TOWARD HEALTH EQUITY

CANADIAN APPROACHES TO THE HEALTH SECTOR ROLE



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The following individuals also contributed actively as members of the Expert Reference Group:

- Sofialeticia Morales, Senior Advisor, Millennium Development Goals and Health Targets, Area of Sustainable Development and Environmental Health, Pan-American Health Organization
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The paper constitutes Canada's case study prepared for and presented at the WHO's 8th Global Conference on Health Promotion in Helsinki, Finland in June 2013. Findings from this paper were also used as background for a presentation at the June 2013 Canadian Public Health Association Annual Conference.

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EXECUTIVE SUMMARY

This report was prepared as part of Canada's contribution to the 8th Global Conference on Health Promotion, to illustrate the roles that the health sector can play in advancing health equity—both through integrating health equity into the policies, programs and practices of the health sector as well as through collaboration with other sectors. These are illustrated by concrete examples drawn from across the Canadian health sector, with a particular spotlight on health entities at three different levels of government: the Government of Canada's Health Portfolio (federal); Alberta Health Services (provincial); and the Saskatoon Health Region (regional). The lessons learned include a number of enabling factors, as well as how to address common challenges that may arise.

Small group interviews were held with leaders in public health from across levels of government. Their observations have been grouped into three thematic areas which summarize where progress has been made in advancing health equity in Canada. The report is framed around these three themes: build a strong foundation for action, establish and use evidence, and collaborate with others outside the health sector. This report summarizes experiences related to each of these themes, as well as success factors, challenges and approaches to meeting challenges.

To build a strong foundation, informants spoke to the importance of leadership; supportive environments, which anchor the integration of health equity as an organizational priority; and capacity, where the individuals and organizations involved have the resources and training necessary to advance and promote the agenda.

Strengthening the collection and use of data and evidence on the state of and trends in inequalities, pathways to inequalities and interventions to address them is critical to guiding intervention and measuring progress. The development, use, and application of evidence are enabled by a robust and collaborative research and policy community, effective knowledge translation and exchange, and means of measuring results. With respect to working across sectors, it was acknowledged that the health sector does not have all the answers and cannot accomplish everything on its own, nor all at once. Instead, the health sector will have optimal impact if it determines where to focus its efforts, demonstrates the value it adds to the process, and works together with other sectors to improve the lives of all Canadians.

The following are a few of the key lessons learned about promoting health equity within the health sector organizations noted in this report:

- *Foster a supportive organizational culture* to recognize and build on elements that embrace equity. For example, leaders or peer champions can be supported to actively advance a health equity agenda internally and externally.
- *Build health equity capacity* among staff through training, funded positions and structural approaches that embed health equity strategists throughout health systems. Universities and research organizations also play an important role in training staff, and in developing and translating research into practice.

- *Develop and use knowledge and evidence* related to health, health equity, and the social determinants of health, including robust data at the local level. Data can be a powerful catalyst for action, particularly when put into context through a solid understanding of attitudes towards health equity within organizations and among allies and the public.
- *Involve marginalized populations* in decision-making, including Canada's First Nations, Inuit and Métis peoples, to provide cultural continuity in improving health outcomes.
- *Clearly understand the interests* of the public and of community allies, and working with partners in a participatory, respectful way.

Overall, it was observed that integrating health equity into policies, programs and practices is a gradual process that evolves differently in different settings. In Canada, there is momentum at the federal, provincial, regional and local levels, with no one level using particular mechanisms exclusively.

1. INTRODUCTION

1.1 PURPOSE

Canadians generally enjoy good health and health outcomes are improving overall. Even so, health inequalities persist and in some cases these inequalities are still growing. For example, life expectancy in Canada has increased by more than 30 years over the past century (83 years for women and 79 years for men), but the life expectancy of Aboriginal people and low income Canadians remains lower than the general population. This pattern is also reflected in mortality rates, and in the prevalence of many diseases including cardiovascular disease, heart disease and diabetes. New immigrants to Canada and Canadians living in rural and remote communities are also more likely to experience health inequalities in access to services or health outcomes. Canada understands that more work is needed to address the significant challenges that remain in advancing equitable opportunities for good health for all Canadians.

There is growing recognition both in Canada and globally that addressing the underlying social determinants of health requires action both inside and outside of the health sector. In May 2012, Canada and other United Nations Member States endorsed the *Rio Political Declaration on Social Determinants of Health* which sets out actions to address health inequities in five thematic areas, one of which is the reorientation of the health sector to more purposefully focus on reducing health inequalities.

Building on the Rio Declaration, the World Health Organization and the Government of Finland called on countries to think about what it takes to support health across public policies in advance of the 8th Global Health Promotion Conference which took place in Helsinki, in June of 2013. Countries of the Americas prepared case studies which reflected country experiences in advancing health equity in public policies. This paper, which describes the experiences of Canadian organizations in advancing health equity, constitutes Canada's case study for that conference. This report will be of interest to individuals working in health sector organizations who want to accelerate their progress in reducing health inequities, through the benefit of learning from other organizations' experiences in the field.

Health inequalities and health disparities refer to differences in health status experienced by different groups in society, regardless of their cause. The term 'health inequalities' is often used when referring to measured differences in health status.

Health Inequities refer to those health inequalities which are avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically.

Health equity is the absence of health inequalities which are avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically.

This document uses the term 'health equity' except where jurisdictions use other terms to describe their work.

1.2 METHODOLOGY

This report was informed by data gathered primarily from two sources:

- **Pan-Canadian small group discussions:** A purposeful sampling of leaders and practitioners from health sector organizations at federal, provincial/territorial and regional levels were invited to participate in one of four two-hour cross-jurisdictional small group discussions to share reflections on how health equity was being advanced in their jurisdictions, and to share success factors, challenges faced and the ways in which challenges were being overcome, as well as to reflect on the overall status of health equity integration in their jurisdictions. In particular, information was gathered on leadership/governance, capacity building, tools/resources, intersectoral engagement, and monitoring/reporting/knowledge exchange. Common themes were identified, and illustrated by concrete examples drawn from those organizations among others. Representatives from eight provincial and territorial governments and nine regional and municipal health sector organizations across Canada participated.
- **Key informant interviews:** Select representatives from three health sector organizations at three different levels of government participated in small group key informant interviews, by organization, to gather in-depth information about how each entity approached health equity integration. These three "featured" health entities were: the Alberta Health Services (provincial); Government of Canada's Health Portfolio (federal); and Saskatoon Health Region (regional). The resulting profiles (section 2) describe their mandates and roles within the Canadian system to provide context for the findings described in later chapters where examples from these organizations are augmented by illustrations from other jurisdictions.

Further details about the methodology used and participating organizations are provided in Appendix A.

1.3 PAPER OVERVIEW

Chapter 2 provides descriptive profiles of the mandates and roles of the three health sector organizations featured in this paper, for context. Chapters 3, 4, and 5 are framed around three themes that repeatedly emerged during the consultations as areas of action that are key to achieving health equity integration. These themes are: build the foundation for action; establish and use a strong knowledge base; and collaborate with non-health sector partners. Reflections on the health sector's role in health equity and related key challenges and enabling factors, are summarized in Chapter 6.

While this paper offers guidance based on Canadian experiences, it must be noted that "no one size fits all". This paper provides some examples of the range of approaches which have been tried. While the focus here is on government or government-funded organizations, the many contributions of health professional and voluntary sector organizations to this field are noted but were not explicitly explored in this report. Also, the themes used are not hierarchical or sequential in nature. Rather, health organizations approach health equity in a manner that suits their respective mandates, strengths, and human resource capacity, as well as the populations they serve and the contexts in which they work.

1.4 THE CANADIAN CONTEXT

Canada is a large, culturally and linguistically diverse nation. Approximately four percent of the 35 million people who reside in Canada are Aboriginal, and 20 percent are foreign born. Canada has a federated system of government, with a division of powers between a national government and provincial/territorial governments. Responsibility for health and social services is shared between these levels of government, with provinces/territories having the largest role in delivery. Canada has a strong commitment to supporting political participation through democratic elections at all levels of government.

Policies and programs that foster good health have been in place in Canada for decades, and new approaches and interventions are continually being developed.

2. SELECTED PROFILES: ILLUSTRATING THREE THEMES

2.1 ALBERTA HEALTH SERVICES: BUILDING THE FOUNDATION

Alberta Health Services (AHS) delivers health services to the province's 3.8 million residents. Divided into five zones for service delivery, AHS has a workforce of almost 100,000 and has been governed by a board that reports to the provincial Minister of Health. As the single health authority for the province of Alberta, AHS has a mandate and structure to support health equity programs at provincial, regional, and local levels.

While AHS is relatively new (created in 2008), it builds on previous efforts within the province to address health inequity:

- In 1998–99, a framework was developed in Edmonton identifying the need to measure and profile variations in population health status.
- The province's 1999 report, entitled *The Report on the Health of Albertans: Looking Through a Wider Lens*, highlighted the health impacts of poverty, poor housing, and other social determinants, and emphasized the need for multi-sectoral action across government departments to improve health.
- In 2005, the Calgary Zone (which includes the City of Calgary and surrounding areas) was the first to issue a health status report showing a health gradient according to 'social districts'.
- In 2008, a report titled *Poverty and Health in Edmonton* was released showing the variation in selected health indicators by deprivation indices.

Other regional and local health sector organizations in Alberta are also building health equity into their work, through local community partnerships and other means. Most recently, collective efforts and momentum across the province have formed the basis of AHS' *Promoting Health Equity Framework* (see Box 1).

BOX 1: AHS PROMOTING HEALTH EQUITY FRAMEWORK

Vision: An organization that advances health equity

Goal: To reduce inequities in population level health outcomes

Purpose: To cultivate a shared responsibility for promoting health equity within and beyond Alberta Health Services

SOURCE: AHS Promoting Health Equity Framework

Overall, AHS takes collaborative action on the social determinants of health through organizational leadership and multi-sectoral stewardship. Health equity will be championed and supported within AHS to improve health outcomes. AHS will also support the work of multiple sectors whose activities directly or indirectly impact health.

Building on academic and experiential evidence, the *Promoting Health Equity Framework* established the conceptual underpinnings, the overall approaches and recommendations to promoting health equity in Alberta over the long term. The *Health Equity Action Plan* stems from the Framework and articulates concrete deliverables that are expected to be achieved within a three year timeframe.

2.2 THE FEDERAL HEALTH PORTFOLIO: ESTABLISHING AND USING A STRONG KNOWLEDGE BASE

Canada's federal government enables action on health equity through three "health portfolio" partners, which work with other federal departments and stakeholders:

- The Public Health Agency of Canada's mission is to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health. It has specific responsibilities in emergency preparedness and response, health promotion, and control and prevention of infectious and chronic diseases and injuries. It further contributes to public health by enhancing surveillance data and expanding knowledge of disease and injury in Canada, and by strengthening intergovernmental collaboration on public health and facilitating national approaches to policy and planning.
- Health Canada is the Canadian government department responsible for helping Canadians maintain and improve their health. Its responsibilities include setting and administering national principles for the health care system through the *Canada Health Act*. In addition, Health Canada provides services directly to First Nations reserves and in some Inuit communities, including health promotion programs and public health services, as well as primary and emergency care services in remote areas where services normally provided by provincial or territorial health plans are not readily available.
- The Canadian Institutes of Health Research (CIHR) is Canada's national health research funding agency. It comprises 13 institutes responsible for creating new scientific knowledge and enabling its translation into improved health, more effective health services and products, and a strengthened Canadian health care system. CIHR supports action across four pillars of health research: biomedical; clinical; health systems and services; and social, cultural, and environmental factors that affect the health of populations.

Each of these three portfolio partners contributes to health equity action in several ways, including by gathering and translating information on health inequity and its potential solutions, and by empowering priority populations through focussed investments and consideration of determinants of health.

2.3 SASKATOON HEALTH REGION: COLLABORATING WITH NON-HEALTH SECTOR PARTNERS

Health services in the Province of Saskatchewan are divided into regions. Saskatoon Health Region is the largest, serving approximately 318,000 residents (approximately 30 percent of the province's population) in more than 100 cities, towns, villages and First Nations communities.

Health data collected in Saskatoon as part of ongoing surveillance made it appear that the health of residents was improving. However, data averaging was hiding the fact that the health of residents was falling behind in some areas of the city.

In 2005, Saskatoon Health Region's Population Health Unit (which later became its Public Health Observatory) collected health data that pointed to serious differences in health status between the six lowest income neighbourhoods and the rest of the city. A comprehensive research study entitled *Health Disparity by Neighbourhood Income* was launched to gain a better understanding of the key determinants involved[6]. The results uncovered substantial health inequalities on a number of fronts.

For example, infant mortality in Saskatoon's low income neighbourhoods was over five times higher than in the rest of the city—a greater gap than in developing nations. Compared to higher income residents, people in the six lowest income neighbourhoods were:

- 15 times more likely to have a teen give birth,
- five times more likely to have an infant die in its first year of life,
- 15 times more likely to attempt suicide.

Rates of some diseases—like chlamydia, hepatitis C and gonorrhea—were many times higher.

With the support of meaningful, comparative local data—a key benefit of public health observatories—the Saskatoon Health Region determined that income often had the strongest independent association with health inequality. Working collaboratively with community partners, 46 policy recommendations were put forward including the following targets related to poverty reduction:

- reduced poverty in households from 17 percent to 10 percent in five years (by 2013),
- reduced poverty in children from 20 percent to 2 percent in five years (by 2013).

A coalition of partners has developed the Saskatoon Community Action Plan to Reduce Poverty, which prioritized action on 15 of the 46 policy options that had been identified. Eight core indicators measure community progress on poverty reduction.[a]

[a] For more information, including progress assessments, visit www.saskatoonpoverty2possibility.ca and choose "community action plan."

3. BUILD THE FOUNDATION FOR ACTION

This section describes some elements identified during the consultations that were considered necessary to advance and sustain action to reduce health inequalities within health sector organizations. These elements are framed as:

- *leadership*—individuals or groups that promote health equity and take action to put the other elements in place;
- *supportive environments*—anchors within organizational guiding documents to integrate health equity as an organizational priority;
- *capacity*—staff and partners that have the resources and training necessary to advance the agenda, enhance internal and public awareness of the issues, and promote action across sectors to reduce inequities.[7]

3.1 LEADERSHIP

Leadership can be demonstrated by individuals or through an organization's structures and governance processes. In practice, they usually build upon each other. Leaders can be instrumental in establishing mechanisms that promote health equity, while in turn those mechanisms can enable health equity leaders to emerge and flourish. Examples of these approaches can be seen in various settings in Canada.

3.1.1 Individual champions

Individual leaders can be champions in a number of ways in their organizations and communities. They can provide a focal point for collective action, promote and advocate at executive level tables, and set performance expectations. Individuals can convey their broad vision of health to cultivate a sense of common action among stakeholders, motivate partners, and engage the public. These "artful" public health leaders are known to be adept at combining a foundation in science with "innovative social strategy, abundant political will, and supreme interpersonal skill."[8]

Examples of leadership in health equity can be found at all levels of public health in Canada. For example, as head of the federal Public Health Agency of Canada, the Chief Public Health Officer chose health inequalities as the topic of his first *Report on the State of Public Health in Canada*[7]. The Public Health Agency of Canada also designated a Health Equity Champion, who has responsibility for developing, implementing, and measuring its performance plans for health equity and determinants of health. The Champion is accountable for raising health equity awareness among staff and executives, and for building skills and capacity. His/her performance is measured, in part, against these responsibilities.

A number of Medical Officers of Health—the lead public health official in many municipal and regional governments—have also established themselves as *de facto* champions of health equity. For example, the Chief Medical Health Officer for the Saskatoon Health Region has built the case for action on health equity by fostering a strong base of evidence and nurturing community support and relationships with senior management and community leaders. In northern Ontario, the Sudbury and District Health Unit's (SDHU) Medical Officer of Health and Chief Executive Officer has conveyed an expectation for health equity to be built through investments in knowledge development, planning, tools, and staffing.

In Alberta, AHS has undertaken efforts to develop health equity champions among its senior leadership, including Medical Officers of Health. In 2012, AHS Population and Public Health hosted a day-long event entitled, *Champions for Health Equity: Leading the Way*. The event, co-sponsored by the Public Health Agency of Canada, was part of the overall effort by AHS to create an organizational foundation that will enable it to improve the health of all Albertans. This event supported and contributed to the development of health equity champions by giving them an opportunity to learn from nationally recognized health equity leaders and AHS health equity champions, as well as to share their perspectives and ideas for action in Alberta.

For example, one idea resulting from the event was that Medical Officers of Health act as spokespeople to explain health inequities to the public as health status reports are released. As well, Medical Officers of Health could engage with leaders in other sectors to create a common understanding of the impact of social conditions not only on health, but on the sustainability of the health care system.

3.1.2 Supportive leadership mechanisms

Supportive leadership can emerge through organized groups, committees or governance bodies working within or across organizational structures. Pan-Canadian and provincial examples follow.

The Pan-Canadian Public Health Network (PHN) was established by Canada's Federal, Provincial and Territorial (F/P/T) Health Ministers in 2005 as a key intergovernmental mechanism to enable F/P/T governments to better work together on public health matters. It is a network of individual experts, drawn from many sectors and levels of government across Canada, who collaborate through this forum to raise issues and address public health challenges for the benefit of all Canadians. The PHN and previous intergovernmental mechanisms have advanced pan-Canadian action to reduce health inequalities in several ways, including having identified roles for the health sector in reducing health disparities (2005), and identified indicators of inequalities (2009). More recently, an interim public health expert advisor has been appointed to work with Aboriginal organizations to identify priorities and expertise in their communities.

The AHS Board, Alberta's governance body for the province-wide health authority, unanimously accepted AHS' *Promoting Health Equity Framework* which sets out the overall approaches to promoting health equity in Alberta over the long term. The recently established Alberta Population and Public Health Council (APPHC) is a separate mechanism committed to promoting health equity. It aims to facilitate the collaboration necessary to address population and public health priorities and strategies, and to enable realization of established goals and outcomes.

3.2 SUPPORTIVE ENVIRONMENTS

3.2.1 Organizational priorities

In addition to showing strong leadership, Canadian health sector organizations that have successfully implemented a health equity approach have established a health equity priority through their institutional mandates, strategic plans, guiding documents, and/or other means. Doing so signals its importance within the corporate culture.

At the federal level, Health Portfolio organizations have made commitments within their strategic plans to address health equity and determinants of health as cross-cutting priorities. For example, the Canadian Institutes of Health Research (CIHR) and its 13 institutes have identified the reduction of health inequities among Aboriginal peoples and other vulnerable populations as a research priority in their collective 2009–2014 *Health Research Roadmap*.

Individual CIHR institutes are also addressing health equity in their strategic plans. For example, as part of its own *Strategic Plan 2009–2014: Health Equity Matters*, the Institute of Population and Public Health supports research that advances understanding of the pathways and interrelated biological, social, cultural and environmental determinants that affect health and health equity.

Health equity considerations also have been embedded into CIHR's project funding mechanisms, including requiring all applicants to identify how sex (biological) and gender (socio-cultural) considerations are integrated into their research proposals. An explanation is required if sex and/or gender are not considered applicable to the research design. As well, many calls for research proposals require partnerships with individuals or community groups to ensure that issues vulnerable groups face are addressed.

Another federal example is Health Canada's *First Nations and Inuit Health Strategic Plan: A Shared Path to Improve Health*. One of the Plan's objectives is to "create appropriate linkages among First Nations and Inuit Health Branch (FNIHB) programs and services with those of other federal departments to support a population health approach and a whole-of-government approach to the social determinants of health." This approach is expected to result in better health outcomes over the long term, paying particular attention to women, children and youth.

At the provincial level, when AHS introduced its *Promoting Health Equity Framework* to staff and senior leadership, careful planning and strategic communications helped to increase buy-in and endorsement. Front-line staff members were pleased to see a dedicated team, resources, and support to help them address equity issues. When the Health Equity team presented the strategy to senior management, the message was framed to appeal to a management perspective .

The AHS *Health Plan and Business Plan 2013–2016* explicitly identifies consideration of health equity as an objective in service planning and delivery. The *Health Equity Action Plan 2013–2016* was developed in alignment with that plan and identifies focused actions that contribute to strategic directions. Strategically positioning this work with organizational priorities was instrumental in getting initial internal buy-in and building momentum to support its implementation.

3.2.2 Legislation

Legislative mechanisms are powerful levers to ensure that policies addressing health equity will be implemented, and there are Canadian examples that illustrate how legislative levers can be used in this way. For example, in 2010 the Province of Ontario passed the *Excellent Care for All Act*[9], which includes equity indicators in the annual quality improvement plans required of health care providers. Executive compensation for all Ontario health care organizations is linked to the achievement of planned targets.

In Québec, the *Public Health Act* (2001) specifies that the Ministère de la Santé et des Services sociaux (Ministry of Health and Social Services, or MSSS) shall "focus, insofar as possible, on the most effective actions as regards health determinants" and especially "actions capable of having an influence on health and welfare inequalities in the population and actions capable of decreasing the risk factors affecting, in particular, the most vulnerable groups of the population."[10]

Section 54 of that Act also empowers the Minister of Health and Social Services to provide advice proactively to other government ministers to ensure the health and welfare of the population are considered in their policy initiatives. As a result, since 2002, all draft legislation and regulations in Québec that are expected to have a significant impact on health must undergo a health impact assessment (HIA). The ministry or agency preparing the legislative proposal is responsible for carrying out the HIA, with the MSSS providing requisite tools, guidance, and technical support.

Preliminary assessments of the implementation of Section 54 identified a need for stronger knowledge translation, and training on the determinants of health and HIAs for ministries for which these concepts are new. Since Section 54 was introduced, acceptance of the HIA requirement has increased, initially among ministries with a social mandate (e.g. education, culture) but increasingly among those with an economic focus.[11]

3.2.3 Alignment with community values

Individuals consulted for this paper noted that frontline workers in public health program and service delivery need to understand their communities to guide effective action on health equity and the social determinants of health. Such an understanding includes detailed awareness of a community's values, opinions, norms, needs, and strengths to point to initiatives that are most likely to garner support and engagement. Familiarity with community organizations already active in advancing health and social equity can also help to identify partners and opportunities for coordination and collaboration.

For example, Saskatoon Health Region has moved quickly to advance action on health equity and determinants of health through its internal operations and engagement with other sectors. This has been achieved by analyzing the region's health inequities and collaborating closely with the community.

The team in Saskatoon consulted with community organizations before releasing its *Health Disparity by Neighbourhood Income* study.[6] It recognized that the findings of inequities in health status could be shocking and that community organizations would be engaged in how to address them. The Saskatoon Health Region also conducted a survey of 5,000 Saskatoon residents, recognizing that public opinion data can have a strong influence on decision-makers' priorities for action. The survey showed that many residents were unaware of the magnitude in health differences between income groups in their city. Once informed, most expressed the opinion that even small inequalities were unacceptable. They also voiced strong support for interventions to address health inequality, particularly among children.

Measuring public and community sentiment regarding health inequity allowed Saskatoon Health Region staff to build on the spirit of collaboration and innovation on health issues, and is considered a factor supporting their ongoing and sustainable success.

3.3 CAPACITY

3.3.1 Staff knowledge and skills

In the consultations for this report, public health leaders reinforced the need to build knowledge and capacity of staff in health sector organizations in the following areas:

- the extent, nature, and drivers of health inequalities,
- how health inequalities can be addressed through policy and program interventions, and
- how health equity considerations can be integrated systematically into their work.

Several Canadian jurisdictions have found innovative ways to strengthen these knowledge areas and skills among staff through training. In addition, organizational capacity can be strengthened through structures that dedicate staff resources to health equity. This can be achieved in a variety of ways, as is demonstrated in the following examples:

- In the province of Quebec, the region of La Montérégie developed and delivered detailed public health training to senior managers responsible for public health, following changes made in 2005 to integrate health service delivery into larger organizations devoted primarily to health care.[12,b] The training program has been adopted by Québec's provincial public health agency and aims to enable a province-wide population-health perspective incorporating health equity into service delivery.
- In 2008, the Province of Ontario's *Public Health Standards*[13] state that addressing the determinants of health is fundamental to its public health work. The province provides funding for each of Ontario's 36 health regions to hire two full-time specialist public health nurses to support priority populations identified through surveillance and assessment, and to address the program/service needs of specific populations negatively affected by determinants of health.

[b] This example is used as one of four case studies developed by the National Collaborating Centre for Determinants of Health to support a workshop hosted in partnership with Canadian Institutes of Health Research's Institute of Population and Public Health. For more information, visit: www.nccdh.ca/blog/entry/casestudy-news.

- In the City of Toronto, Ontario, the health equity team is situated in the office of the Medical Officer of Health, signaling the importance of equity issues. In addition, members of the Toronto Board of Health—which determines public health policy and advises City Council on health issues—receive equity health training. The Sudbury and District Health Unit positions health equity specialists on the frontlines to ensure work is driven by community needs.
- In Alberta, AHS has engaged health equity strategists who consult within central planning areas. They provide the organization with the capacity to better understand the needs, assets and perspectives of communities; embed health equity perspectives into planning; and strengthen the ability to deliver appropriate and sustainable health services.

Partnerships between health sector organizations and research institutes have also opened doors to health equity training for health practitioners in various regions. While they take different forms, the goals and outcomes are similar: to advance health equity and create healthier communities. Examples of jurisdictions engaged in research partnerships include the Sudbury and District Health Unit in northern Ontario[14] (see Box 2), the Territory of Nunavut, and the regional health unit in Antigonish, Nova Scotia.

BOX 2: 10 PROMISING PRACTICES TO GUIDE LOCAL PUBLIC HEALTH PRACTICE TO REDUCE SOCIAL INEQUITIES IN HEALTH

1. Targeting with universalism
2. Purposeful reporting
3. Social marketing
4. Health equity target setting
5. Equity-focused health impact assessment
6. Competencies/organizational standards
7. Contribution to evidence base
8. Early childhood development
9. Community engagement
10. Intersectoral action

SOURCE: Sudbury and District Health Unit, 2011

3.3.2 Health equity resources and tools

Significant activity is taking place in Canada to use, adapt or develop tools to support the routine consideration of health equity in program and policy.

AHS is enhancing existing planning tools to include an equity lens in determining priorities and services throughout its operations. A priority-setting tool will be used to integrate health equity into zone, strategic, and program planning. In this manner, health equity considerations are expected to be embedded in planning rather than being treated as a separate work stream. For example, a health equity lens will be applied to the intake process in health care delivery so that clients using emergency services frequently can be assessed on their living conditions and access to a family physician. Those in need can then be connected to community-based services to reduce or eliminate ongoing visits to the emergency department. In this way, health equity can be addressed in parallel with health system goals to improve efficiency in emergency healthcare services.

Health Equity Impact Assessment (HEIA) tools are being used in a range of contexts, including:

- In Toronto, integrating health equity considerations in planning and service delivery in hospitals;
- In Manitoba, prioritizing population groups for vaccine access as part of their pandemic H1N1 influenza response;
- In Alberta, serving as the basis for discussions about health equity with staff and community members and helping shape local priorities and plans around health equity.

The National Collaborating Centres (NCCs) for Healthy Public Policy and Determinants of Health have produced a guide entitled *Tools and Approaches for Assessing and Supporting Public Health Action on the Social Determinants of Health and Health Equity*.[18] This reference guide describes resources such as checklists, lenses, and HEIA tools to assess conditions that create health inequities and develop services to reduce them.

3.3.3 Capacity within priority populations

Dedicated human and financial resources support community capacity by empowering better planning, delivery, and monitoring of health services. Health Canada and the Public Health Agency of Canada have a number of programs that address the health of vulnerable populations and empower self-directed action on health equity.

Some First Nations, Métis, and Inuit communities experience poorer health status than non-Aboriginal Canadians. Related factors include colonization, intergenerational trauma and resulting marginalization. While far from resolved, efforts are being made and incremental gains seen in community self-governance.

For example, at the national level, the Health Portfolio has collaborated with the Assembly of First Nations and the Inuit Tapiriit Kanatami (the national First Nations and Inuit representative organizations in Canada, respectively) to jointly explore issues of mutual interest to advance First Nations and Inuit health.

There is an ongoing need in some First Nations and Inuit communities for improved services and trained health professionals, researchers and health program managers. The challenges of community development, capacity building, and empowerment within these communities are often compounded by complex intergenerational trauma. These realities call for a unique approach guided by indigenous principles of community-centeredness and leadership, a holistic view of health and wellness, and cultural competence, among others.

At the provincial level, British Columbia's First Nations Health Authority represents an innovative health care governance model. The first of its kind in Canada, it is expected to enable First Nations to control and administer their own health programs and services (see Box 3).

BOX 3: THE BRITISH COLUMBIA FIRST NATIONS HEALTH AUTHORITY

The move towards a First Nations Health Authority was first outlined in the 2007 *British Columbia Tripartite First Nations Health Plan*, which described a new governance approach for the delivery of health services to First Nations in BC. In October 2011, the Government of Canada, Province of British Columbia (BC), and BC First Nations signed the *British Columbia Tripartite Framework Agreement of First Nation Health Governance*. This agreement creates a new health governance structure under which the BC First Nations Health Authority plans, designs, manages, and delivers health programs for First Nations in BC. This is consistent with evidence that cultural continuity, including control of service provision on reserves, is associated with better health on reserves. This agreement transfers federal responsibility for planning, design, management and delivery of First Nations health services and programs to the new First Nations Health Authority, and build a more integrated health system for First Nations in BC.

Under this new arrangement, funds will be transferred from federal and provincial sources to the First Nations Health Authority. The new structure will incorporate First Nations knowledge, beliefs, values, practices, medicines and models of health and healing to support culturally competent care for BC First Nations people. It will also carry out research and policy development in the area of First Nations health and wellness. The new governance model is expected to build a more equitable health system, with a focus on addressing the overall determinants of health.

See www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2011/2011-133bk-eng.php

4. ESTABLISH AND USE A STRONG KNOWLEDGE BASE

The World Health Organization (WHO) Commission on Social Determinants of Health has referred to knowledge, monitoring and skills as the "backbone of action" on health problems and health inequities.[15] This chapter describes the roles of various levels of government in establishing and using knowledge and evidence on health equity.

4.1 SURVEILLANCE AND MONITORING

In Canada, many jurisdictions are building and supporting the case for action for health equity by gathering clear, detailed and comparable data which reveal the size of and trends in health inequalities. Interviewees noted that documenting evidence within each jurisdiction can be key to giving the issue increased attention.

For instance, in 2008 the Canadian Institute for Health Information's Canadian Population Health Initiative (CPHI) published a report that assessed gaps in health in 15 urban centres in Canada.[17] It served as a catalyst for action in Winnipeg, Regina, Edmonton, Halifax and other communities. For example, in Winnipeg, locally relevant, comparative health data helped public health leaders strengthen ties with anti-poverty and other community organizations, and served to raise the profile of health inequity with senior management within their health region.

Regular health status reports form the basis for evidence regarding health inequalities in a number of jurisdictions in Canada. For example, regular monitoring and reporting on health and social inequities in Montreal have helped to support efforts to calm traffic in certain neighbourhoods and defeat plans for building a casino in a disadvantaged community. In Alberta, AHS public health staff used existing data documenting health inequalities, along with other research products, to build support among senior management for its *Promoting Health Equity Framework*.

Some organizations have sought to fill knowledge gaps by creating their own research infrastructures. Over the past 10 to15 years, Saskatoon Health Region and its Public Health Observatory have built up sufficient research capacity to enable the two organizations to carry out both ongoing health surveillance and focused research. Augmented by consultations with government agencies and community organizations, this capacity allows them to generate the evidence base needed to support policy development and advocacy efforts.[6]

At the federal level, the Public Health Agency of Canada is working in partnership with the Canadian Institute for Health Information and Statistics Canada to develop a report on health inequalities to serve as a baseline to monitor related trends in Canada. The report will draw on a set of indicators of health inequalities developed by the Pan-Canadian Public Health Network, as discussed in 3.1.2 above.

Similarly, Health Canada supports the First Nations Regional Health Survey (RHS), a longitudinal study which gathers information about the health, wellness and health determinants of people living in First Nations communities across Canada. The survey fills a data gap pertaining to the health of First Nations people living on reserve who have been inadequately reached by or excluded from major national and regional health surveys in the past. It is fully directed and controlled by First Nations, and is guided by a Cultural Framework that ensures that data are collected, interpreted, and presented in a manner consistent with First Nations' holistic understanding of health and well-being and ways of seeing, relating, knowing and being. Data from its first two phases in 2002/03 and 2008/10 have been published in reports available from the First Nations Information Governance Centre.[c]

4.2 RESEARCH TO INFORM ACTION

Increased efforts are being made within and across sectors to create a more robust and collaborative research and policy community that focuses on health equity as well as mentoring to build capacity in the next generation. Better links across the research, policy and practice communities are contributing to richer capacities to undertake and use research. Such partnerships have led to improved knowledge and action on health literacy in Nova Scotia, homelessness in Manitoba, food security in the Yukon, transportation in New Brunswick, and effective public health interventions in Québec, for example. The CIHR's Institute of Population and Public Health and the CPHI also published a *Population Health Intervention Research Casebook* that describes collaborations in population health intervention research.[16]

The federal Health Portfolio supports research, knowledge development and knowledge exchange to better understand the nature of health inequalities and identify what works to advance health equity and in what contexts. For example, the Public Health Agency of Canada's Innovation Strategy funds community-led projects that apply proven and promising population health interventions for children, youth and families in different contexts and with different populations, such as recent immigrants, Aboriginal peoples, and families living on low incomes. Projects to date focus on healthy weights or mental health promotion, and must demonstrate how they expect to contribute to reducing health inequalities. Funding proposals are evaluated in part on considerations given to health inequalities and/or how health equity may be improved in the design and adaptation, implementation and delivery, "scaling up," and evaluation stages of their projects (see Box 4).

[c] RHS results are published online here: www.rhs-ers.ca/node/6

BOX 4: THE GOVERNMENT OF CANADA INNOVATION STRATEGY—PROMOTING HEALTH EQUITY IN INTERVENTION RESEARCH

In 2010, the Innovation Strategy launched an open call for project proposals under the theme of *Achieving Healthier Weights in Canada's Communities (Phase 1)*. To support the application of sex- and gender-based analysis (SGBA) and related health equity concepts to these projects, the invitation to solicit proposals for project funding included:

- information on how obesity and related risk factors varied by multiple determinants of health,
- a guide for application of SGBA to community based programs, and
- encouragement to consider sex and gender in project and proposal development.

An analysis of how those proposals considered SGBA and health inequalities was used to guide program administrators as well as community-based project recipients in applying SGBA and health equity considerations to community-based programs. Also, SGBA was added as one of the rating criteria against which proposals for Phase 2 of *Achieving Healthier Weights in Canada's Communities* were assessed for potential further investments.

Work is now underway to build sex, gender and equity into the operating guidance documents for community-based programs funded across the Health Portfolio.

See www.phac-aspc.gc.ca/ph-sp/fund-fonds/index-eng.php

CIHR's *Pathways to Health Equity for Aboriginal Peoples* program, announced in 2012 as a Roadmap Signature Initiative, funds research projects aimed at increasing understanding of how to implement and scale up interventions and programs to improve health equity across diverse Aboriginal communities. It is co-led by the Institute of Aboriginal Peoples' Health, the Institute of Population and Public Health, and the Institute of Gender and Health. The initiative focuses on four specific areas identified as priorities by Aboriginal communities and federal/provincial/territorial governments: suicide, tuberculosis, oral health, and diabetes. Funded projects will be co-led by researchers and community-level knowledge users, including Aboriginal community participants.

In the short-term, *Pathways to Health Equity for Aboriginal Peoples* is expected to:

- increase capacity for Aboriginal communities to identify and resolve health issues,
- foster effective and equitable partnerships across disciplines and sectors, and
- use indigenous knowledge and ways of knowing to advance health, well-being and resilience of Aboriginal peoples.

In addition to their other investments, in 2011 CIHR's Institute of Population and Public Health (IPPH) invested in programmatic grants on health equity. Eleven teams have been supported to undertake population health intervention research, including research on implementation systems orientation. All projects have a focus on health equity in Canada and/or in lower-middle income countries.

The IPPH also supports research chairs in applied public health in partnership with the Public Health Agency of Canada, the Centre de recherche en prévention de l'obésité, le Fonds de recherche du Québec—Santé, the Québec Ministry of Health and Social Services, and the Heart and Stroke Foundation of Canada. It is investing $15 million over five years to support program and policy intervention research relevant to national-level public health. The investment also aims to foster formal linkages with the public health system to support the timely and effective application of research into policies, programs and practice. There are currently 13 Applied Public Health Chairs, many of whom focus on advancing health equity. The IPPH and the Public Health Agency of Canada are currently planning the next phase of the Applied Public Health Chairs program.

4.3 KNOWLEDGE TRANSLATION AND EXCHANGE

The Public Health Agency of Canada funds six NCCs to support effective knowledge translation and exchange across Canada. These NCCs serve as vehicles for translating public health research into practice.

For example, the NCCDH advances knowledge on the social determinants of health with a strong focus on health equity. It produces evidence summaries and reviews, and organizes workshops, webinars, forums and presentations. One of its key roles is to connect health equity researchers, planners and practitioners across Canada to facilitate knowledge exchange and experiences in implementing health equity plans. Two other centres, the NCC for Aboriginal Health and the NCC for Healthy Public Policy, also incorporate a strong emphasis on equity into their work.

In 2006, the Public Health Agency of Canada launched the Canadian Best Practices Portal (CBPP), a web-based resource to improve policy and program decisions by enabling access to the best available evidence on chronic disease prevention and health promotion practices. The portal contains more than 370 community-based and population health interventions, including interventions focusing on key determinants of health and health inequalities such as income or gender; and or populations of interest such as Aboriginal populations. Efforts are underway to expand the CBPP's inventory of population health interventions that are effective in addressing health equity and the social determinants of health.

4.4 PERFORMANCE MEASUREMENT AND EVALUATION

In order to advance health equity, it is important to measure results. AHS participants noted that health equity could become a key influencer of performance measures in all AHS' service delivery plans. For example, AHS' 2013–2016 Health and Business Plan will be measuring the percent of complex or high needs populations attached to a primary health home as one indicator of bringing appropriate care to the community for populations that experience barriers to health care in Alberta.

In the Northwest Territories, health departments are measuring equity performance as documented by health status reports that track health outcomes and the determinants of health. Vancouver Coastal Health Authority is using a "balanced scorecard" to measure quality of care and "care of our communities", including a focus on determinants of health.

Program evaluations play an important role in targeting health programs where they are most needed. For example, in the Yukon Territory, an evaluation of a tobacco cessation program revealed it had much greater uptake in urban versus rural communities. That finding led to a systematic approach, using an equity tool, to determine a better way to address smoking cessation in rural areas.

Similarly, immunization rates in the Saskatchewan cities of Regina and Saskatoon are being compared on a monthly basis by nursing zone and neighbourhood, based on socioeconomic status. In the three years since it began monitoring immunization rates, the Regina Qu'Appelle Health Region has reduced by approximately 12 percent a gap in rates between two-year-olds in the highest versus the lowest income groups. In Saskatoon, since interventions were put in place in 2007, the gap between those living in the highest and lowest quintiles of deprivation has been reduced by over one-half (from 30 percent down to 12 percent). Both jurisdictions continue to work to reduce the remaining gaps.

5. COLLABORATE WITH NON-HEALTH SECTOR PARTNERS

A key role of the health sector is to "engage with other sectors in health disparities reduction."[1] The WHO considers the engagement of other ministries and government agencies "an essential responsibility" of the health sector.[19] It notes that many other government departments and non-governmental groups must be involved in sustainable efforts to reduce health inequities, including groups dealing with income distribution, poverty reduction, education, and housing. Structures that support intersectoral action can facilitate collaboration and help public health practitioners influence action on health equity.

5.1 STRUCTURAL SUPPORT

At the national level, the Canadian Council on Social Determinants of Health (CCSDH) serves as a collaborative, multisectoral stakeholder group with a mandate to provide the Public Health Agency of Canada with advice relating to the implementation of the *Rio Political Declaration on Social Determinants of Health*. The CCSDH is also a key structure for facilitating and leveraging action on the social determinants of health through its member networks and targeted, intersectoral initiatives. It has representation from various levels of government (federal, territorial and municipal), civil society, Aboriginal peoples, business, employers, labour, and academia. It is co-chaired by the Public Health Agency of Canada and a non-governmental organization.

Similar structures can be found at provincial and regional levels. For example, the Province of Saskatchewan funds 10 multi-jurisdictional regional intersectoral committees to improve integration and delivery of human services. The Saskatoon Regional Intersectoral Committee (SRIC) has acted successfully to reduce health inequities in that city. Its 30 members represent four municipal departments, seven provincial ministries, two federal agencies, researchers, Aboriginal organizations and a dozen community-based groups. All are senior members of their organizations, with decision-making powers to address intersectoral issues to improve health and well-being.

SRIC coordinates linkages that influence policies, programs, and resource deployment, and can help to jumpstart early collaboration. For example, when Saskatoon Health was preparing its population health status report for public release, public health staff presented the data first to the SRIC. This gave members of the SRIC an opportunity to review together their past actions and future plans on health equity. Several played key roles in facilitating ongoing dialogue and encouraging other organizations to get involved in developing solutions.

Health sector officials are increasingly involved in provincial and regional intersectoral committees to address poverty, homelessness, crime, or other deep-rooted social challenges. A key general lesson drawn from these intersectoral experiences is that careful assessment is needed to determine the value the health sector's involvement can add. Public health has often played a strong leadership role. For example, the Saskatoon Health Region co-chairs the multi-sectoral Saskatoon Poverty Reduction Partnership with the United Way. In other instances, the health sector has played a more supporting role. For example, in Québec and Nova Scotia, the

health sector is one of many partners on the interministerial committees responsible for guiding the implementation of provincial poverty reduction strategies. As a regional level example, the Guysborough Antigonish Strait Health Authority in Nova Scotia has made significant contributions to the development and implementation of the Antigonish Poverty Reduction Coalition's five-year action plan. The plan aims to improve transportation, food security, income security, education, health services and other key determinants of health.

5.2 ENGAGEMENT OF COMMUNITY PARTNERS AND STAKEHOLDERS

Numerous jurisdictions have learned that engaging communities through consultations, collaborations, and/or programmatic partnerships helps forge links for effective action (see Box 5 for a description of the Canada Prenatal Nutrition Program, a federal example). For example, success in establishing a social inclusion strategy in the Yukon Territory has been attributed to community involvement and citizen advocacy. One particularly visible and reputable community group was central to involving the public to guide the development of research and strategy to reduce poverty. In the Province of Newfoundland and Labrador's Western Health Region, access to healthy food emerged as a concern, with poor food quality, limited selection and affordability identified as barriers. Members of a community advisory committee recommended a strong leader with an interest in community gardens and found someone willing to donate land. Health promotion staff contributed ideas for local alternatives to fresh fruits and vegetables, with options for healthy foods on a lower budget, such as wild game. Volunteers will be asked to provide the labour required when the project begins. Health promotion staff noted that when residents contribute to the solution of a community issue, they have a vested interest in making it succeed.

BOX 5: THE CANADA PRENATAL NUTRITION PROGRAM

Since 1995, the Canada Prenatal Nutrition Program (CPNP) has helped communities to provide health and social supports for pregnant women and new mothers facing poverty, teen pregnancy, lack of social support, alcohol or substance dependency, or other challenging circumstances that put their health and the health of their infants at risk. Working in partnership with community health and social service organizations, the CPNP contributes to reduced health inequities by investing in improving rates of normal birth weight and initiating breastfeeding among participating vulnerable women. It currently operates roughly 330 projects in over 2,000 communities, serving approximately 50,000 women per year.

In 2009, the CPNP was evaluated for its impact on maternal health behaviours and birth outcomes and infant health.[5] Findings revealed that women who were highly involved in CPNP projects were more likely to:

- reduce the number of cigarettes smoked,
- quit consuming alcohol,
- consume prenatal vitamins,
- give birth to a full-term, healthy weight infant,
- initiate breastfeeding and breastfeed longer.

See www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/cpnp-pcnp/evaluation-eng.php

Often the private sector can also play an important role. For example, in Nunavut, the public health coordinator addressed a food security issue by establishing relationships with local food retailers largely through face-to-face contact with local staff. These efforts led to a number of initiatives to promote healthy, affordable eating such as providing food discounts, in-store taste-tests, and recipes.

The media can be a strong ally in equity work. In Montreal, when asked how the news media perceive that city's annual reports on health disparity, editorial staff said the reports are "crucial as a credible source of information." The media can help facilitate better understanding of equity issues by the public, which is important to the democratic process.

A common lesson learned by many public health sector organizations is that clear language about public health is important for communicating both to stakeholders and the public. For example, Vancouver Coastal Health's programs have had greater acceptance when "equity" language is not used. In Sudbury, Ontario a video created by the Sudbury and District Health Unit entitled *Let's Start a Conversation About Health…and Not Talk About Health Care at All*, addresses equity without once using the words "equity" or "disparity". Instead the video uses simple terms and phrases like, "poverty = poor health" and "the more money you have, the healthier you are" (see Box 6).

BOX 6: *LET'S START A CONVERSATION ABOUT HEALTH … AND NOT TALK ABOUT HEALTH CARE AT ALL*

The Sudbury and District Health Unit (SDHU) created *Let's Start a Conversation about Health … and Not Talk About Health Care at All*—as a tool to raise awareness among community decision-makers about the broad factors that influence health. The video and user guide contain five main messages:

1. Health improves at every rung up the income and social ladder.
2. Everyone has different opportunities for health, largely influenced by their social and economic conditions.
3. Social and economic conditions are the result of actions we can all take. Individually and collectively, we can make decisions and choices that are good for our communities and our health.
4. Health care alone cannot fix our problems.
5. We all have a role to play.

A staff evaluation of the program has helped SDHU identify ways to improve ongoing use of the video and guide. They plan to continue to use the tools to reach non-health sectors in the community to highlight health inequities and provide tangible examples of tools and actions that can help reduce those inequities. Evaluation results have also identified opportunities to further challenge common community misperceptions about members of priority populations and to include them in ongoing planning processes.

Over 21 other health organizations from across Canada and internationally have since adapted the video to their own context.

See www.sdhu.com/content/healthy_living/doc.asp?folder=3225&parent=3225&lang=0&doc=11749

The Saskatoon Health Region is well known in Canada for involving partners effectively in all aspects of its health equity work.[20,] From the beginning, community partners have been involved in decision-making processes to address health inequities. Recognizing that many organizations in Saskatoon had been working for a long time to address poverty and other social determinants of health and that community buy-in was key to effecting change, the Saskatoon Health Region team began its own health equity work by engaging over 60 governmental and non-governmental organizations.

In Saskatoon, productive collaboration with community members and other government partners was achieved through:

- *Respecting all participants*—The public health team recognized the valuable work already occurring across sectors in the community and built on existing bonds between individuals and organizations to create working relationships of trust, mutual respect, and accountability.
- *Creating conditions that allow all stakeholders to have a voice*—To be most effective, consultations were carried out to ensure the voices of community members were heard. Discussions were held in venues known to participants who were often invited by personal contacts from community organizations. Efforts were made to address barriers to participation, such as a lack of child care or transportation.
- *Involving people with lived experience*—From participatory research through to planning action on issues that affected them, personal experience was valued. Community-based organizations helped engage people living in disadvantaged situations in specific, meaningful roles.
- *Establishing common ground*—To begin consultations on a positive note, all parties were asked: "What do you agree with in the [*Health Disparity in Saskatoon: Analysis to Intervention*] report?"[21] Identification of common ground was deemed essential for collaboration.
- *Considering timing*—Patience and tenacity were required to find the right timing and opportunities to effect change.

When advocating for action on health equity, the Saskatoon Health Region ensured it presented the evidence and a proposed way forward in a manner that resonated with key audiences, by:

- ensuring recommendations were made with the input of partners from many sectors,
- tailoring the language of health equity to fit the audience being addressed (e.g., "a healthy community" or "creating prosperity"),
- holding technical briefings with editorial boards and journalists prior to the release of key reports to provide the media with context and guidance for interpreting the research, and
- humanizing the issue of health equity when engaging with decision-makers and the public through the use of stories and images alongside the empirical evidence.

6. SUMMARY OF WHAT WE HEARD

Integrating health equity into an organization is a gradual, iterative process, the pace and success of which can be affected by barriers and challenges. This section captures some key observations by participants about challenges as well as factors and approaches that may enable, accelerate, or facilitate the advancement of health equity approaches.

CHALLENGE	APPROACHES /FACTORS THAT MAY ENABLE PROGRESS
FOUNDATION *The scope of the endeavour:* The breadth of action required to advance health equity can seem overwhelming.	• Strong, sustained leadership enables organizations to dedicate the time and resources and maintain the long-term view required for effective action. Leaders may be formally designated and supported or informal, self-driven champions. Leadership can be nurtured in a number of formal and informal ways, such as mentorship and training. • Health equity integration calls for a culture change in how health sector organizations and governments operate.
Capacity limitations: Integrating health equity at an operational level requires new skills, tools and capacities. Retaining trained staff in remote areas is also a challenge.	• To reduce the burden (real and perceived) on staff and minimize turnover, resources must be in place to support appropriate training and capacity building. • Structural approaches that allocate resources to dedicated staff to focus on health equity (whether centrally or in program areas) also builds capacity. • Universities and research organizations also play an important role in training staff, as well as developing and translating research into practice.
Organizational structure: Administrative structures that separate public health from health care can create barriers between health and social services. Incentive structures may also operate against certain kinds of research and intersectoral work.	• Ongoing efforts are needed to further promote and incorporate health equity and social determinants of health in the design and delivery of health care services. • In some cases mechanisms may be in place to support collaborative work, but are underused due to a lack of awareness or an assumption that new ways to address issues are needed. Promoting those mechanisms could yield results.
Fiscal constraints: Fiscal pressures can limit efforts to implement and mobilize a health equity agenda within organizations and regions. Intense collaborative work can be a significant financial burden, particularly for small organizations.	• Positioning health equity as a 'way of doing business' and a way to more effectively achieve existing goals can help. • Demonstrating the value of applying a health equity lens can help. Starting small and/or aligning health equity integration work with priority health issues can also strengthen support.

KNOWLEDGE BASE *Data limitations:* A health equity approach relies on access to accurate data at each jurisdictional level, but such data are not always available.	• Access to data at the neighbourhood level, as well as data for First Nations and Inuit populations, may be found particularly meaningful and practical so consideration could be given prioritizing them, depending on the context.
Lack of supportive tools: Tools that have been tested for effectiveness in different settings are needed to support implementation.	• Health equity teams need to work with staff to pilot, adapt or even develop new tools that will work for all groups across the continuum of care, in various settings and at all management levels. They should be prepared to demonstrate how applying the tools can result in positive changes to program, policy and research.
COLLABORATION WITH NON-HEALTH SECTOR PARTNERS *Competing agendas:* Each organization involved in multi-sectoral approaches has its own agenda and priorities. The challenge is to find common ground and position efforts to promote health equity as contributing to everyone's work.	• It is recognized that different approaches will be required to frame health equity messages to ensure they resonate with various audiences such as health practitioners, clients, media and the general public. At AHS, considerable time was taken to develop a glossary of terms to ensure that health equity language and definitions were understood by members of its senior leadership team. • A solid grasp of the external context (i.e. public and community organizations' views) paves the way to work with partners in a participatory, respectful way.
Communication and engagement: The complexities of health equity and social determinants call for active and reciprocal communication and engagement with many actors, which can be challenging to coordinate.	• A range of communication modes, from community meetings and the use of social media to one-on-one conversations, may be needed to meet everyone's needs, including varying literacy levels. • Engagement practices that involve populations (including Aboriginal peoples) living in conditions of vulnerability in decision-making may provide the cultural continuity important to improving health outcomes.
Imbalance of power: Power differences and dynamics—either within governments, across government and non-government sectors, or within communities need to be acknowledged and effectively managed.	• To avoid having community-based organizations feel overwhelmed by larger health organizations, have various partners lead different initiatives while ensuring necessary supports are in place. Partners can share the spotlight in announcements, and the broader community can be involved in developing action plans.
Managing diverse expectations: Some staff and community partners may want to move forward more quickly than others are able to support.	• To implement processes effectively and efficiently, health equity teams need well-articulated implementation plans to keep staff and partners focused on immediate goals while sustaining a coherent approach to achieve the long-term objectives.

7. CONCLUSION

In this paper, experiences of Canadian health sector organizations in advancing health equity within and beyond the health sector have been described and synthesized, in the hope that individuals working in health sector organizations who want to accelerate their progress in reducing health inequities will benefit from this knowledge.

This report demonstrates how some health sector actors in Canada have recognized health equity as an important consideration, and found ways to integrate these considerations in guiding their priority setting, programming and evaluation. At all levels of government, there are examples of health sector organizations that are continuing to develop and use a range of health equity mechanisms and structures, build capacity to generate and use research data and knowledge, and partner across sectors with diverse stakeholders and allies. Despite differences in how health systems are organized, most jurisdictions are implementing forms of intersectoral and cross-government approaches to reduce health inequities.

In Canada, public health normally leads in advancing the formal goal of health equity, but it may be most successful when it can advance both public health and other government priorities simultaneously. Given that many of the levers affecting determinants of health lie outside the health sector, it cannot expect to accomplish everything on its own, nor all at once. Instead, the health sector will have optimal impact if it determines where to focus its efforts, demonstrates the value it adds to the process, and works together with other sectors to improve the lives of all Canadians.

APPENDIX A—METHODOLOGY

This Appendix provides additional detail of the project activities to supplement the methodology overview provided in section 1.2.

PAN-CANADIAN SMALL GROUP DISCUSSIONS:

PURPOSE:

Four two-hour pan-Canadian small group teleconferences were held:

- To gather information and insights from a cross-section of federal, provincial/territorial, regional, and municipal health sectors across Canada about experiences in integrating health equity perspectives, tools, resources and capacities within their organizations' policies, programs, and practices as well as the broader health sector; and to identify common barriers to and enablers of successful health equity integration; and
- To strengthen existing networks and knowledge exchange among public health practitioners from across Canada.

PREPARATORY MATERIAL PROVIDED TO TELECONFERENCE PARTICIPANTS:

The following sample questions were provided in advance to teleconference participants:

- Please tell us about your experience in integrating health equity into policies, programs and practice within public health, including with the wider health system. You will each have about 4 minutes to introduce the approach your organization is pursuing. Think about one or two specific examples that describe your broad approach.
- What challenges did you encounter in the process of integrating health equity, and how did you deal with these challenges?
- To what extent, and how, did you involve community organizations/NGOs, the general public, other government departments and jurisdictions, and/or other stakeholders? Please describe that experience. Did it go as you expected?
- What would you say are your accomplishments in integrating health equity and what were the critical success factors?
- What other lessons did you learn that would be helpful to others (including an international audience)?

The following blank table was also provided to participants to encourage them to reflect on their experience and knowledge in advance of the teleconference:

EXAMPLES OF HEALTH EQUITY INTEGRATION				
	How has leadership, governance, and priority-setting influenced your…	How has capacity building, tool and resource development played a role in your…	How have intersectoral, government stakeholders, and community engagement informed your…	How have monitoring, reporting and knowledge translation activities supported your…
Policies				
Programs				
Practices				

The teleconferences were audiotaped for the purposes of note taking and the identification of emergent themes.

SMALL GROUP TELECONFERENCE PARTICIPANTS:

Efforts were made to include representatives from as many provinces and territories as could participate as well as a mix of jurisdictional levels and organizations at different stages of health equity integration. Additional participants were selected from health organizations in rural, remote and northern regions of the country.

One or more individuals from the following organizations participated, varying in level and role from Chief Medical Officer of Health to front line service provider:

- Population Health, Vancouver Coastal Health, British Columbia (local, large urban)
- Ministry of Health British Columbia (provincial government)
- Government of Northwest Territories (territorial government)
- Department of Health and Social Services, Government of Yukon (territorial government)
- Population and Public Health Services, Regina Qu'Appelle Health Region (local, mid-sized urban)
- Population Health Unit, Northern Saskatchewan Health Authorities (local, rural)
- Population Health Initiatives, Winnipeg Regional Health Authority, Manitoba (local, mid-sized urban)
- Healthy Equity Unit, Office of the Chief Provincial Public Health Officer, Manitoba Health (provincial government)
- Access & Equity, Toronto Public Health, Ontario (local, large urban)
- Community and Population Health Branch, Ministry of Health, Ontario (provincial government)
- Health Equity, Health Promotion Division Sudbury and District Health Unit, Ontario (local, small urban and rural)
- Institut national de santé publique du Québec (provincial institute)

- Centres de santé et de services sociaux de Montréal, Québec (local, large urban)
- Government of Nunavut (territorial government)
- Region 3, Government of New Brunswick (local, provincial government)
- Guysborough Antigonish Strait Health Authority (GASHA), Nova Scotia (local, rural)
- Western Health, Newfoundland (local, rural)

KEY INFORMANT INTERVIEWS:

Representatives from the following organizational units from the three featured health sector organizations participated in the in-depth key informant interviews. One teleconference meeting was held for each of the three organizations:

1. **Alberta Health Region**
   - Office of the Senior Medical Officer of Health
   - Population and Public Health
   - Aboriginal Health Program
   - South Zone
2. **Federal government Health Portfolio**

   Public Health Agency of Canada
   - Social Determinants and Science Integration Directorate, Health Promotion and Chronic Disease Prevention Branch
   - Strategic Policy and Ministerial Services Directorate, Health Promotion and Chronic Disease Prevention Branch

   Health Canada
   - Strategic Policy, Planning, and Information Directorate, First Nations and Inuit Health Branch

   Canadian Institutes of Health Research
   - Institute of Population and Public Health
   - Institute of Gender and Health
3. **Saskatoon Health Region**
   - Medical Health Officers
   - Public Health Observatory

PROJECT DIRECTION:

Throughout this project, an Expert Reference Group provided guidance, information, and feedback to the project scope, aims, strategies and activities in an advisory capacity. In addition, members suggested individuals and/or organizations for inclusion in the consultations and provided meaningful feedback on the teleconference discussion guide and revisions to the report outline and content.

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