Which to focus on?

The Toronto Central LHIN should focus its efforts on those social determinants where the impact on health disparities is greatest and clearest in Toronto; where the research, analyses and voice of a major healthcare institution could carry the most weight; where cross-sectoral collaboration could have the greatest effect; and where there are already solid local initiatives and institutions to build on. Three issues should be considered to begin with:

- working to build federal, provincial and local support for expanded supportive housing:
  - the link between inadequate housing in general and lack of support for those with specific needs has been very well documented;
  - as has the positive impact of supportive housing on consumer's health and health opportunities;
  - there are many experienced providers and proven models to build on;
  - supportive housing would immediately benefit populations facing the most severe heath disadvantages – homeless people, those with mental health challenges, people with disabilities, etc.;
- working with a broad range of providers and stakeholders in coalitions seeking to ensure dental care for marginalized populations:
  - this also is high on the provincial agenda so there is a real opening for progress;
  - the Toronto Central LHIN could pioneer comprehensive and connected local implementation by enabling its HSPs to integrate expanded dental care into their programs – e.g., CHCs and other centres could be excellent locations for community dental clinics;
  - if funds for the dental care initiative flow through public health, then this will provide an excellent opportunity to develop effective collaborations with Toronto Public Health, across the five GTA LHINs;
- working with service providers and community groups to improve settlement support for immigrants:
  - the Toronto Central LHIN has a vital direct role to play in ensuring that access and quality of healthcare services meets the diverse needs of newcomers;
  - but the roots of the health disparities facing immigrants lie far outside the healthcare system in inadequate settlement support, employment discrimination, inadequate housing, etc.;
  - joining with others to win improved settlement, language, training, employment support and community development would directly benefit the health of a vital disadvantaged population.

Determining which broader policy issues to take up is another area where community involvement and deliberative dialogue will be key to ensuring that the directions and priorities chosen reflect community needs and perspectives.

11. Innovation Through an Equity Lens

One of the key roles of LHINs is to support innovation that drives system integration and transformation. In planning its overall innovation, the Toronto Central LHIN could identify the most promising areas, barriers or opportunities from an equity perspective.

Not all projects will be all about equity. But equity should be one of the criteria for determining research and service innovation priorities, and should at least be considered in planning all pilot projects and research. The overall innovation funding and should be two-pronged:

- **all** research and innovation proposals and projects would need to **take equity into account**;
- **some** proportion of innovation funding would **focus on disparities and disadvantaged populations**.

Build on the Best Local Evidence

The Toronto Central LHIN and all other sectors of the healthcare system should base their planning and delivery on the best available evidence.

One of the critical success lessons from Regional Health Authorities across the country is the importance of very good local data and research. Solid local evidence is necessary to dramatize the extent and damage of health disparities and to build public awareness and support for action. Comprehensive detailed data is equally vital to guide planning and resource allocation, and to assess program impact and overall progress.

Better Equity Data

Very clever epidemiological work has been done within the Toronto Central LHIN and elsewhere to mix and match available disparate sources of data. And there are some good sources of comprehensive data: locally, the Toronto Community Health Profiles and the Diabetes Atlas; and provincially, the POWER research study will provide population health data by LHIN. But there are still very significant gaps in being able to, for example, understand health utilization patterns by race, ethnocultural background, length of time in the country for immigrant populations or sexual orientation. Nor is there sufficiently fine grained data by these and other social categories for overall health or particular conditions that can be disaggregated to a local enough level. Addressing these gaps should be an ongoing priority for the Toronto Central (and for other LHINs as well).

The first step is to identify what kinds of equity relevant data to collect and for what planning purposes, and the most efficient and reliable means to collect this data. An effective starting point would be to call a consensus conference of epidemiologists, health data and evaluation experts, statisticians, diversity practitioners, community service providers, hospitals and other stakeholders to analyze the social, economic, cultural, and health data needed. One outcome will be identifying the standardized equity relevant data that the Toronto Central LHIN will want collected. Even better would be co-sponsoring the conference with other LHINs and MOHLTC, and beginning to identify equity data to be consistently collected province-wide.

Then Toronto Central LHIN can use its various levers and relationships to require that this data be consistently collected:

- RFPs could require that every proposal should indicate how equity and diversity relevant data will be collected, and how that data will be used in project monitoring and evaluation;
- all contracts for research, pilot and other service projects would specify the socio-economic data to be collected;
- funding, accountability and performance management agreements would specify how HSPs would collect appropriate social and economic data on clients using their services.

These requirements will need to be carefully phased in so that they do not impose too high an administrative burden on service providers and so that the collection process is as efficient and reliable as possible. The data will not be perfect or totally comprehensive at once, but very quickly an increasing amount of data will be collected on more and more clients, at more and more service points.

Finally, and building upon the consensus conference, the Toronto Central LHIN, coordinating with other LHINs and the MOHLTC, should advocate with the Province, federal government,

Statistics Canada, and other key research institutions for them to begin to systematically collect the kinds of population health data needed and to figure out ways in which available data can be disaggregated to small enough areas to be useful for LHIN level planning.

Recommended Action	Expected Outcome
11.1 Call an expert consensus conference in the next 12 months to determine the epidemiological and population health data needed to support equity-driven planning; On the basis of this conference, and of broader expert consultations, develop a health equity data collection to be phased in over three years.	An increasing amount of reliable population health and equity relevant data; In turn supporting increasingly effective planning.

The Toronto Central LHIN could partner with other LHINs and/or the Ministry, and with equity organizations and applied research institutions to organize this consensus conference.

Equity-Relevant Research

The Toronto Central LHIN could continually scan the professional and research literature to analyze the best available evidence and 'best practices' for service interventions on health disparities and population health. It will be especially interested in more applied research that can be used to drive equity planning and investments.

Key directions to build an equity research agenda will include:

- mining existing locally based and equity relevant research, including community-based research;
- building on local centres that specialize in urban health and equity relevant research, such as CRICH (the Centre for Research on Inner City Health);
- highlighting areas where more research and better sources of data are needed;
- funding or brokering research as possible;
- funding methodologies and approaches – such as community-based research – that are particularly well suited to yielding rich and nuanced understanding of healthcare needs, challenges and perspectives of disadvantaged populations.

Recommended Action	Expected Outcome
11.2 Explore how a defined proportion of the Toronto Central LHIN budget could be devoted to research and service innovation: • management to report early enough in the next 24 months to influence budget planning for the year following; • with a target of some significant (to be defined) proportion of research and innovation funding devoted to equity and diversity-relevant questions; • with a target of at least 5% of the Toronto Central LHIN research funding for Community-Based Research;	Incentives and resources are dedicated to equity-relevant research and innovation; Practical and applied knowledge is yielded to address health disparity challenges

Recommended Action	Expected Outcome
• with an analysis of how HSPs can be encouraged and enabled to undertake equity-driven research and service innovation.	

Build on Existing Networks and Providers

A key component of this discussion paper is to build on existing strengths and opportunities:

- many providers are already focused on equity and disadvantaged populations - hospitals (and the Hospitals Collaborative on Marginalized Populations), CHCs, community-based agencies, neighbourhood multi-service centres, etc.
- similarly, there are many partnerships and collaborations addressing access barriers and disadvantaged communities;
- some networks have done considerable planning that the Toronto Central LHIN should link into:
  - one example cited above was to build on the many needs assessments and planning analyses already done within the Aboriginal community;
  - a second is to work with the AIDS Community Planning Initiative, which brought together Toronto AIDS service organizations to plan and coordinate the sector;
- plus, many well-connected broad networks are committed to equity:
  - the three overall networks of WEUHA, SETo and Solutions and their Inter-Network Coordinating Group that cross the Toronto Central LHIN;
  - mental health, seniors and other specialized networks;
  - the new province-wide but based in Toronto Rainbow Health Network;
  - some – such as the Francophone service network especially – have pioneered cross-LHIN coordination.

An excellent example that links to the critical need for good local data discussed above is the well-established Toronto Community Health Profiles. Working with profile partners, the Toronto Central LHIN could fund expansion to include even more equity relevant data.

However, the Toronto Central LHIN cannot assume that additional equity-driven planning and coordination can be taken on by these networks. Many are stretched to capacity, have little or no independent research or administrative resources, and are vulnerable to key staff from member institutions moving on. The Toronto Central LHIN should analyze how to proactively enable those networks and collaborations with the greatest equity and innovation potential.

Working with providers and networks, the Toronto Central LHIN should assess if the potential of equity-based collaboration is limited by capacity gaps, and be prepared to invest in communications, coordinating, research and other enabling support to the networks and partnerships if necessary.

A starting point should be:

Recommended Action	Expected Outcome
11.3 Commission an inventory of local provider and network collaborations and partnerships, especially those geared to equity and diversity – to report in the next 24 months; This should assess capacity needs and make recommendations on how to support the most effective coordination and collaboration directed towards heath equity; This assessment should be designed from the outset as a first step towards creating a sustainable database of partnerships and collaborations.	Will be better able to build on current potential and strengths of existing networks and collaborations; Will identify areas where capacity enhancement is needed; All of which will support more effective community-based innovation and collaborations on equity issues.

The Toronto Central LHIN has already initiated such an inventory of local health, epidemiological, community-based and other research. This inventory of collaborations, partnerships, and networks can be designed to complement the research inventory.

Enable Equity-Driven System Transformation and Innovation

One of the defining purposes for the Toronto Central LHIN and other LHINs is to coordinate, enable and facilitate innovation and system transformation. This report sets out how this innovation can be equity-driven.

Incentives and Expectations

Supporting innovation should not just involve one-time research or pilot projects. Providers should be encouraged to build innovation into their core operations. Many currently do, but, beyond the major hospitals engaged in academic research, providers have to support front-line innovation and research on an ad hoc basis as money is available.

The Toronto Central LHIN can re-orientate service agreements so that stronger expectations and incentives for innovation are gradually phased in: expectations that all providers would engage in appropriate equity-relevant research or service innovation as part of their overall programming, and dedicated funding lines to support this innovation.

Training and Capacity Building

In addition to the direct levers, resources and powers discussed so far, the Toronto Central LHIN also has more indirect means to influence provider behaviour and support organizational change. For example, it can provide or broker equity and diversity training towards enhancing culturally competent care:

- CAMH and St Michael's staff and others on the Health Equity Council have provided diversity training in several GTA LHINs;
- partnering with the Health Equity Council and others, the Toronto Central LHIN can work to support that consistent diversity training is available where needed;
- The Toronto Central LHIN could resource such training to ensure all providers can benefit.

Towards supporting broader organizational transformation:

- The Toronto Central LHIN can provide or broker consultant-type support in which experts and practitioners advise providers and networks on equity and diversity strategies and organizational change (a kind of SWOT equity team);
- The Toronto Central LHIN can share success stories and lessons learned as providers begin to more systematically address equity issues.

Human Resources

A comprehensive approach is not just about fairness and equity for consumers, but for the huge numbers of people who work in healthcare. The Toronto Central LHIN needs to ensure that the healthcare system provides fair pay, working conditions and equal opportunities, and that HSP work forces reflect the diversity of contemporary society. It can do this through the same menu of levers: building employment equity into requirements, accountability agreements and other performance management processes.

Employment equity is also a crucial enabler of innovation and reform. In order to encourage flexibility and experimentation in service delivery, it must be possible to develop different ways of working and to shift staff and resources from area to area, both within institutions and ultimately from sector to sector. But it is hardly equitable to develop this flexibility at the expense of healthcare workers. Improving service delivery must not result in any loss of pay or seniority for workers. The necessary flexibility and responsiveness can only happen within a strong overall commitment to employment equity and solid labour adjustment policies; one part of which is that wages and conditions for personal support workers, nurses, nurse assistants, and other providers need to be comparable in the community and hospital sectors.

Access to Information

One of the pre-conditions for equitable access to care is understanding enough about the healthcare system to know how and where to go for care. That such information is not equitably available is why the navigation support discussed earlier is so critical to more marginalized populations. But it also highlights the importance of improving access to health information.

This could use innovative web-based delivery. For example, the LHIN could see its own site as a portal connecting residents to information on providers across the network and providing plain language information resources about health issues, conditions and treatment options.

The Toronto Central LHIN could also encourage or fund community groups to provide popular and accessible sources of information about their services. One promising idea is the proposal for a *Toronto in Colour* project, which would enable groups representing different ethno-cultural communities to post and share their needs assessments, service planning, community research, epidemiological data and other information.

Recommended Action	Expected Outcome
11.4 Fund and support *Toronto in Colour* in the next 24 months	More rich and nuanced understanding of health and social needs and situations of diverse racialized communities; Experience in developing equity-geared information and knowledge management systems that can be generalized.

Development of electronic health records and integrated health information management systems will be a critical part of overall system transformation. As in other facets of health reform, to the extent that improved information management will improve accessibility and navigation, then this can disproportionately benefit the more disadvantaged. But these benefits will not happen automatically. Equity will need to become one of the factors routinely considered in developing information system requirements and architectures.

Information resources and management will need to be specifically designed to meet the challenges of isolated and vulnerable populations. Councils have addressed the dangers of the 'digital divide' in which access to computers and the Internet is limited, with an adverse impact on access to healthcare services. These equity constraints will need to be proactively taken into account in information planning.

Valuable examples of IT innovation with an equity angle are already underway in Toronto. The award-winning CAISI project (Community Access to Integrated Services and Information) is a database to store the health and other relevant records of homeless people so that they do not need to repeat their histories as they move from shelter to shelter or hospital to hospital, and so that each healthcare provider has up-to-date information. This project has involved homeless people directly on its planning committee in developing the database and the kinds of information that need to be collected.

Recommended Action	Expected Outcome
11.5 Fund and support the CAISI project (Community Access to Integrated Services and Information) in the next 12 months	Improved accessibility for a very disadvantaged populations; Experience in equity-driven IT innovation that can be adapted to other populations and issues

Sharing and Building on Local Innovation

There is a huge amount of innovative work addressing health disparities in front-line service delivery and in providers and networks across the city. But the potential of this innovation is limited because forums and capacities do not exist to systematically share experience and information on what is working (and not working) well.

There is a critical need for an infrastructure to:

- share information and experience across the system;
- collect and identify innovations and equity-driven interventions;
- assess what is promising;
- more systematically evaluate pilot projects and service models;
- publicize and promote the most promising innovations; and
- scale up and adapt interventions that are working.

This kind of innovation knowledge management should really be a provincial responsibility. But the Toronto Central LHIN should be ready to establish a local information sharing infrastructure to enable continual innovation on its own if necessary. Alternatively, it could pilot the idea for the Province. Whether such a knowledge management infrastructure would be best located within the Toronto Central LHIN, based at an existing academic or research institution or be independent would need to be carefully analyzed.

Recommended Action	Expected Outcome
11.6 Working in collaboration with the Province, local healthcare providers and knowledge exchange experts, the Toronto Central LHIN could establish or support the development of a knowledge management infrastructure geared to supporting front-line innovation addressing health disparities in the next 24 months	Improved sharing of experience and innovation across the healthcare system; Which will support enhanced innovation overall; These benefits need not be confined to Toronto, and this infrastructure can play an important innovative role in Ontario and Canadian health reform.

To highlight the considerable innovation and hard work going on among front-line providers addressing health disparities, the Toronto Central LHIN could institute an annual award for equity innovation.

12. Making This Happen

The Toronto Central LHIN would need to make a major commitment to driving all these changes forward. But it will never be able to achieve all this on its own. Building broad provider, stakeholder and community support for concerted action on health disparities will be crucial.

The Toronto Central LHIN will need to make building momentum and mobilizing support for this discussion paper a major focus of its stakeholder relations and community engagement efforts for the immediate future. This means also being open to possible refinements and adjustments to specific recommendations, and involving consumers and providers in planning how to put this discussion paper into practice on the ground.

Recommended Action	Expected Outcome
12.1 The CEO report to the Board in the next 12 months on how broad healthcare provider, consumer and community support for these activities will be mobilized and how ongoing stakeholder relationships and community engagement will support moving forward.	Support for the equity activities will be increased and broad public and community momentum for change will be sustained.

Creatively Allocate Funding to Build Equity

Hospitals, long-term-care facilities, CHCs and other community agencies will still need to be providing their core services, even as they gradually change the way they provide them to more consistently address equity. How equity-driven incentives and requirements can be built into the allocation of funds for core services has been detailed earlier. But the scale of these ongoing services and expenditures means that shifting the ways routine service funding is allocated will be incremental and gradual – meaning that most funding at the LHIN's disposal is a relatively blunt policy instrument.

But some sources of funding are more flexible – and therefore can be more strategically and quickly deployed towards health disparities. Recent examples have been a series of pilot projects specifically designed to address access barriers or disadvantaged communities. At the same time, new or additional money can be adapted for equity purposes from the start. For

example, one major provincial goal for the Aging at Home Strategy was to allocate a significant proportion of funds to innovative and path-breaking projects. This was extended in the Toronto Central LHIN to have some of these projects focused on health disparities.

It will be crucial to have sufficient flexible streams of funding that can be allocated towards addressing identified access barriers, priority disadvantaged populations or equity-focused innovation.[19] The greater the proportion and amount of funds that can be allocated towards new or emerging equity objectives or to pilot and experiment promising new directions, then the more effectively the Toronto Central LHIN can strategically focus its resources on health disparities.[20]

The overall model then is two-pronged: to gradually change the way core services – and the vast majority of funds – are provided to incorporate equity and diversity; and to use discretionary and new resources to support initiatives and experimentation that can have a more immediate impact on inequitable access or health disparities.

Sophisticated Staging

This is a large and complex plan and its implementation will need to be multi-pronged and multi-phased. The examples of addressing particular access barriers or populations show how coordinated action across many providers and spheres is needed to tackle deep-seated health disparities.

Many projects directed towards equity are currently underway, and there will continue to be more in the near future as this equity approach unfolds. But all the recommendations cannot be developed at the same time. This could overwhelm the capacity of the overall healthcare system, individual HSPs and the Toronto Central LHIN to manage change. And some more complex initiatives will inevitably take longer to plan and implement: getting the mechanisms and indicators right first time and carefully building 'buy in' from health service providers and community stakeholders will be crucial. On the other hand, the fact that so many networks and providers have been developing equity-driven services and innovations for years means that many initiatives are ready to proceed very quickly.

Timeframes have been attached to the specific recommendations throughout; the goal is to begin some critical initiatives at once to build momentum and show progress, and then to carefully dovetail other actions so they reinforce and build upon each other over the next three to five years.

Implementation will be iterative as experiments are evaluated, lessons are learned from pilot projects and early implementation, and programs and directions are re-adjusted. And all of these separate initiatives need to be organized and dovetailed as part of a coherent overall approach.

At the Toronto Central LHIN

The Toronto Central LHIN is well poised to develop and implement the recommendations in the health equity discussion paper:

[19] The principle would parallel that of employment equity in which enhanced investment in disadvantaged sectors is necessary to address proportionately greater barriers and inequities.
[20] In fact, a key thing the Province can do to support local action on equity is to ensure each LHIN has a certain proportion of its budget available for experimentation and service innovation.

- health disparities and their underlying social determinants of health have been prioritized from the start;
- the Board has emphasized health equity and has devoted resources to developing a strategic framework;
- management and staff have been incorporating equity and diversity into their planning, community engagement and resource allocation;
- many community partners and service providers support the emphasis on health equity and are open for concerted action;
- critical new initiatives have taken equity into account in their planning and specific pilot projects addressing equity issues have been launched.

There are five major things the Toronto Central LHIN could do to continue to make significant progress on addressing health disparities in Toronto and to ensure this discussion paper will be successful:

- confirm an inspiring vision for building health equity in Toronto and identify health equity as one of its main strategic priorities;
- the LHIN may have gone as far as it can within available resources, and should dedicate additional staff, resources and management to focus on equity;
- demonstrate its commitment and vision through its own training, recruitment and human resources policies, internal accountability, planning and performance management, and governance;
- develop a comprehensive communications to build public and stakeholder awareness and support for decisive action on health disparities;
- demonstrate its accountability by making an annual report to the community on progress on equity.

Create a Health Equity Team

There is nothing in this discussion paper that is not either underway or consistent with current thinking and initiatives. But current staff are far too stretched to be able to take on additional functions, and equity will always be in danger of being squeezed out by other pressing program requirements and deadlines. One success condition identified in the research on leading Regional Health Authorities across the country was dedicated staff and management with specific equity and diversity responsibilities.

To implement this health equity discussion paper effectively, the Toronto Central LHIN could:

- undertake needs assessment and applied research to identify and analyze local barriers to equitable access, unmet needs and gaps in services;
- assess equity and diversity strategies and initiatives in other jurisdictions, analyze if and how they could be adapted to local conditions, and understand the wider policy and program environment within which the equity approach will need to operate;
- identify and develop:
  - possible program and policy solutions to access barriers and service gaps;
  - pilot and demonstration projects;
  - with cost benefit, program and service evaluation, and other analyses to test and refine these various options; and
  - solid project management;
- understand the major sectors within the healthcare system;

- have clear understanding/experience of equity and diversity research, theory and practice – and familiarity with health equity impact assessment, diversity checklists and other planning tools;
- mobilize community engagement and outreach, including building upon and supporting the role of the existing provider and community networks;
- put social determinants of health into action through:
  - facilitating and enabling networks;
  - supporting cross sectoral partnerships and alliances;
- community development/animator or capacity building functions.

Most of these capacitates already exist to varying degrees within the Toronto Central LHIN, but staff have significant other planning and operational responsibilities. Without additional dedicated resources, the comprehensive health equity discussion paper recommendations outlined here cannot be achieved.

There are various ways such capacities could be secured: one of which is developing a new equity team within the Toronto Central LHIN. Based upon the experience and structure of leading Regional Health Authorities:

- this would not necessarily need to be a separate unit solely devoted to equity/diversity, but it does need a very clear focus and sufficient resources to get key initiatives done;
- whatever other functions it has, the unit would need to be primarily responsible for implementing and sustaining the equity approach;
- it should be located in a central position within the Toronto Central LHIN – with sufficient authority to drive cross-organizational coordination and concerted action;
- it needs a strong senior manager – there was generally a Director of Population Health in leading RHAs surveyed. Defining senior management responsibility for equity will be a crucial starting point.

The Toronto Central LHIN has been quite successful in bringing in external experts and/or establishing well focused task forces to address key system issues. A similar approach could be considered for equity. This may be best seen as complementing dedicated internal resources, and could be especially significant in getting the equity discussion paper moving before additional staff can be hired.

In addition, contract staff or consultants could be brought in quickly to do in-house research, evaluation, community consultations or other projects, and to provide project management for specific initiatives.

While this report has emphasized that dedicated staff resources for equity are absolutely vital, it has not commented on how this can be organized; that is the responsibility of senior management.

Toronto Central LHIN Equity Fund

A pervading theme throughout this plan has been that while equity should be considered in all funding and performance management, significant ear-marked resources should be specifically targeted to equity-based initiatives. Various recommendations have been made for equity-focused funding towards particular barriers, populations or innovation goals. These could be pulled together into a coherent equity funding stream.

This dedicated funding should be called the *Toronto Central LHIN Equity Fund* or other appropriate and inspiring name. There is great symbolic and communications value in actually 'naming' this commitment.[21] It is also easier to manage and hold staff accountable for outcomes if equity-dedicated funds are consolidated in one stream. This funding should be coordinated out of the new health equity team.

Build Equity into How the Toronto Central LHIN Works

The Toronto Central LHIN should demonstrate its seriousness and commitment to equity though its own actions as well. It cannot ask providers to transform themselves without mirroring these goals in its own operations. This means building equity and diversity into its fundamental organizational fabric and working culture so that:

- diversity is fundamental to recruitment, training, mentoring, promotion, retention and all facets of human resources;
- equity expectations are part of internal performance management:
  - this is especially important for the CEO and senior management;
  - but cascading expectations will make equity part of many other staff's accountabilities as well;
- prioritizing equity transparently and systematically in planning and priority setting:
  - from strategic planning through budget and priority planning cycles to operational planning;
  - using gender analysis, health equity impact assessments and other tools;
  - building equity criteria and indicators into all scorecard, dashboards, checklists and other planning tools;
- similarly, building equity into governance at all levels:
  - so that the Board reflects the communities served by the Toronto Central LHIN;
  - advisory and action committees are well grounded in local communities;
- into all community engagement, including developing creative and responsive ways to engage marginalized communities, and build their diverse needs and perspectives into planning.

Here again, the Toronto Central LHIN is moving along with these **directions already.**

Recommended Action	Expected Outcome
12. 2 The CEO report to the Board in the next 24 months on how recommendations for developing health equity capacities and funding stream, and building health equity into the LHIN's organizational fabric will be addressed.	The goals of incorporating sufficient resources and focus to be able to act on equity are accomplished – but with the necessary operational flexibility and ownership.

Accountability and Community

The Toronto Central LHIN should report annually on progress against equity targets and indicators across the healthcare system:

- analyzing progress by sector – e.g., key developments and challenges in hospital, CHC, long-term care, other community providers, etc.

[21] Which in turn supports effective messaging: Toronto Central LHIN can say that X% of its discretionary spending is devoted to equity.

- specifying progress by institution if appropriate – just as progress on waiting times and other comparable performance data is reported;
- analyzing progress by priorities:
  - on language, physical accessibility and other barriers; or
  - on populations such as homeless health (if agreed indicator was an increasing % with primary care, then what trend?) or tailored programs for new immigrants.

This should be seen as part of the LHIN's accountability to the community. Creative ways of involving residents and community representatives in this evaluation should be developed, using the existing Councils, Panels, neighbourhood based forums and other means.

Recommended Action	Expected Outcome
12.3 As part of annual reporting, publicly report on progress against equity targets and indicators across the system; This should be incorporated into ongoing community engagement processes so that residents play a role in assessing progress and advising on program or resource adjustments.	Accountability to the community on health equity is enhanced for the Toronto Central LHIN and all service providers

Tell the Equity Story

Creating an equitable healthcare system will inevitably be a long and complex process: it will not happen without significant public, community, service provider and other stakeholder support. This requires a comprehensive communications to:

- highlight the extent and damaging impact of existing health disparities:
  - equity initiatives in leading Regional Health Authorities across the country began by making disparities a pressing public issue through intensive communications and public mobilization campaigns;
  - identifying health disparities as both a critical issue of social fairness and justice and a significant brake on healthcare system efficiency and innovation;
- at the same time, highlight that there is a lot going on;
  - the Toronto Central LHIN has initiated a range of initiatives;
  - many providers are working hard to address health disparities on the ground;
  - the goal will be to show that well coordinated initiatives can make a big difference in addressing the impact of health disparities and to build momentum and support for change within the healthcare system;
- publicize how the Toronto Central LHIN is building equity into everything it does:
  - so equity is featured in stories about new initiatives, in reports on progress and activities;
  - with the goal of building support for the Toronto Central LHIN's equity approach and momentum for implementing it.

There are many means and forums for this communication: developing an equity page on the web site, drawing out disparity data in fact sheets, highlighting promising front-line initiatives on the site, newsletters, media contacts and campaigns, etc. All of these means are currently in place; what is needed is a proactive and sustained communications focusing on equity.

CONCLUSION

The Toronto Central LHIN is committed to enhancing health equity for all its residents. This report sets out twelve over-arching directions and a series of 35 concrete recommendations that will reduce inequitable access to healthcare, target critical barriers and disadvantaged communities, and encourage innovation and system transformation to enhance equity.

This report recommends first of all to:

1. Create a powerful and inspiring vision of health equity and make a clear strategic commitment to reducing health disparities.

Then build equity into service provision by:

2. Setting clear and achievable expectations, such as requiring health equity plans from health service providers;
3. Building equity into all aspects of ongoing performance management – from clear targets and indicators through incorporating equity into service accountability agreements.

While strategically targeting investments and service interventions for the greatest equity impact by:

4. Reducing language, navigation and other barriers to equitable access and high-quality healthcare for all;
5. Concentrating comprehensive and multi-disciplinary services in the most health disadvantaged populations and communities.

And build equity into system transformation by:

6. Strengthening the services and spheres that can make the most difference to reducing health disparities – such as enhanced primary healthcare;
7. Building equity into crucial directions for health reform – such as chronic disease prevention and management;
8. Driving patient-centred care through an equity lens – so that well focused program interventions take account of the more challenging circumstances and greater needs of disadvantaged populations and quality improvement is seen through an equity lens;
9. Investing up-stream in health promotion and preventive services through an equity lens – concentrating specifically designed services in areas and communities with the greatest needs;
10. Addressing the wider social determinants of health through cross-sectoral collaborations, comprehensive community-based care that reflects the lived experience of disadvantaged communities, and policy advocacy;
11. Driving continuous service and system-level innovation through an equity lens – developing better sources of equity data, relying on solid local research, enabling front-line innovation, and creating forums to share lessons learned.

And to make all this happen:

12. Implementing through careful staging, momentum building and community mobilization, and by dedicating additional resources within the Toronto Central LHIN to really be able to focus on equity and diversity.

The proposed activities in the discussion paper are comprehensive and wide-ranging. But it is also grounded in solid experience. Initiatives from around the world, across Canada and across

this city show that action on health disparities are possible, and point the way to the most promising directions.

The framework is intended to be pragmatic and practical. All the recommendations cannot be addressed at once, and careful staging will be critical. Timeframes for specific recommendations have been designed so they can be effectively dovetailed and phased in to have the greatest impact, while not overwhelming the LHIN and its partner health service providers. There is also room for learning: recommendations can – and should – be flexibly adapted to take account of experience as they are implemented and as their impact is evaluated. The overall framework five years from now will no doubt look considerably different than envisioned.

Many promising equity-driven initiatives are already underway across the LHIN, there is considerable community and provider support for action, and quick progress is possible on many fronts. Moving decisively on ‘ready-to-go’ issues will build momentum for addressing the more complex longer term recommendations and deep-seated barriers and disparities.

Working collaboratively with all the Toronto Central LHINs health service provider partners and many diverse communities, implementing these directions will reduce inequitable access to healthcare, target critical barriers and disadvantaged communities, and encourage innovation and system transformation to enhance equity. The LHIN has a tremendous opportunity to make a huge contribution to equitable healthcare for all its residents and to a vibrant and healthy city.