Reducing Health Disparities:
HOW CAN THE STRUCTURE OF THE HEALTH SYSTEM CONTRIBUTE?

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The Wellesley Institute engages in research, policy, and community mobilization to advance population health.

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Executive Summary

This paper develops, based on Canadian experiences, a picture of what organizational form would be effective for the health sector to do its part in reducing health disparities. The purpose is to inform discussion and analysis of how to organize Ontario's health-care system to increase the potential for reducing health disparities, in the context of any possible reorganizing of Local Health Integration Networks (LHINs). Other provinces have tended to adjust the mandate and boundaries of their Regional Health Authorities (RHAs) some years after they were initially established. In Ontario the future of the LHINs was explicitly on the agenda in the last provincial election. The Wellesley Institute wants to ensure that the reduction of health disparities is foregrounded in the policy dialogue on Ontario health care structural reform. Hence, the question becomes not simply what reforms will support more effective and efficient health care delivery, but more specifically what reforms and structures will reduce disparities. This paper reviews the experience of RHAs across the country and identifies key directions and success conditions for health system governance and organization that will enhance population health and health equity.

The first step is that governments have to take disparities reduction seriously and hold themselves accountable for achieving it. If the definition of success in health care is only about access to acute care and related resources, disparities reduction will be a "nice to have" but nothing that really drives decision-making or resource allocation.

The paper identifies the following organizational features for reducing disparities. These features combine aspects of different designs from across Canada, while expanding the role and importance of public health leadership in the health system, critical to reducing disparities. The term public health in this paper is taken to mean public and population health. A health system organized to enhance equity would include:

1. A provincial office of public health to become the body responsible for population health, including both its medical and non-medical determinants, and for evaluating performance in relation to health outcomes and quality of services, and in which reduced disparities are among the health outcomes. The provincial public health officer plays a key management role in aligning resources to needs to achieve population health, including reduced disparities. The office has the required information and tools. The role also implies taking a leadership role with respect to other government sectors and the public for increasing understanding of health impacts.
2. Regional authorities based on socio-political places and coherent with other authorities, in particular municipal and county boundaries, with responsibility for population-level health and thereby committed to reducing health disparities. Each authority is led by a strong public health department, with the public health officer playing a key management role, and with the capacity to reallocate resources, aligning resources to needs to reduce disparities. Public health has a leadership role in identifying disparities and doing proactive work at a policy and societal level to reduce them. The authority provides care through networks for primary health care and creates partnerships to work on non-medical determinants.
3. Primary health care networks to provide integrated community-based care to specific sub-regional communities and populations. Services include primary health care centres and teams, home care and possibly continuing care and community hospitals. Primary health care is the main place in health care where there is strong potential for reducing disparities, and the key is that the care be needs-based, which means radically reconceived and expanded.
4. A single provincial authority for the management of specialist services and tertiary hospitals, to be treated as provincial resources. The authority would be mandated to monitor disparities in use of services and to reduce systematic underuse relative to need among disadvantaged populations.

5. Provincial governments to provide strong mandates for disparities reduction, while being wise about sharing and devolving authority, and developing commensurate framework agreements and appropriate funding arrangements with aligned incentives. It is extremely important to talk about indicators of disparity as integral aspects of the mission and the performance framework for health care.

Although the paper does not itself make explicit recommendations for Ontario, we can see that the LHINs and the Family Health Teams, Community Health Centres, and other Ontario structures are a reasonable platform on which to build for transforming existing structures into disparities-reducing opportunities. However, Ontario should also consider establishing meaningful regions from a population health perspective, and more effectively building upon existing public health resources.

A. Introduction

This paper develops, based on Canadian experiences, a picture of what organizational form would be effective for the health sector in reducing health disparities. It was commissioned by the Wellesley Institute to inform its analysis of how equity can be incorporated into ongoing policy deliberations on reform of Ontario's health-care system, in the context of any possible reorganizing of Local Health Integration Networks (LHINs). The future of the LHINs was much debated in the Ontario provincial election, which was held on October 7, 2011. The Ontario Conservatives had a vocal and long-standing pledge to eliminate the LHINs as part of their campaign platform. The Ontario NDP also supported their elimination. The Liberal victory, albeit one seat short of a majority, reduces the likelihood of LHIN elimination, although there remains the possibility of some sort of structural reform. The Wellesley Institute prioritizes the reduction of health disparities and wants to be prepared with its own proposals for input into the policy dialogue on Ontario health care structural reform. Hence, the question becomes not simply what reforms for more effective and efficient health care delivery, but more specifically what reforms to reduce disparities.

There is no definitive, evidence-based answer to this question. We must rely on informed opinion, local evaluations, and analysis based on experience and studies about what has worked elsewhere and why. The paper does not directly address what should be adopted by Ontario. Health care reform is a political process, and requires negotiation and cooperation with multiple stakeholders, and the context is different in each province, constraining and shaping the possibilities. The paper focuses on building a picture of what options would contribute to reducing disparities and how.

If the LHINs and other structures in the Ontario health system were to be revised, this would present an opportunity to build on what is there, as well as to learn from the experience elsewhere, to move to a structure and measures that foster the reduction of health disparities.

In preparing this paper, I relied on previous work I have done for the Wellesley Institute on regionalization and the reduction of health disparities and in my former role as Director of the Canadian Centre for Analysis of Regionalization and Health. I also used relevant literature and consulted with key informants across the country.

It is worth reminding readers at the outset that structural reform has limits. In the absence of leadership, mandates, funding, aligned incentives, and good programs, structural reform cannot hope to succeed. On the other hand, structural problems can impede many well-intentioned efforts, and are worth paying attention to. In our 2004 essay about regionalization in Canada, co-author Steven Lewis and I focused on this conundrum.[1] We went through the specific ways in which the structural reform of regionalization might logically be expected to contribute to the health reform goals of the period, and why. I discuss these points further below in the context of the potential for reducing health disparities.

The first step is for government to take disparities reduction seriously and hold itself accountable for achieving it. If the definition of success in health care is really about access to acute care and related resources, disparities reduction will be a "nice to have" but nothing that really drives decision-making or resource allocation.

1 Lewis S and Kouri D. Regionalization: Making sense of the Canadian experience. Health care Papers 2004;5(1).

B. Structure and Roles

1. DEVOLUTION IN OTHER PROVINCES

The major form of health devolution in Canadian provinces other than Ontario has been regionalization, beginning with Quebec in the late 1980s. Although the priorities varied by province and the regions derived their authority from the provincial government, a strong rationale in the early years was to enable decisions to be taken in a less politically partisan way, to carry out health care within a population health framework and to be responsive to communities. The province retained its overall authority, setting mandates and priorities, and therefore remains very important for the health disparities agenda.

Over time, provincial health ministries have tended to reassert their authority and micromanage Regional Health Authorities (RHAs), which consequently have become more administrative bodies. Over the 20 years since regionalization emerged as a strategy, it has undergone many changes. The number and size of regions have changed, as have the responsibilities and authority of RHAs. In 2008, Alberta, once one of the most strongly regionalized provinces, eliminated its regions without warning. PEI had abolished its regions shortly before. Also in 2008, New Brunswick went from 8 regions to 2 (Table 1).[2]

TABLE 1

PROVINCE	ESTABLISHED	RESTRUCTURED	SELECTED CHANGES
British Columbia	1997	2001	There are 5 RHAs (covering 16 Health Service Delivery Areas) and 1 Provincial Health Services Authority. Before restructuring, there were 11 Regional Health Boards, 34 Community, Health Councils and 7 Community Health Services Societies.
Alberta	1994	2002 and 2003 and then 2008	There are no regions. Care is administered through Alberta Healthcare Services. Before 2008, there were 9 RHAs, and before that, 17.
Saskatchewan	1992	2002	There are 12 regional health authorities and board members are appointed. Before that there were 32 health districts.
Manitoba	1997-1998	2002	There are 11 RHAs. Before that there were 12.
Quebec	1989-1992	2001 and 2003-2004	There are 18 Agences (formerly RHAs) and a varying number of Centres de services de santé et de services sociaux. Before reorganization in 2003, there were 18 RHAs.
Nova Scotia	1996	2001	There are 9 District Health Authorities. Before that, there were 4 RHAs.
New Brunswick	1992	2002 and 2008	There are 2 RHAs. Before 2008, there were 8, previously Hospital Corporations.
Prince Edward Island	1993-1994	2002 and 2005	There are no health regions as of 2005. Before that there were 4 RHAs and a Provincial Health Services Authority responsible for secondary and tertiary acute care services. Before that, there were 5 RHAs.
Newfoundland	1994	2008	There are 4 regional health authorities. Before that, there were 2 integrated boards, but also 6 institutional health boards and 4 health and community services boards.

2 The Territories are not included because their systems are so different. Ontario LHINs have not been restructured.

Alberta might over time provide a natural experiment about the effect of structural reform on the potential for reducing health disparities. Through Alberta Health Services, health care is administered by one single authority, albeit under five administrative zones. At the other end of the continuum, Quebec has a two-tiered regional structure, with 18 health regions, each having service delivery networks (the number of networks in a region varies, to a maximum of 12 in the case of Montreal).

2. PUBLIC HEALTH

In regionalized provinces outside Ontario, public health functions are mainly located within RHAs. As we discuss below, the public health community now views itself in a broader role compared to the recent past and has become the main champion in many places for working on the determinants of health and reducing health disparities. (This was also a primary focus in the early days of the Public Health Agency of Canada.) One argument is that the Public Health Officer's presence as part of the management team in a health authority means equity programs have higher priority.

In Quebec, the public health department of each of the RHAs is supported by the Institut national de santé publique (INSPQ), a provincial agency for research and professional development in public health. The INSPQ is funded by the provincial government and is relatively well resourced with hundreds of employees. In Quebec, public health has historically encompassed a population health approach and several provincial laws reinforce its role with respect to health determinants and equity.

3. REDUCING HEALTH DISPARITIES

In the last several years, reports on reducing health disparities have shown that the only way to secure significant future health gains in Canada is to reduce health disparities — that is, to ensure that the health status that has been possible for the best off is also enjoyed by those in other social classes — and that the health sector has an important role in doing this. An early document in this century made the case for Canada. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, the paper outlined the roles of the health sector in reducing health disparities:[3]

> Research has consistently shown that a limited number of non-medical determinants underlie the greatest health disparities. The most appropriate and effective way to improve overall population health status is by improving the health of those in lower SES groups and other disadvantaged populations…
>
> The health sector has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities.

For the health sector, reducing disparities requires efforts in three areas: (1) health-care system changes to address disparities in access and use of services; (2) partnerships, collaborations and policy advocacy with agents outside the health system to address disparities due to non-medical determinants; and (3) exercising a leadership role in monitoring health status and keeping the goal of reducing disparities on the societal agenda.

> Engaging citizens in order to foster public awareness and support is also key to reducing

3 Reducing Health Disparities – Roles of the Health Sector: Discussion Paper. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004.

health disparities to the maximum possible extent.[4]

In 2011, the Wellesley Institute identified many of the strategies and tools now being used in RHAs to reduce disparities (Table 2). They cover the range of the three roles mentioned above. Although such strategies are also possible in a non-regionalized context, they are less likely. Institutional barriers do impede sharing knowledge, creating understanding and collaborating effectively, as do geographic distances. Regionalization both consolidated multiple local authorities under a single umbrella and decentralized management of health services from the provincial level.

TABLE 2: STRATEGIES AND TOOLS FOR REDUCING HEALTH DISPARITIES – CANADIAN RHAS[5]

Local research and analysis of disparities
Primary health care practices and resources
• Location of services
• Appropriate care
Partnerships
• Poverty reduction collaborations
• Early childhood development
• School-based strategies
Public education and policy advocacy
Community development and participation
Aboriginal Health
Alignment: Reshaping RHA policy and practice
• Corporate commitment
• Health equity lens
• Health care equity audit
• Indicators and performance measures

> Because they are more often and more severely sick or injured, people in the lowest quintile of income groups use approximately twice as much in the way of health care services as those in the highest quintile…
>
> [The health sector must] Reduce financial and non-financial barriers to health care and public health, and develop strategies to improve access, comprehensiveness, appropriateness, coordination and follow-up for disadvantaged populations.[6]

4 Reducing Health Disparities – Roles of the Health Sector: Discussion Paper. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004.

5 Kouri D. Learning from others: Health equity strategies and initiatives from Canadian Regional Health Authorities. Wellesley Institute. 2011.

6 Reducing Health Disparities – Roles of the Health Sector: Discussion Paper. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004.

C. Alignment

1. AUTHORITY, MANDATES AND ACCOUNTABILITY

Balancing the power relationship between a provincial government and its devolved authorities will always be a challenge. In the classic model of devolution, the province retains responsibility for setting overall strategy and expected outcomes, but devolves authority for regional management and implementation. The province provides global budgets based on evidence-based needs assessments, and holds the authority accountable for results. However, with performance measures being as weak as they are in health care, and with the high stakes of certain kinds of health care problems, partisan politics unavoidably enter the fray. Provincial governments get nervous and begin to micromanage. We know that provincial managers have tended to resist yielding power to RHAs,[7] especially in the early stages of devolution. Indeed, the challenge of balancing authority was the main theme of the 2008 Effectiveness Review of the Ontario LHINs.[8]

Power imbalances mean devolved authorities will be less effective and will have less latitude to innovate. With respect to equity, the problem will be exacerbated by the fact that partisan politics, particularly in the current era, respond to certain inequities more than others. For example, rural-urban inequity gets a stronger voice than do inequities between poorer and richer neighbourhoods in urban centres. Problems with waiting lists and urgent care issues get a stronger hearing than do problems of chronic disease care.

Devolved authorities respond to mandates. Therefore, reducing disparities has to be part of their mandate, with funding arrangements designed accordingly. Needs-based funding would take into consideration the needs of the population and the level of disparities. Mechanisms such as funding envelopes could protect the future-oriented, longer-term allocations from the pressure to spend on the urgent and higher profile needs (for example, the early one-way valve in Saskatchewan allowed funding to flow to community-based services, but not the reverse).

Performance evaluations should also be designed accordingly. Developing good performance measurement, management and evaluation systems for health organizations is still in progress, however, especially those that take equity into account. What are the indicators of success that do not foster gaming (e.g. serving only the healthiest populations that will show the best outcomes) and cost shifting (e.g. pouring resources into reducing wait times for particular procedures at the expense of other conditions, treatments and populations)? How do we identify success in reducing disparities attributable to organizational performance and not to wider social trends?

> To be effective, health indicator sets should include measures of the extent of disparities as well as the causes and costs of disparities, and the extent to which health sector programs widen or reduce them. Disparities cluster in lower SES groups; indicators should therefore be broken down by SES group. This may require the capacity to link health sector indicators to social and economic indicators. A performance framework and supporting information system oriented to reducing health disparities would look very different from one focusing on technical quality or short-term outcomes alone. Health promotion and prevention indicators would be more meaningful with an SES breakdown.[9]

2. ALIGNING RESOURCES TO NEEDS

The strongest promise of devolution was in its potential to better align resources to needs. This begins with good needs assessments. Health regions have been creating tools to measure need and in particular intra-regional disparities in need within their region, as well as among their regions.[10] However, the key is in being able to

7 For example, see the 2002 survey of Saskatchewan Regional Health Boards, reported in Lewis and Kouri, 2004.
8 Ontario Ministry of Health and Long-Term Care. MOHLTC-LHIN Effectiveness Review Final Report. Government of Ontario. 2008.
9 Reducing Health Disparities – Roles of the Health Sector: Discussion Paper. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004.
10 Reducing Health Disparities – Roles of the Health Sector: Discussion Paper. Prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. 2004.

move resources to address the disparities. In our 2004 analysis, we listed the following elements as important for devolved authorities to effectively align resources to needs:

- Province genuinely committed to needs-based resource allocation and population health mandate, versus rhetorically committed, but more traditional in practice
- RHA supports and prioritizes population health mandate
- RHA has authority to reallocate resources
- Good needs assessment protocols
- Good performance measurement and reporting mechanisms vs. focus on utilization targets, not impact or distribution
- Disadvantaged populations have effective voice and influence
- Elites support a needs-based allocation of resources
- Evidence-based policy and practice vs. provincial government allowing interest groups to end-run regions and have directions and decisions reversed, provider resistance or RHAs' agendas being derailed by interest groups
- Adequate information base regarding interventions as well as needs

We also pointed out that the current Canadian reality, however, was the following:

- Restrictions on reallocation vary from some to significant
- Provinces struggling with population health mandate and accountability
- RHAs struggling with population health mandate and accountability
- Needs assessments generally done but of varying quality
- Information systems still developing
- Performance measurement and reporting in early stages
- Some provincial governments more prone to end-runs and intervention in RHA affairs than others

Reallocating resources to meet needs is a contentious process, especially in a time of shrinking real budgets. It is important for provinces to stand by regional authorities who actually manage to do this, rather than, as often happens, respond to partisan interests that do not reduce disparities.

There is the related question of aligning individual provider incentives to foster desired outcomes. This is one of the more difficult things to do in health care. The role of health providers is to respond to need, but also to reduce need. Tying funding solely to needs risks creating perverse incentives for providers to show continuing high needs. On the other hand, financial rewards for reducing needs will result in a misalignment of resources to needs. An appropriate incentive structure must be designed, taking these complexities into account. At a minimum, agreements with providers should be designed so that financial incentives are commensurate with activities entailed in reducing disparities (for example, harder-to-serve populations require more time and complexity of care). It is also important to reward efforts in other ways, through peer recognition. Finally, while it is normal for providers to become attached to their own units of works and clients, this can turn into turf protection unless there is attention to higher-order organizational goals of reducing disparities for the population.

In summary, provincial governments need to provide strong mandates for disparities reduction, while being wise about sharing authority, and developing commensurate framework agreements, performance measurement and management, and appropriate funding arrangements with well-aligned incentives.

D. Organization

1. WHICH SERVICES WHERE?

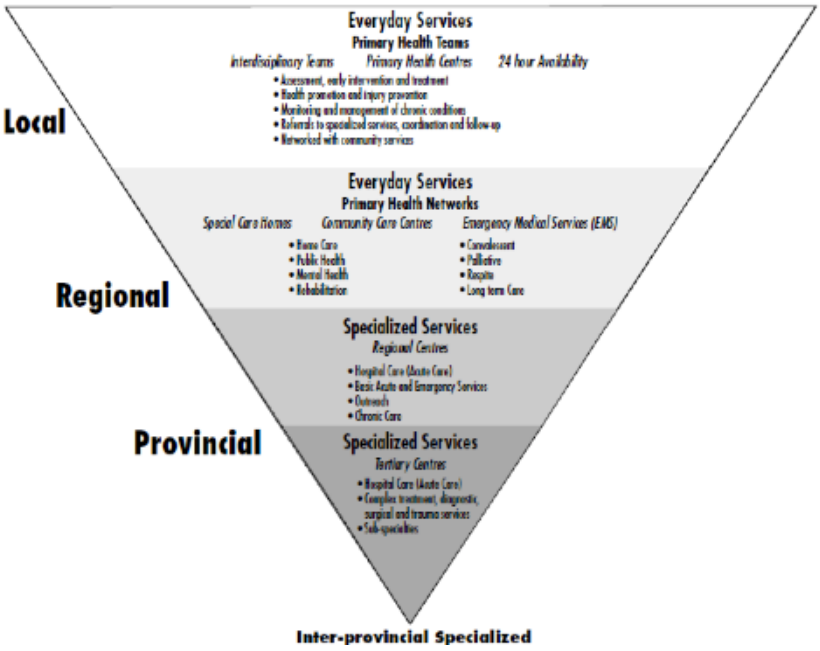
There are several factors to consider in the question of whether to devolve, or not, responsibilities and services and how to organize them. Some have to do with the effectiveness and efficiency of delivering health care ser-

vices, such as the ability to create practice communities, distance from the population and economies of scale. Others have to do with the appropriate alignment of health care with other socio-political geographic areas such as cities or some rural municipalities, where the population has developed the sense of a shared "place."

Administrative efficiency will seek to balance economies of scale obtained by serving higher numbers within one program or service area, with the problems of creating service areas that are too large for serving people effectively and for effective management. And this balance will be different depending on the nature of the service. Size matters. Alberta, for example, after eliminating its health authorities, continued to rely on sub-provincial administrative zones.

Figure 1 is from a 2001 review of Saskatchewan's regionalized system.[11] The graphic (just a model, not a representation of the Saskatchewan system) argues that services more linked to primary and community-based care should be regionalized while more specialized services should not be.

FIGURE 1 - SERVICE DELIVERY MODEL (FYKE, 2001)



2. PRIMARY HEALTH CARE

Most provinces have recognized the need to establish some method to organize primary and community-based care around local structures. Primary health care is the main place in health care where there is any prospect for reducing disparities, and the key is that the care be needs-based, which means radically reconceived and expanded.

Primary health care provides continuity of care, early detection, and good follow-up, especially combined with local outreach to harder-to-serve populations. The best model includes health care teams of multiple providers, including home care and possibly continuing care. These are important in reducing health disparities: poor people have greater prevalence of chronic illnesses, and have fewer resources to manage them. They have poorer housing, less access to transportation, and less money for prescriptions and good food. With lower education, they are less likely to understand complex care instructions. Finally, they are less likely to have good social support. Services that cover the continuum, that are tailored to fill support gaps experienced by

11 Caring for Medicare: Sustaining a Quality System. Saskatchewan Commission on Medicare. Commissioner Kenneth J. Fyke, Government of Saskatchewan. April 2001.

patients, that are located where people live, that provide outreach for early detection, as well as follow-up and ongoing care will reduce disparities.

The organization favoured in some places is to establish locally-based networks for delivery, based on pathways, protocols and care models appropriate to the particular population. Designing care networks rather than less flexible structures allows for adaptability to local situations, while providing an umbrella for collaboration. It also can take opportunities from, rather than discount, the informal networks and relationships that develop to enhance care. Developing primary health care networks requires negotiations, setting targets and performance indicators. Tying these networks to a specific population base (or natural communities, as the term is sometimes used) will provide accountability and reduce gaming in evaluating performance. Client rosters can be developed, for example, based on geographic assignment and client choice.

Chronic illness is one important area that will benefit from enhanced primary health care. In addition to being of benefit to disadvantaged populations, as we discuss above, improvements in chronic care management will contribute specifically to the welfare of the elderly, whose numbers are increasing.

Children will also benefit from enhanced primary care. We know infant mortality is higher in disadvantaged populations, so pre- and post-natal programs in poorer neighbourhoods and partnerships with high schools that have a high proportion of student mothers will mean healthier mothers and healthier babies. Early childhood development is a key health determinant. Nutrition programs, immunizations and early learning programs are examples of supports that will reduce disparities in child development and therefore have long-term benefits. Our earlier review, in Table 2, shows that primary health care strategies are being used in RHAs to reduce disparities — including, as in the example of Winnipeg RHA, locating centres in underserved areas and ensuring that care is appropriate and understood by patients (in their case, mostly Aboriginal residents). Such strategies require collaboration and integration of multiple health care providers as well as other support services, including educators, facilitators, translators, patient advocates, social workers and justice workers.

In our 2004 analysis of regionalization, Lewis and I made the case that integration of services was one of the two most important potential impacts of regionalization (the other being aligning resources to needs as discussed above.) However, the factors required to maximize that impact included:

- Wide scope of services falling within RHA mandate
- Consolidation of authority over various programs and sectors
- Provincial funding formulae aligned with goal
- RHA autonomy to reallocate resources
- Organizational charts that promote integrated planning and management

We summarized the Canadian situation at the time as being:

- Generally wide range of services under RHA authority
- MDs and drugs not included in RHA mandates
- Regions have privately owned facilities and affiliation agreements
- Provincial funding often comes with conditions such as utilization targets
- Issues with provider contracts and morale

The expansion of primary health care requires, as is being tackled in various provinces with more or less vigour and success, negotiating appropriate framework agreements with providers, in particular physicians but also others, including nurses, pharmacists, etc. Funding agreements to primary health care centres will also have to be developed, to include staffing for non-medical personnel, including navigators, translators, and facilitators, family support workers, as we discuss above. Community Health Centres are a proven model for delivering com-

prehensive and integrated primary care, especially for vulnerable populations and communities.

Client rostering methods are being developed for both funding mechanisms as well as for service provision. Of interest is a proposal recently published in Longwoods[12] for structuring health care services in Ontario. It is entitled: Are Integrated Health care Organizations Right for Ontario?

> Integrated Health care Organizations (IHOs) would combine responsibility for the delivery of acute care, primary care and home care in one organization. Additional functions could be added over time as the IHO matures, with emergency medical services (EMS) and medication management/drug programs being logical candidates. IHOs need to be large enough to achieve economies of scale, but small enough to be manageable.

It goes without saying that the level of public funding for primary health centres will have a major impact on disparities, including how much financial support is provided for home care, continuing care and pharmaceuticals.

Finally, although not often discussed in relation to reducing disparities, electronic health records are crucial. Having a universal patient health record accessible to all providers is a requirement of a proactive and long-term approach to care management, an approach that is least available to those on lower incomes, who more often resort to hospital emergency rooms and other forms of fragmented care.

3. PUBLIC AND POPULATION HEALTH

Public health is key to reducing health disparities, having both programmatic and leadership roles. In this paper, we use the term public health as covering public and population health. The National Collaborating Centre on the Determinants of Health outlined the following four roles for public health in reducing disparities:

- Lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in the health determinant/inequities.
- Assess and report on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities/inequities.
- Modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations (i.e., do planning and implementation of existing programs considering inequities).
- Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs.

Whether regionalized or not, all provinces have a chief public health officer. Some also have a population health promotion role in the provincial government. This has the advantage of enabling healthy public policy at the provincial level, the locus of many economic and social determinants, such as policies on taxation, income, employment, education, housing and social support. (However, whole-of-government strategies for health and its determinants are few and far between in Canada.)

In most regionalized provinces, there is also a public health officer and office in the health regions. As we discussed above, this has the advantage of bringing equity issues to the broader management table of the health region. Several RHAs are using health equity lenses and similar tools to help identify and reduce inequities in access and provision of services. Through the leadership of its public health office, an RHA can be moved to an organization-wide commitment to disparities reduction.

The strongest potential role for public health, both in the province and the devolved authority, is to monitor the health of the population, and to provide leadership in both the health sector and the wider society in

12 McLellan B, Egberts MC and Ronson J. Are Integrated Healthcare Organizations Right For Ontario? A brief for the Minister of Health and Long-term Care. Longwoods Essays. 2011.

mobilizing to reduce disparities.

Population health observatories are developing as a formal method for doing this. Indeed, needs assessments and health status reporting for a "place" add to the acceptance of the concept of population health. There is an ability to focus on meaningful local data, identify pockets of poverty, and understand community context and historical grievances.

A useful role for the devolved authority is dialogue with the population, in particular marginalized populations, encouraging participation in making priorities and needs known. The authority should also work to increase public understanding about the social determinants of health, including the level of health disparities and their negative impact on the whole community, and in bringing the community onside in addressing them. This is part of the leadership role that is required of the health sector in reducing health disparities.

The strategies in Table 2 include partnerships and coalitions, including around poverty reduction, early childhood development and school-based strategies. RHAs also have community development strategies to enhance the capacity of marginalized communities to organize themselves, their economies and their social supports, thereby improving their chances of better health over the long term.

Above we noted that one aspect of devolution is appropriate alignment of health care with other socio-political "places." This is important for moving health care from a services-only focus to a one about population and public health. An aligned devolved authority allows and fosters shared responsibility and partnerships around the social determinants of health, and shapes understanding in the public about how health is created, in addition to services. Contiguous boundaries with other authorities are important for cross-sectoral work and partnerships with local authorities on healthy public policy and programs (municipal governments, schools, community-based organizations, etc.). In Montreal, health agencies participate in the Tables de Concertation (leadership forums) for municipal areas and in Saskatchewan, at the Regional Intersectoral Committees. These are not health bodies, but organizations initiated with other sectors in mind, in which health participates. These bodies are where healthy public policy strategies such as Health Impact Assessment can be introduced. It is often more possible to build these combined efforts at a local level. (Municipal governments have been called the next frontier for action because of the increasing importance of urban design and their role as incubators of experiments in community development.)

4. HOSPITALS AND SPECIALIZED SERVICES

One of the major problems in the evolution of regional governance has been where hospitals fit. There are several reasons not to decentralize specialized services. Quality research has shown that many (not all) specialized services require higher volumes to be of higher quality, therefore calling for centralization, or concentration, of services. As these resources are relatively more scarce and expensive, they should be managed provincially, or even in some cases, across provinces. A provincial agency could be established that funds and manages only these hospitals, applying performance and accountability criteria specific to them. The BC Provincial Health Services Authority has this responsibility. This concentration does produce inequity in distribution, and residents of the larger cities, where the specialized services are located, will benefit. However, managing the services with explicit attention to equity (e.g. ensuring access to transportation to specialized services and using innovative means such as telehealth to bring specialized services to other regions) is a better solution than ignoring the maldistribution that would result in any case. Therefore, tertiary care hospitals should be treated as provincial resources and managed accordingly.

On the other hand, small community hospitals, which provide services mainly to local residents and whose services are more care than cure, should be integrated into the community-based care continuum and therefore be under the aegis of a devolved organization.

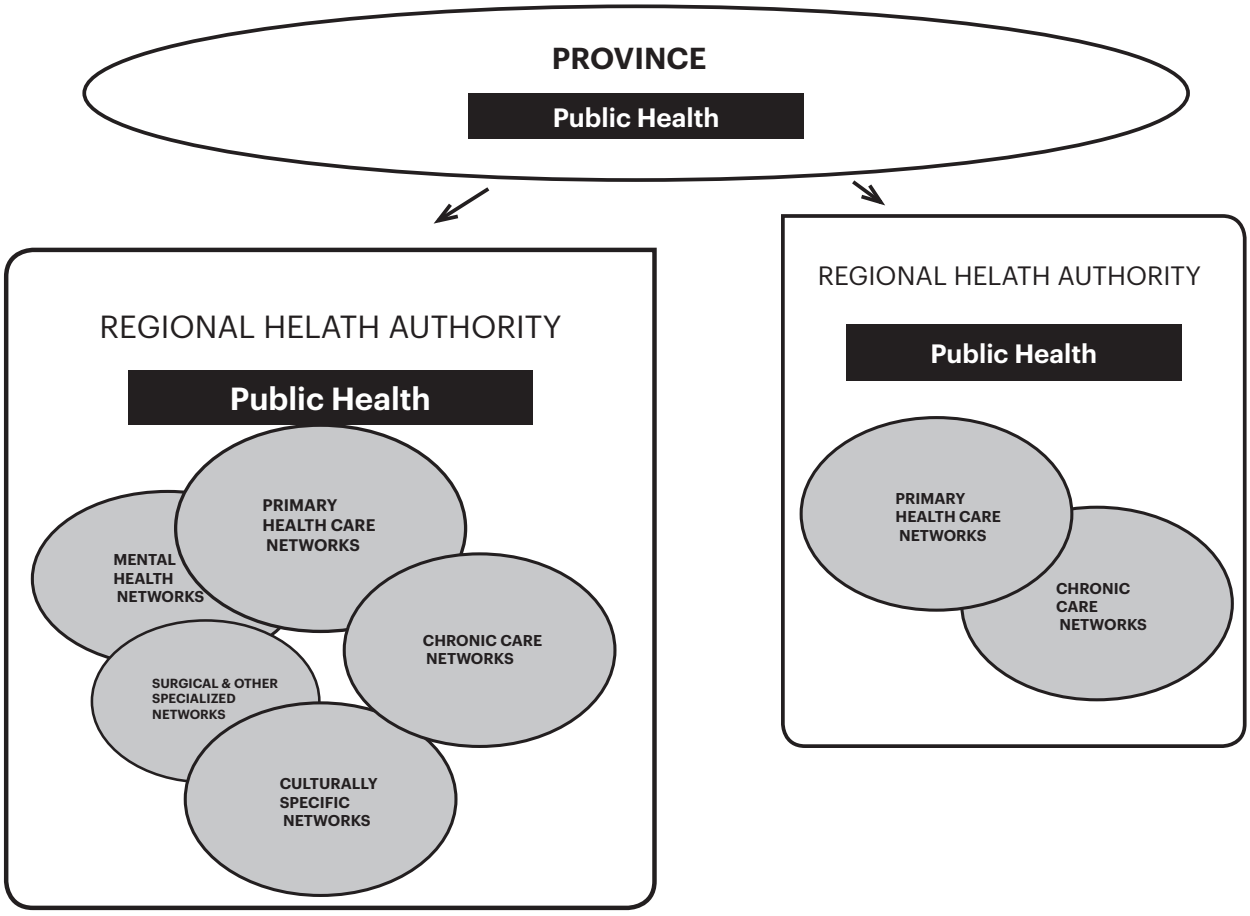
Deciding where middle-sized hospitals fit remains a challenge, however. There is a case to be made that the devolved organization should be responsible only for strictly community-based care, and that hospitals could preoccupy the networks and detract from their disparities-reduction work. On the other hand, hospitals provide care to a local catchment area, and for this reason should be integrated into local service networks. Indeed, even for tertiary care hospitals under a provincial responsibility, there is no reason they could not link to the service networks as appropriate (e.g. working with primary health care and other networks to ensure effective referral and follow-up).

The role of the hospital has important implications not just for care and funding, but also for stakeholder relations. The relationship of primary health care providers to the hospital is highly significant, and framework agreements would come into play here.

5. PUTTING IT ALL TOGETHER

We noted above that one aspect of designing devolved health care organizations was about creating integrat-

FIGURE 2 - ILLUSTRATION OF PUBLIC AND PRIMARY HEALTH RELATIONSHIP IN PROVINCIAL AND REGIONAL CONTEXTS*



*Notes on Figure 2

1. In the rectangles, the public health role is one of leadership, management and evaluation to drive population health outcomes.
2. The ovals depict various types of service provider and community networks. Public health will also play a role in these networks, e.g. in primary health care teams with immunizations or nutrition education.
3. Depending on the population needs and the services available, networks can include multiple inter-disciplinary providers, home care, and perhaps continuing care and community hospitals.
4. As depicted above, different health regions (e.g. large urban on the left and rural on the right) could have different numbers and complexities of networks.

ed and manageable service areas, while another was to align the socio-political nature of health to its "place." Responding to these two aspects will sometimes yield different answers for how to design devolved health authorities. Certainly, the answer will be different for densely populated centres compared to rural areas. One solution is to do something similar to what Quebec has done, which is to create an authority that is based on a socio-political region, with responsibility for population health for that area, including public health, needs assessment, reporting, etc, while also creating sub-regional servicing networks responsible for specific catchment areas. The number of these sub-regional areas can vary depending on the size and make-up of the region, allowing for flexibility (Figure 2). This is similar to the NHS design of strategic regions and primary health care trusts. (However, a combination of issues makes the NHS a difficult model to emulate for Canadians: the public-private relationship is difficult to square with our Canada Health Act, and it is undergoing structural change in any case; in addition, the dense population of the UK is different from most of Canada).

In some forms of devolution most common in Canada, most sub-regional boards were eliminated on the basis that multiple governances impede collaboration. In Ontario, however, the argument was that the local boards are resources and that collaboration should be fostered not forced. The Longwoods paper we referred to earlier takes a different view:[13]

> There are live examples today where integration has worked well, and we will explore some of them. However, the problem is that these examples have not been propagated and generalized and both care quality and efficiencies have suffered as a result. Put multiple functions and organizations under common governance and leadership and real change can happen relatively quickly. Quinte Health care Corporation (QHC) is a great example.

How to move on this is up to Ontario based on its own political context. The instability created by sweeping structural changes may be counterproductive. On the other hand, continuing with an ineffective system has its own costs. The network model in Figure 2 can work with either.

E. Conclusions

Our purpose in this paper was to identify and develop, based on Canadian experiences, a picture of what organizational form would be effective for the health sector to do its part in reducing health disparities. Our analysis has led to the following organizational features for reducing disparities, as per Figure 2 above and the elements below. However, the first step is for government to take disparities reduction seriously and hold itself accountable for achieving it.

The features below combine aspects of different designs from across Canada, while expanding the role and importance of public and population health leadership in the health system, critical to reducing disparities.

1. A provincial office of public health to become the body responsible for population health, including both its medical and non-medical determinants, and for evaluating performance in relation to health outcomes and quality of services, and in which reduced disparities are among the health outcomes. The provincial public health officer plays a key management role in aligning resources to needs to achieve population health, including reduced disparities. The office has the required information and tools. The role also implies taking a leadership role with respect to other government sectors and the public for increasing understanding of health impacts.
2. Regional authorities based on socio-political places and coherent with other authorities, in particular municipal and county boundaries, with responsibility for population-level health and thereby committed to reducing health disparities. Each authority is led by a strong public health department, with the public health officer playing a key management role, and with the capacity to reallocate resources, aligning resources to needs to reduce disparities. Public health has a leadership role in identifying disparities and doing proactive work

13 Ibid.

at a policy and societal level to reduce them. The authority provides care through networks for primary health care and creates partnerships to work on non-medical determinants.

3. Primary health care networks to provide integrated community-based care to specific sub-regional communities and populations. Services include primary health care centres and teams, home care and possibly continuing care and community hospitals. Primary health care is the main place in health care where there is strong potential for reducing disparities, and the key is that the care be needs-based, which means radically reconceived and expanded.
4. A single provincial authority for the management of specialist services and tertiary hospitals, to be treated as provincial resources. The authority would be mandated to monitor disparities in use of services and to reduce systematic underuse relative to need among disadvantaged populations.
5. Provincial governments to provide strong mandates for disparities reduction, while being wise about sharing and devolving authority, and developing commensurate framework agreements and appropriate funding arrangements with aligned incentives. It is extremely important to talk about indicators of disparity as integral aspects of the mission and the performance framework for health care.

We do not directly address to what extent the proposals should be adopted by Ontario. Health care reform is a political process, and requires negotiation and cooperation with multiple stakeholders, and the context is different in each province, constraining and shaping the possibilities. Certainly, the LHINs and the Family Health Teams, Community Health Centres, and other Ontario structures are a reasonable platform on which to build to transform existing structures into disparities-reducing opportunities. However, Ontario also would need to consider establishing meaningful regions from a population health perspective, and ensuring effective building upon existing public health resources.