National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

CASE STUDY
Winnipeg

BRIDGING THE GAP BETWEEN RESEARCH AND PRACTICE

MAKING THE CASE FOR HEALTH EQUITY INTERNALLY: WINNIPEG'S EXPERIENCE

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- Marli Sakiyama, Winnipeg Poverty Reduction Council
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ABOUT THE NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

The National Collaborating Centre for Determinants of Health is one of six National Collaborating Centres (NCCs) for Public Health in Canada. Established in 2005 and funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases, and health inequities.

The National Collaborating Centre for Determinants of Health focuses on the social and economic factors that influence the health of Canadians. The Centre translates and shares information and evidence with public health organizations and practitioners to influence interrelated determinants and advance health equity.



About the Case Study

This case study is one of four case studies that illustrate the application of social determinants of health (SDH) in public health. Each of the case studies reflects a different geographical region of Canada. The case studies were developed as a knowledge exchange tool to support a workshop hosted by the National Collaborating Centre for Determinants of Health and the Canadian Institutes of Health Research Institute of Population and Public Health in Toronto, Ontario on February 14-15, 2012.

To enable learning and possible implementation of the processes discussed at the workshop, the four case studies were developed. Each case study includes a description of the context, issues addressed, activities undertaken and the possible application of the approach to public health work.

The process used to develop the case studies is outlined in *Bridging the Gap between Research and Practice: methodology for case study development.*

Other case studies in the series include:

- Building Leadership Competency in Public Health: Taking advantage of changes in health delivery in Québec
- Empower the Community: New Brunswick's Approach to Overcoming Poverty
- Improving Health Equity in Saskatoon: From Data to Action

All documents are available at www.nccdh.ca

Introduction

A 2008 report on urban health[1] showed that people living with the lowest socioeconomic status in Winnipeg were showing up in city hospitals at two or three – sometimes even five – times the rate of its wealthiest residents. Winnipeg had among the highest differences in hospitalization rates between low and high socio-economic status groups in Canada. The report provided relevant, local and comparative health data – a catalyst for action on health disparity in that city. Public health leaders used the opportunity to strengthen ties with anti-poverty and other community organizations, and to raise the profile of health inequity with senior management within their health region. Will their efforts translate to improvements in the health of Winnipeg's poorest residents? This is an ongoing story that describes an innovative way to cast a health equity lens over all aspects of the Winnipeg Regional Health Authority, including health services delivery and long-term care.

Setting the Stage: Health Disparity in Winnipeg

As described in the Canadian Population Health Initiative report, Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada[2], Winnipeg had among the highest differences in hospitalization rates between low and high socio-economic status groups in Canada, in 7 of the 13 indicators studied. The differences were greater than in most other Canadian cities for:

- Asthma in children – 3.0 times *(pan-Canadian average – 1.6)*
- Injuries in children – 2.5 times (pan-Canadian average – 1.2)
- Injuries for all ages – 2.2 times (pan-Canadian average – 1.4)
- Unintentional falls – 1.8 times (pan-Canadian average – 1.3)
- Land transport accidents – 1.9 times (pan-Canadian average – 1.3)
- Diabetes – 3.7 times (pan-Canadian average – 2.4)
- Substance-related disorders – 5.0 times (pan-Canadian average – 3.4)

The urban health report provided local, timely, comparative health data that pointed to serious health inequity in Winnipeg. Preparation for anticipated media questions made the evidence a key catalyst to raise the profile of health disparity among senior management and key leaders at the Winnipeg Regional Health Authority. While the media attention was less than predicted, the presentation of the data by the Population and Public Health staff and the Research and Evaluation team resonated with senior management. It validated and increased visibility of the issue that was already known to staff in an informal, intuitive way, as well as from other reports and studies over years. For senior management, the data fit with their experience of high demand for acute care services seen in higher admission rates or longer lengths of stay in Winnipeg hospitals compared to other urban centres in Canada. It countered the interpretation that differences in acute care were solely due to inefficiencies, and pointed to a population that is sicker and has more social complexities than in other urban centres and may, therefore, require more care.

The resulting regional response had two main thrusts – one to strike a committee to work internally to identify issues that could be addressed to reduce health disparity through ongoing programs, processes and leadership, and another to work more closely with partners in the community. Efforts began to produce a report to stimulate conversation with the community - with partners at all levels – to create a regional strategy with recommendations that all parties could act upon.

The Issue/Challenge

Responses to an internal questionnaire showed that many groups within the Winnipeg Regional Health Authority had a good understanding of health equity and could articulate their equity promotion activities and plans. At the same time, others had little recognition that promoting health equity required anything more proactive than just "opening doors to all comers". Also, there was no common framework or regional strategy

to pull the work together. To make a difference in health equity, it was critical to make the case that equity promotion should be a recognizable part of the organizational culture and become top of mind for all planning and service delivery.

The Environment

The CIHI report stimulated two regional commitments in 2009:

1. A committee was formed with broad representation from senior managers and staff of Winnipeg Regional Health Authority programs and sites, spanning acute to community care, to explore a regional disparity reduction strategy (later reframed as a health equity promotion strategy).
2. The Winnipeg Regional Health Authority increased its participation in the newly formed Winnipeg Poverty Reduction Council to assist in addressing root causes of health disparity and to nurture new partnerships in the community. Within Winnipeg, an increasing critical mass to address poverty seemed to be forming.

Key Players

The internal health disparity/health equity promotion committee, the *Promoting Health Equity Oversight Committee*, was named to reflect a strengths-based approach. Its aim was to identify issues that could be addressed to reduce disparity through ongoing programs and processes within the Winnipeg Regional Health Authority, and to work more closely with partners beyond health care to promote health equity. At the same time, Winnipeg Regional Health Authority began to work with the Winnipeg Poverty Reduction Council - providing resources and having staff on their committees to ensure a health presence in their planning.

The Promoting Health Equity Oversight Committee is chaired by the Medical Officer of Health, Population and Public Health. It began in earnest in September 2010 (delayed due to the H1N1 pandemic). It is a large internal group (over 30 people), with three executive co-sponsors at the Vice-President/Executive Director level, and representation from community care, acute care and long term care, and key sites and programs, including community health agencies. The Oversight committee reports to senior management through the Regional Management Committee with updates at least every six months.

Three working groups are currently active:

- Partnership Working Group (about 10 members) - to identify and maximize external partnerships with organizations addressing health and social issues related to socioeconomic status
- Planning Working Group (about 10 members) – to insert consideration for health equity into all operational decision making (planning, finance, logistics and human resources)
- Directional Working Group (about 15 members) – to research and describe local health equity status and best practice intervention recommendations, and draft the Winnipeg Health Region Health Equity Promotion directional report, based on available evidence.

The Directional Working Group is developing a report to stimulate further discussion, consultation and engagement, to form the basis for an action plan on specific priority areas of intervention. Three task teams have been established to help prepare the report: Describing the Problem, Best Practices and Communications. After completion of the report and consultations, the Directional Working Group and its task teams will likely disband and be replaced by Action Plan working groups to focus on implementing the recommendations.

The Process to Implement Action Aimed at Reducing Health Disparity

All Working Groups and Task Teams are actively gathering research to inform their actions, including:

1. *An environmental scan and gap analysis* of organizations most actively involved in poverty-related health equity work in the community and at the regional, provincial, national and international levels. To date, over 100 existing partners have been identified. (Partnership Working Group).
2. *Indicators to describe health inequity* in the health region, with candidates being researched through a review of 14 local reports to determine the immediate availability of data (and associated gaps) specific to these indicators. Reports reviewed include community health assessments, reports of the Manitoba Centre for Health Policy (University of Manitoba), as well as population and disease-specific reports (Describing the Problem Task Team).
3. *Key recommendations to promote health equity*, found by reviewing over 80 resource documents or websites. Over 1000 recommendations have been gleaned through this review. (Best Practices Task Team)
4. *Program budgeting and marginal analysis* process where equity was one of twelve criteria used to assess new initiatives (influenced by the work of the Planning Working Group).

Overcoming Challenges

- **Finding evidence and expertise** – Although there are no formal links to external research organizations, academics and other researchers are included on all committees or consulted when required. While more formal agreements would be helpful, good relationships exist with individual researchers and institutions, and fruitful collaborations exist.

- **Competing interests for budget** – Funding health disparity work would contribute greatly to a sustainable health care system, but shifting dollars to health equity efforts is challenging. It will require the right evidence – and courage – to move funds from health services to preventive work. For example, improving the lives of homeless people will result in fewer visits to the emergency room, but decision-makers will need to see more than evidence to make these changes. Health system and public support will be required.

> "Public Health, or even the Health Region, doesn't need to own or manage everything that is going on. In many cases, we can be the 'cheerleaders', not the 'flag-bearers'. At the same time, we need to coordinate our efforts, to make sure each partner is taking on the right role."
>
> WHRA PUBLIC HEALTH STAFF

- **Establishing priorities** – After reviewing a wide range of health equity reports, over 1000 recommendations have been collected. Setting 'doable' priorities has yet to take place. To do so, actions need to be identified that are both important and feasible, based on evidence and examples from other communities. Other considerations will include partners' and other stakeholders' views of the relevance of various actions, and their potential roles in working towards them.

- **Determining roles** – While the Winnipeg Regional Health Authority is stepping up its role in health equity, staff recognize that many organizations came before them in addressing inequities. They consciously work to connect with those already involved, to recognize them, and to add value to their work with the intent to amplify, not overtake, their efforts. They recognize the need to earn, not demand, credibility.

- **Public health advocates** – Advocacy must be approached with considerable finesse, particularly when coming from within a government funded department, health authority or organization. It is an important public health tool, but needs to be applied strategically. Approaches that stimulate effective action may not necessarily be those that involve open and public challenges to the government of the day – civic or provincial. Advocacy efforts, mentoring and support can occur at many levels, both within a large health organization, and with partners.

Developing Common Ownership of Health Equity

A key strategy to build momentum on any issue is to create a sense of common or shared ownership. The Winnipeg Regional Health Authority is using multiple approaches, both formal and informal, to develop a sense of joint responsibility. It is hoped that if senior management, committee members and staff are exposed to equity issues in many different ways, the health equity lens will seep into their mindset. Some of the approaches being used are:

- **Build on existing efforts –** It is important to recognize the past and ongoing efforts of the many people who have worked on health equity for their entire careers. Regional staff avoid portraying theirs as a new initiative, but rather as one that is coming alongside and adding energy to longstanding, commendable work.
- **Nurture champions –** Working with individuals both inside and outside the organization, staff are trying to establish champions for health equity. Internal leaders, particularly those who have a longstanding commitment to the issue, are being recruited to leadership positions on the Oversight Committee, working groups or task teams. Community opinion leaders, who are influential and bring extensive networks, are being invited to join groups, thereby increasing their investment and ownership. At all levels, staff promote the work to key individuals through meetings or conversations.
- **Create links between evidence and existing priorities –** Connections between health equity and existing key priorities of Winnipeg Regional Health Authority are being established. Just as data from the CIHI report was a catalyst for action, ongoing analysis of process and outcome indicators will allow managers to determine how actions on health equity are affecting other outcomes. The 'business case' for health equity must dovetail with other issues management is addressing.
- **Communicate –** Learning a lesson from the lack of visibility early on in their efforts, staff are now using a variety of measures to keep health equity a priority, from written updates, to personal conversations, to putting the issue of health equity on the agenda for the Board of Directors' annual retreat.
- **Be part of the community –** the Winnipeg Regional Health Authority has recently re-located its corporate offices to the inner city, providing an opportunity for staff to be closely involved in the community that confronts considerable challenges related to health equity.
- **Partner with a community school –** In 2009, a partnership was created between William Whyte School, located in the inner city, and the Winnipeg Regional Health Authority corporate office staff. In addition to providing funding, staff are helping with fundraising, inviting students to perform at the Winnipeg Regional Health Authority corporate events, and awarding "*You Can Do It*" cash prizes, which are held in trust for winners' post secondary educations. Feedback has shown higher school attendance and return rates, attributed to volunteer efforts. The relationship continues, with consideration to expand to a second school.
- **Put 'skin in the game' at the Winnipeg Poverty Reduction Council –** Winnipeg Regional Health Authority provides resources, including initial funding for a position within the Winnipeg Poverty Reduction Council, to 'keep an ear to the ground' regarding initiatives related to health equity. This enhances networking, by creating an infrastructure in which existing groups are linked, from the grass-roots to the policy level.

> Having people step into leadership roles increases sense of being 'inside' the issue and part of the action.
>
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Maintaining leadership and motivation

While public health is leading the process, ongoing leadership is required to maintain momentum for a health equity initiative.

- **Embed equity within formal and informal leadership structures –** A number of positions of influence exist throughout the health region, and it is critical that equity take hold within at least one of them, to change the tone, direction and priorities of the system. Otherwise, it is very difficult for public health to have an impact on organizational practices and culture.
- **Motivate through involvement -** Keeping people motivated requires an understanding of their interests and the benefits they get from being involved. Feeling that they are part of something important, meaningful and successful is key. It is particularly important to recognize what motivates champions and to facilitate the sense of satisfaction that drives them.
- **Balance the pace of work –** It takes time to fully engage people, but once established, efforts must move quickly enough to see results – recognizable 'wins'.
- **Keep equity 'on the agenda' –** The work of health equity must be profiled from many directions, in many forums, so being involved creates a sense of belonging to something that is big and pervasive. Relating the work to existing priorities and events is important, so people see the relevancy of their work on an ongoing basis.
- **Communicate, encourage, and appreciate –** It is easy for people to start to feel disconnected and drift away. Staff make a point of keeping in touch – with calls, email, visits, chats – with a sense of appreciation rather than demand, so people realize they are needed but not taken for granted.
- **Harness critical mass –** Issues that get profile, build more profile. Issues that get people involved, attract more people. Involving senior leaders gets management involved, and once management is involved, senior management keeps hearing about the issue.

Strengths of the Winnipeg Approach

- A region-wide committee leading efforts
- All sectors involved at the working level (working groups, task teams)
- Common ownership, including the endorsement and involvement of senior Winnipeg Regional Health Authority management
- Well-established and effective relationships in the community and with researchers

While still early in its process, Winnipeg Regional Health Authority has been able to accomplish a considerable amount, including:

- Regional Health Plan proposals are being evaluated with health equity as a criterion.
- Population and Public Health strategic plans are being developed around the concept of 'targeted universality'.
- Consideration is being given to further refining how public health resources are allocated - on the basis of community need, not population.
- Draft conceptual frameworks have been proposed.
- Mapping discussions are underway.
- The Winnipeg Regional Health Authority Health Equity report is currently being drafted.

QUESTIONS
TO CONSIDER

- How would you present the case for action on health equity to decision-makers in your organization? What arguments would you use to urge them to action?
- How would you best engage community partners and researchers involved in the process, to help get management 'buy-in' and stimulate the translation of research into action?
- How would you overcome the following challenges to implement a health equity strategy in your situation?
  - Develop a sense of common ownership
  - Find the evidence, expertise and resources required
  - Maintain leadership and motivation
  - Set doable priorities
- Having read about Winnipeg's effort, what are the elements you think will lead to its success? How would you apply these elements to your own situation?

REFERENCES

[1] Canadian Institute for Health Information. (2008). *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada.* Ottawa, ON: Canadian Institute for Health Information.

[2] Ibid.

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