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for Determinants of Health

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INTEGRATING SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY INTO CANADIAN PUBLIC HEALTH PRACTICE:

Environmental Scan 2010

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A four-member expert reference group provided strategic guidance to this project:

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EXECUTIVE SUMMARY

The National Collaborating Centres (NCCs) for Public Health were created to promote and improve the use of the results of scientific research and other knowledge to strengthen public health practices and policies in Canada. The NCCs identify knowledge gaps, foster networks and translate existing knowledge to produce and exchange relevant, accessible, and evidence-informed products with researchers, practitioners, and policy-makers.

The National Collaborating Centre for Determinants of Health (NCCDH) is one of six NCCs funded by the Public Health Agency of Canada (PHAC). The focus of the NCCDH is on the social and economic factors that influence the health of Canadians. The NCCDH's recent work has concentrated on early child development, particularly public health home visiting programs.

The NCCDH has requested this environmental scan to inform its future direction, priorities and activities through an analysis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health. A four-member expert reference group was established to provide strategic input into the conduct of the scan.

This environmental scan utilized four information gathering approaches: a focussed scan of the literature; 31 key informant interviews with practice and research experts; four focus group teleconferences to validate early emerging themes; and, an online survey with over 600 respondents. There was considerable convergence of the findings across the four information gathering approaches.

Public health interest and action on health determinants to reduce health inequities is reflected throughout public health's history including major public health concepts and reports of recent decades (e.g., Ottawa Charter, Reports on Health of Canadians, population health approach, etc.). Explicit expectations for action on health determinants are increasingly embedded within defining parameters of practice such as core public health program and accreditation standards.

Despite public health's more distant and recent history, public health action on broader health determinants is not widespread and may even be viewed as 'new'. Either the application of foundational concepts was never universally institutionalized throughout public health or enough time has passed and pressures exerted upon the public health sector that they have been lost. Even within early adopter organizations, action on determinants of health is still at a relatively early stage of implementation versus having been institutionalized throughout. A number of pervasive challenges are barriers to more widespread action. These include: the lack of clarity regarding what public health should or could do; a limited evidence base; preoccupation with behaviour and lifestyle approaches; bureaucratic organizational characteristics; limitations in organizational capacity; the need for leadership; more effective communication; and supportive political environments.

There are also a number of opportunities for achieving success. First, there is the past experience of successively addressing major society-wide challenges (e.g., sanitarians, tobacco control). Increasing evidence to inform

action will result from the Institute for Population and Public Health's (IPPH-CIHR) strategic focus on health equity-related research. Several public health organizations are taking action on health determinants and will thereby add to existing knowledge (i.e., 'learn by doing'). As evidenced by the interest in this environmental scan, there is considerable and widespread interest in action on health determinants within the public health community. There is also evidence of interest from many sectors across society.

In its initial years of operation, the NCCDH has mainly been focussed on specific health determinants or on particular interventions. The challenge with this approach is that the NCCDH risks being relevant to only a particular program area of public health organizations. Determinants also tend not to function in isolation, but to cluster. Individual public health organizations will choose priorities based on the local context, which may not align with the NCCDH's chosen focus. An alternative option would be to take a broader perspective on determinants as part of the population health approach. However, this would provide little guidance as to what the NCCDH should focus upon.

An alternative option is to focus the NCCDH's knowledge synthesis and translation efforts on supporting public health action on health determinants to reduce health inequities. Despite substantial improvements in the health of the public on average, there continue to be marked differences in health experiences among Canadians. Among public health staff, there appear to be misperceptions that a population health approach equates with targeting the 'general population'. Depending on the type of intervention, there are increasing concerns that some public health interventions may contribute to inequities.

Focusing on the reduction of inequities would provide a cross-cutting approach that could encompass multiple determinants and be relevant to public health organizations across the country. Such a focus would be consistent with the many international, national, provincial and local/regional reports that have highlighted the existence of inequities and recommended action. Several key informants stressed that what was required was for the NCCDH's focus to be less about specific determinants and more about critical thinking and reflective practice to incorporate consideration of inequities in all of the actions of the organization. Through a series of knowledge translation products and activities (e.g., evidence synthesis, frameworks, case studies, tools, training, etc.), the NCCDH can address a cross-section of determinants, issues, populations, and settings.

Overall, there appear to be four key roles for public health action on health determinants to reduce health inequities:

- **Assess and report** on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities/inequities.
- **Modify/orient** public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations (i.e., do planning and implementation of existing programs considering inequities).
- **Engage** in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs (i.e., when looking at the collectivity of our programming for 'x', where are the gaps?).

- **Lead/participate and support** other stakeholders in policy analysis, development and advocacy for improvements in health determinant/inequities.

There was widespread agreement regarding these roles for public health among key informants, focus group participants, and online respondents. Scan participants suggested a number of additional 'roles' that reflect approaches and areas for capacity building:

- Leadership
- Organizational and system development
- Development and application of information and evidence
- Education and awareness raising
- Skill development
- Partnership development.

A matrix of these two lists may assist public health organizations, as well as the NCCDH, to analyze gaps and identify opportunities for strengthening practice.

To achieve optimal impact on the field of public health, the NCCDH should become the 'go-to' hub for information and assistance on public health action on health determinants to reduce health inequities. It should be the lead source of current, quality, and relevant evidence and thinking in this area. It should synthesize

what we know, may know and do not know regarding health gradients, inter-relationships and pathways among determinants. It should capture and build on existing promising practices and ensure their learning and experience are integrated with existing evidence. Since public health action addressing health determinants to reduce health inequities affects all aspects of programming, the work of the NCCDH needs to be informed by a strong understanding of the public health practice context at individual, organization and system levels. Leadership is essential for establishing organizational action on health determinants including its influence on priority setting, allocation of resources, modeling desired behaviours, establishing strategic partnerships, and overseeing implementation. As such, public health leaders will require particular attention and support in the work of the NCCDH.

The action of the NCCDH needs to be strategic in order to increase linkages between the practice and research communities, particularly considering the synergy with IPPH's research priorities. Reflecting the cross-cutting nature of the work, the NCCDH should collaborate and coordinate with the other NCCs and to support consideration of inequities in their work.

The main body of this report discusses in more detail the implications for NCCDH priorities and actions and the appendices provide additional supplementary materials.

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LIST OF ACRONYMS

| | | | |
|--------|--|--------|---|
| BC | British Columbia | NCCEH | National Collaborating Centre for Environmental Health |
| CIHI | Canadian Institute for Health Information | NCCHPP | National Collaborating Centre for Healthy Public Policy |
| CIHR | Canadian Institutes of Health Research | NCCID | National Collaborating Centre for Infectious Diseases |
| CPHA | Canadian Public Health Association | NCCMT | National Collaborating Centre for Methods & Tools |
| CPHI | Canadian Population Health Initiative (CIHI) | OPHS | Ontario Public Health Standards |
| CPHO | Chief Public Health Officer (PHAC) | PATH | People Assessing Their Health |
| DOH | Determinants of Health | PBS | Public Broadcasting System (U.S.) |
| F/P/T | Federal, Provincial, Territorial | PHAC | Public Health Agency of Canada |
| HIA | Health Impact Assessment | PHO | Provincial Health Officer |
| INSPQ | Institut national de santé publique du Québec | RFP | Request for Proposals |
| IPPH | Institute of Population and Public Health (CIHR) | SDOH | Social Determinants of Health |
| MPH | Master of Public Health | SES | Socio-Economic Status |
| NCC | National Collaborating Centre | UPHN | Urban Public Health Network |
| NCCAHA | National Collaborating Centre for Aboriginal Health | WHO | World Health Organization |
| NCCDH | National Collaborating Centre for Determinants of Health | | |



Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010

INTRODUCTION

The National Collaborating Centres (NCCs) for Public Health were created “to promote and improve the use of [the results of] scientific research and other knowledge to strengthen public health practices and policies in Canada. They identify knowledge gaps, foster networks and translate existing knowledge to produce and exchange relevant, accessible, and evidence-informed products with researchers, practitioners, and policy-makers.”¹

National Collaborating Centres for Public Health

- » Aboriginal Health (NCCAHA)
- » Environmental Health (NCCEH)
- » Infectious Diseases (NCCID)
- » Methods & Tools (NCCMT)
- » Healthy Public Policy (NCCHPP)
- » Determinants of Health (NCCDH)

Six NCCs were established across Canada, each with a particular area of focus (see box). According to its website, the NCCDH “focuses on the social and economic factors that influence the health of Canadians.”² The NCCDH’s recent work has concentrated on early child development, particularly public health home visiting programs.³

The primary audiences for the NCCs are public health decision-makers, practitioners and researchers. While there are many other sectors with an interest in, and ability to influence health determinants, the focus of the NCCDH is on how best to support, through knowledge synthesis and translation, the practice of its public health audiences as they engage and partner with these other sectors.

The NCCDH has requested this environmental scan to inform its future direction, priorities and activities through an analysis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health. The specific deliverables stipulated in the NCCDH’s request for proposals (RFP) are listed in Appendix 1. It should be noted that this scan is not intended to be a review of the past work of the NCCDH nor is it to develop the NCCDH’s future strategic or implementation plans – although it is expected that the scan’s findings will be used to inform these subsequent planning steps.

Subsequent chapters of this report outline the environmental scan’s methodology (2), findings (3), analysis and implications (4), and next steps (5). The appendices provide a list of acronyms used in the report and additional detailed and supplementary materials.

METHODOLOGY

Overview

The RFP's description of the expectations for this environmental scan indicates a potential rethinking of the strategic direction of the NCCDH as compared with a simple refining of existing efforts. As such, ascertaining the state of current thinking, evidence and practice was viewed as a priority in order to inform future strategic directions. Since the scan needed to be completed within a 10-week time period overlapping the summer, efforts concentrated on two information gathering approaches: conducting a scan of the scientific and grey literature; and, conducting key informant interviews with practice and research experts. These approaches were supplemented with two others: an online survey to acquire broader input, particularly from front-line public health staff; and, a series of focus groups to also seek broader input and, in particular, seek validation of the emerging themes from the scan of the literature and initial key informant interviews. Considering the available timelines and project resources, a splitting of responsibilities between the project consultant and the NCCDH were arranged (see Appendix 2 for further details).

An expert reference group was established to provide input and guidance at key points in the project including: the identification of potential key informants and reference documents; the discussion of identified themes and their analysis; and, discussion of a draft version of this final report. Since only two reference group members were available for this latter step, additional input on the draft report was sought from two previously interviewed key informants.

This chapter provides a brief overview of each of the information gathering approaches. Appendix 9 provides additional discussion of implications for future information gathering efforts by the NCCDH.

Scan of the Literature

The overall intent of this component was to address the following questions:

- What is the state of thinking, evidence and action on health determinants in public health practice?
- What examples are there of health determinant frameworks, approaches, tools and training that are available to, or being applied in, a public health context?
- What additional key informants should be considered for this environmental scan?

A focused approach was taken to identify key reports:

- Requests to NCCDH and the expert reference group for key 'not-to-miss' reports
- Search of websites of progressive public health organizations known to the NCCDH and the project consultant to be engaged in action on health determinants
- Search of selected organizations' websites that would be a source of key documents and reports (see Appendix 2).

Additional sites and materials were identified following leads from this primary search, as well as suggestions from key informants and focus group participants.

Key Informant Interviews

The initial list of key informants was developed by the NCCDH with input from the expert reference group and the project consultant (see Appendix 3). The key informant questionnaire was developed by the project consultant with input from the NCCDH and the expert reference group (see Appendix 4). A total of 31 key informant interviews were completed, which compares favourably with the scan's target of 25-35. The extent of key informant participation on relatively short notice provides an indication of the level of interest in the topic area and in the future direction of the NCCDH.

While the intent was to identify additional key informants through the key informant interview process and the online survey, the timing of many of the primary interviews and the availability of online survey results did not permit the inclusion of additional interviewees. Since the main themes from the key informant interviews were largely consistent, it is unlikely that the addition of more interviewees would substantively alter the identified strategic themes.

Online Survey

The online survey was included to broaden input into the environmental scan. Based on the timing of the survey (June-July) and the limited response to a survey during the NCCMT's environmental scan, it was hoped that up to 200 respondents might participate.

One of the challenges in the design of the survey was how best to structure the questions. The extent of perceived uncertainty regarding public health's work addressing health determinants would tend to favour open-ended questions. However, close-ended questions are more straight forward to analyze. A mix of questions was eventually chosen (see Appendix 5). The questions were translated into French and piloted in both languages. Piloting of the surveys indicated that they could be completed in approximately 15 minutes.

Promotion through electronic networks and at three public health-related conferences (Canadian Public Health Association, the Community Health Nurses of Canada, and the NCCPH Summer Institute) resulted in over 600 responses. The close-ended questions had many non-responders, although many individuals provided responses to the open-ended questions. In addition to the incorporation of selected survey findings into this report, Appendix 6 provides additional survey results. The NCCDH has also prepared a more detailed technical report to inform its future analysis and decision-making. The sheer volume of responses provides an indication of the level of interest in action on the health determinants and the respondents provide a potential pool of contacts for future communication and involvement in the NCCDH's knowledge translation efforts.

Focus Group Teleconferences

The focus group teleconferences were included to provide an additional opportunity for information gathering beyond the key informant interviews and to provide an early validation step of emerging themes from the scan of the literature and the key informant interviews collected to-date (approximately 1/3 of total). While it had been intended to have a focus group for each target population sub-group (decision-makers, front-line staff, researchers), a total of 4 teleconferences with between 3-7 participants were conducted (see Appendix 7). The participants in each focus group tended to be a mix of mainly front-line and middle management staff. A summary of the main themes and implications from the scan of the literature and the initial 13 key informant interviews was provided to focus group participants prior to the teleconferences. The two-hour teleconferences involved a guided discussion of the emerging themes and possible implications of the findings to-date. Appendix 8 provides a listing of key feedback points received from the focus groups.

FINDINGS

There was considerable convergence of the findings across the four information gathering approaches. This chapter provides a synthesis of those findings with the first section addressing the context for public health action on the health determinants, which is then followed by a discussion of the challenges and opportunities for such action.

Context for Public Health Action on the Determinants of Health

In order to set the stage for the subsequent section's descriptions of challenges and opportunities for public health action, this section provides an overview of key terms and concepts, historical background on public health, recent major reports on health determinants, and current formal expectations for public health action.

Key Concepts and Terminology

A recent analysis by Daghofer and Edwards provides the following descriptions of several key concepts and terms:⁴

DETERMINANTS OF HEALTH: the range of personal, social, economic and environmental factors that determine the health status of individuals or populations. The Public Health Agency of Canada lists the following as examples of determinants of health: income and social status; social support networks; education; employment and working conditions; genetics and biology; social environments; physical environments, personal health practices, healthy child development; health services; gender; and culture. These determinants intersect and interact with one another, so that the health of any individual is a complex summation of factors.

SOCIAL DETERMINANTS OF HEALTH: social determinants of health can be understood as the social conditions in which people live and work.

HEALTH EQUALITY/INEQUALITY: the generic terms used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups...that need not imply moral judgment. Some inequalities reflect random variations (i.e., unexplained causes), while others result from individual biological endowment, the consequences of personal choices, social organization, economic opportunity, or access to health care. Public policy is concerned with health inequalities attributable to modifiable factors, especially those that are perceived as inequitable.

HEALTH EQUITY/INEQUITIES: those inequalities in health that are deemed to be unfair or stemming from some form of injustice. The crux of the distinction between equality and equity is that the identification of health inequities entails normative judgment premised upon (a) one's theories of justice, (b) one's theories of society, and (c) one's reasoning underlying the genesis of health inequalities. Because identifying health inequities involves normative judgment, science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair.

HEALTH DISPARITIES: differences in health status that occur among population groups defined by specific characteristics. For policy purposes, the most useful characteristics are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socioeconomic status, Aboriginal identity, gender, and geographic location.

Public Health's Roots and History

Interest in why some people are healthy and others are not reflects the basis of the field of public health. This field emerged in the 1800s in response to large differences in observed health outcomes. In the mid-1800s, the father of epidemiology, Dr. John Snow, analyzed the London cholera epidemic attempting to determine why some people were sick and dying, and others were not. His well known study led to the identification of the contaminated water supply and the removal of that supply's water pump handle.⁵ An early sanitarian, Sir Edwin Chadwick, documented marked differences in mortality rates among population groups and argued the need for clean water, removal of wastes and other public policies.⁶ He used economic arguments to convince decision-makers and his work led to the first Public Health Act and Board of Health.⁶ His work, while eventually successful, was not initially enthusiastically received and he even had to use his own funds to pay for his report's publication.

Within Canada, public health leaders, over 80 years ago, were clearly speaking of conditions that we would today categorize as health determinants:

Every nation that permits people to remain under the fetters of preventable disease, and permits social conditions to exist that make it impossible for them to be properly fed, clothed and housed, so as to maintain a high degree of resistance and physical fitness, and that endorses a wage that does not afford sufficient revenue for the home, a revenue that will make possible the development of a sound mind and body, is trampling a primary principle of democracy under its feet. (Toronto Medical Officer of Health, 1929).⁷

Admittedly, the structure and specialization of roles within society have become considerably more complex over time, but the underlying perspective and impetus for public health action has not changed as evidenced by the 1998 annual report from the Montreal Public Health Department:

When we know that poverty is often associated with poorer health, this situation must be recognized as a critical public health issue...The poverty striking close to 30% of Montreal's population constitutes a problem that the Department of Public Health cannot ignore...The Department is thus joining other social actors on the Montreal scene as a partner, who, armed with its specific brand of expertise, is determined to commit its forces to the common struggle... Reducing inequalities in health and well-being is essential to the progress of our society. Such an objective calls for the enthusiastic participation of every citizen and demands the concerted efforts of all sectors of society. The Department of Public Health is resolutely setting out on this path, counting on stepped-up relations with its travelling companions.⁸

Canada has been an international leader in gaining a better understanding about what makes and keeps people healthy. Key reports include:

- *A New Perspective on the Health of Canadians* (Lalonde Report) – 1974: raises human biology, environment and lifestyle to a level of categorical importance equal to that of health care organization.⁹
- *Ottawa Charter for Health Promotion* (Ottawa Charter) – 1986: describes the five components of health promotion action, as well as the prerequisites for health, which include: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.¹⁰
- *Achieving Health for All: A Framework for Health Promotion* (Epp Framework) – 1986: identifies challenge 1 as “reducing inequities in the health of low-versus high-income groups.”¹¹ Implementation strategies include fostering public participation, strengthening community services and coordinating healthy public policy.
- *Report on the Health of Canadians* – 1996: prepared for the F/P/T Ministers of Health, this report describes how health is not shared equally by all sectors in Canadian society and how health inequalities can be reduced by addressing living and working conditions; the physical environment; personal health practices and coping skills; and, health services.¹²
- *An Integrated Model of Population Health and Health Promotion* (Population Health Promotion Cube) – 1996: the three dimensions of this cube include determinants of health; Ottawa Charter actions; and, level of intervention.¹³
- *Toward a Healthy Future: Second Report on the Health of Canadians* – 1999: this follow-up report for the F/P/T Ministers of Health, further describes the influence of health determinants on the health of Canadians, including inequities.¹⁴
- *The Population Health Template: Key Elements and Actions That Define a Population Health Approach* (Population Health Approach) – 2001: this planning framework incorporates measuring population health status, analyzing health determinants, evidence-based decision-making, increasing upstream investments, multiple strategies, public involvement and inter-sectoral collaboration.¹⁵

While a detailed analysis of the evolution of thinking represented in these reports is beyond the scope of this environmental scan, there is little doubt that a focus on the health of populations including the analysis of, and action to address, health determinants are intrinsic to the practice of public health. As described by the Public Health Agency of Canada:

A population health approach focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, rather than individuals. Focusing on the health of populations also necessitates the reduction in inequalities in health status between population groups. An underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities. The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement.¹⁶

As noted above, reducing inequalities and inequities in health status between population groups is intrinsic to a population health approach. Interest in reducing inequalities/inequities has increased in recent years recognizing that improvements in overall measures of population health have not necessarily been reflected in reductions of health inequities among populations. The next subsection will describe major reports addressing health determinants and equity, which is followed by a description of formal expectations for public health action.

Recent Major Reports Addressing Health Determinants and Equity – Selected Examples

In recent years, there have been several major reports addressing health determinants and equity from a range of sources. Although written for a broader audience than just the public health sector, these reports provide context and guidance for public health action. The following is a brief and non-exhaustive overview of selected reports.

- *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper* – 2005.¹⁷ This discussion paper summarizes information on the existence of health disparities in Canada, the causes and costs of health disparities, and the role of health services in addressing disparities. With respect to this latter point, the report notes that both health care and public health policies and activities can either reduce or increase health disparities depending on how they are implemented and taken up by the population. Noting that generalized public health interventions can potentially increase disparities due to greater uptake by more privileged populations, the report states that “the most appropriate and effective way to improve overall population health status is by improving the health of those in lower SES groups and other disadvantaged populations.”

A health sector framework for addressing health disparities is outlined:

- Take an integrated approach to disadvantaged populations
- Focus on four key policy directions for the health sector:
 - *Make health disparities reduction a health sector priority*
 - *Integrate disparities reduction into health programs and services*
 - *Engage with other sectors in health disparities reduction*
 - *Strengthen knowledge development and exchange activities.*

- *Population Health Policy: Issues and Options* – 2008.¹⁸ This report from the Standing Senate Committee on Social Affairs, Science and Technology reviews the types of health determinants and the estimates for their impact on health outcomes, as well as the continuing deficiency in common understanding about health determinants among the public. The report identifies four key issues and possible options to address them:
 - *Tracking health outcomes and supporting research on interventions to enhance the health of the population*
 - *Reorienting government policy*
 - *Implementing an Aboriginal population health strategy*
 - *Fostering political will.*

- *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* – 2008.¹⁹ The WHO Commission's report documents the health inequalities among and within countries. It explains that these inequalities reflect to a large degree inequities since they "arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces." Following an extensive review of the evidence, the Commission identifies three principles for action:
 - *Improve the conditions of daily life*
 - *Tackle the inequitable distribution of power, money, and resources*
 - *Measure and understand the problem and assess the impact of action.*¹⁹

- *Healthy People, Healthy Performance, Healthy Profits: The Case for Business Action on the Socio-Economic Determinants of Health* – 2008.²⁰ This Conference Board of Canada report provides health and economic arguments to support action on health determinants. The report outlines a framework for business action, as well as recommendations for areas of government action to support this action (e.g., tax or subsidy incentives to adopt agreed upon strategies to address one or more determinants; facilitate communication between employers and businesses, communities, and policy-makers; showcasing and celebrating successful initiatives and outlining the steps to success).

The initial two reports of Canada's Chief Public Health Officer (CPHO) have focused on health inequalities and child development,^{21,22} and are discussed in greater detail later in this report.

In analyzing these reports, Daghofer and Edwards identify the following guiding principles that are shared among the reviewed reports: social justice; universal and targeted programs; accountability and best practices; and, levelling up, not down.⁴

The authors also identify six cross-cutting strategies that appear in the reviewed reports:

1. Invest in social policies, programs and incentives for action (8 of 8 reports)
2. Develop and transfer knowledge (8 of 8 reports)
3. Provide leadership (7 of 8 reports)
4. Foster inter-sectoral action (7 of 8 reports)
5. Build public and political support (6 of 8 reports)
6. Develop community capacity (3 of 8 reports).⁴

While this analysis provides important context, it does not explicitly indicate what public health organizations can and should do to address inequities. The following sub-section reviews current expectations for public health action.

Formal Expectations for Public Health Action on Health Determinants and Health Inequalities/Inequities

PUBLIC HEALTH LEGISLATION

Provincial/territorial public health acts are of varying age and explicitness regarding the expectations for public health action overall. Quebec's *Public Health Act* provides a particularly comprehensive description of the functions and roles of public health. With respect to health determinants, it states that its contents pertain to "the means of exerting a positive influence on major health determinants, in particular through trans-sectoral coordination."²³ Further details are provided in Appendix 10.

PUBLIC HEALTH CORE PROGRAMS

Three provinces have legislatively linked descriptions of public health 'core programs'. These documents provide explicit expectations for public health actions including those addressing determinants and health inequalities/inequities. For example, the new Ontario Public Health Standards (OPHS) state:

Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes.

A key component of the requirements outlined in the Ontario Public Health Standards is to identify and work with local priority populations. Priority populations are identified by surveillance, epidemiological, or other research studies and are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level. The Ontario Public Health Standards incorporate and address the determinants of health throughout, and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.²⁴

In British Columbia (BC), the public health core function framework includes a lens to assess and address health inequalities, which “have their roots in the social, economic, cultural, and environmental determinants of population health.”²⁵ While these determinants are not within the direct control of the public health sector, public health can contribute to reduce inequalities in health by:

- documenting inequalities, reporting on them so as to draw public attention to them, and analyzing the factors that contribute to these inequalities
- working with communities to change the conditions that contribute to inequalities in health in their community
- advocating for healthier public policies and changes in social, economic, cultural, and environmental conditions that will reduce inequalities in health
- directing programs to high-risk/disadvantaged groups
- improving access/removing barriers to public health programs
- forging partnerships with other organizations to address multiple barriers and/or issues in a coordinated and comprehensive manner
- using community development as a means to support self-advocacy and self-reliance
- ensuring that the core programs provided by the health authorities reflect the priorities of the people with greatest need.²⁵

BC has developed a series of model core programs, each supported by an evidence review paper, which integrate consideration of health determinants and a reduction of health inequities.²⁶ An additional evidence review document addresses the equity lens component of the overall framework.²⁷

Quebec’s Public Health Program states “through its objectives, the program strives to change the determinants of health and well-being, enhance health and well-being, and reduce health or psychosocial problems and injuries.”²⁸ The Program document contains discussion of different types of health determinants and the strategies that are reflected across all programs:

- Strengthen the potential of individuals
- Support community development
- Participate in inter-sectoral action that promotes health and well-being
- Support groups that are vulnerable
- Encourage use of effective clinical preventive practices.²⁸

PUBLIC HEALTH CORE COMPETENCIES

The *Core Competencies for Public Health in Canada (Release 1.0)* provide a description of the essential knowledge, skills and attitudes necessary for the practice of public health.²⁹ While many of the key concepts related to addressing health determinants and health inequities are included, at least implicitly, recent analysis commissioned by the NCCDH concluded that:

To adequately reflect the significance of the determinants of health framework in contemporary public health theory and practice, it is recommended that the current Version 1.0 of the Core Competencies be revised to include more specific content related to the determinants of health framework, that this content include statements concerning public health values and attitudes and that the content be incorporated directly into the Core Competency Statements themselves.³⁰

Some key informants also commented that staff attitudes and values are critical for health determinant-related work, which would argue for them being more explicit in future versions of the core competencies for public health.

PUBLIC HEALTH ACCREDITATION

Accreditation Canada provides accreditation of regional health authorities containing public health teams across Canada (with the exception of Ontario, which has a different health system structure). Both the general and more specific public health standards are explicit about assessing and taking action on health determinants. For example, the expectations for all accredited organizations include the following:

Organization's leaders support and participate in ongoing community development to promote health and prevent disease (e.g., advocating for healthy public policy affecting determinants of health).

The governing body plays an advocacy role in the community. Examples include supporting healthy public policy to address the determinants of health (e.g., smoking bans in public places, environmental health legislation, and raising community awareness about issues).³¹

Further details are provided in Appendix 11. Within Ontario, public health units can voluntarily request accreditation by the Ontario Council on Community Health Accreditation.³² Its accreditation materials make occasional mention of health determinants, but are not as explicit as those of Accreditation Canada.

Summary

Following a brief overview of key terminology, this section has highlighted the current breadth of interest in health determinants, which increasingly is focused on the reduction of health inequities. Such a perspective is by no means new for public health as it was a major impetus in the creation of the field and key concepts are embedded throughout major public health reports of recent decades. Of particular concern is the continuing existence of health gradients and the potential for some public health interventions to contribute to inequities. A current trend is to embed more explicit expectations for public health action on health determinants within defining parameters of practice such as accreditation standards. There is also at least one example of explicit inclusion of expectations for public health action on health determinants within a provincial public health act (Quebec), as well as in the three provincial core public health program requirements (BC, Ontario, Quebec).

State of Public Health Action on Determinants of Health and Health Inequities

Several examples of public health organizations that are engaged in action on determinants of health to reduce inequities were encountered during this scan. There was general agreement among key informants that these examples represented early adopters/innovators versus being reflective of typical or widespread public health practice in this country. In addition, even within these early adopter organizations, action on broader determinants of health is still at a relatively early stage of implementation versus having been institutionalized throughout. Further details regarding these examples will be provided later in this report. The purpose of this section is to explore the number of pervasive challenges that are barriers to more widespread action, as well as the many opportunities that also exist.

Challenges to Public Health Action

The literature scan,³³⁻³⁵ key informant interviews, and focus groups indicate a number of challenges to public health action on health determinants and inequities.

THE EXISTING EVIDENCE BASE

Challenges regarding the extent of existing evidence include the nature of the relationship between determinants and health outcomes, as well as the interventions to effectively address this relationship. The influence of health determinants on health outcomes assessed through the steepness of gradients show that these gradients can vary for different outcomes, by interactions with other determinants (e.g., gender), by country, and over time.^{36,37} There are an increasing number of detailed reports describing determinants and gradients.^{7,21,38,39} There are a variety of frameworks for conceptualizing the pathways and inter-actions among determinants, but it is unclear which should be used when to guide research and interventions. There is a need for greater synthesis and wider understanding of what we know and do not know regarding existing gradients, the complexities of interactions among health determinants and pathways to health outcomes in the Canadian context.

There also appear to be a number of conceptual issues. Among public health staff, there appear to be continuing difficulties reconciling individual-level versus population-level approaches.³⁵ Some key informants indicated a widespread misperception among public health staff that a population health approach means to only target the general population and to thereby not include targeting of higher risk/priority populations.

Perhaps related to the foregoing conceptual challenges, there are also challenges related to the evidence for interventions. As noted in a recent report.

Although many in public health are committed to the need to reduce social inequities in health, they do not have tangible evidence-informed strategies for this work. The public health field requires such strategies along with supports to translate evidence and develop sustainable implementation strategies.³⁴

There are many organizations across Canada that are applying public health principles to address health determinants to reduce inequities and 'learning by doing'. To a large extent, their work is not widely known. As one key informant indicated, every public health worker should know the 'stories' of these innovators. However, much of the knowledge is produced by practitioners in service delivery mode where publishing is not a priority, and mechanisms are not well developed to capture and disseminate the learning from these experiences.³⁴ In addition, there are limited mechanisms for public health practitioners to share experiences and challenges.

There is also a limited cadre of evaluators working in this area. In order to build the evidence, interventions need to be evaluated so that our understanding of what works and does not work is continually improved. Developing and interpreting evidence in this field is not without its challenges. There are multiple inter-related determinants operating at multiple levels over the life course. Randomized trial evidence is rare and similar to the overall field of public health,⁴⁰ reviewers of evidence have needed to utilize a variety of approaches.³⁴

Public health staff have a need for 'ammunition' (e.g., summary of latest evidence, economic analyses, etc.) to inform their analyses and actions and are forced to search far and wide for this material or develop it themselves. For example, in the absence of existing syntheses, individual public health organizations have proceeded with conducting extensive literature reviews in order to inform local public health action.^{34,39} After assessing the impact of poverty across their catchment area, a key informant indicated that it would have been very helpful to have a list of available policy options by level of government to inform his organization's recommendations and actions. Key informants observed that there are likely potential overlap areas between NCCDH and NCCHPP, as well as NCCAH that provide opportunities for collaboration and coordination of efforts.

UNCLEAR WHAT PUBLIC HEALTH COULD/SHOULD DO

Many of the recent high profiles reports on health determinants and health inequities do not explicitly indicate or illustrate what public health could or should do in this area. While there are many lists of determinants, they do not capture the interactions among and pathways through which determinants are believed to act and thereby provide guidance regarding specific interventions. Since most determinants are outside the direct control of the public health sector, determinants and inequities can be viewed as outside of public health's mandate. Despite the field's historical roots and the conceptual thinking reflected in decades of landmark reports, work on health determinants and inequities can be perceived as 'extra work' or 'too big' for public health, particularly considering the resource pressures on public health organizations.

LIMITATIONS OF EXISTING PUBLIC HEALTH PRACTICES

Many key informants indicated that public health has to move beyond just describing inequities and progress to taking action. Some key informants also expressed concern that there is a tendency to rely on quantitative methods to assess needs and that qualitative methods are also often required to more fully understand needs, meaning of results to communities, community problem solving, etc. In addition, in rural and remote areas with limited population size, alternative approaches to assessing needs are often required.

Key informants described a continuing preoccupation by public health with behaviour and lifestyle approaches such that the default is often services to the middle class with emphasis on 'education' versus structural or tailored approaches to priority populations. As one key informant noted, it is often easier to create a pamphlet or post information on the web than to tackle more challenging issues.

A limited number of jurisdictions have explicit expectations for action on health determinants and inequities. However, these expectations are not necessarily actively supported or reinforced. As one key informant commented, unless accountability for taking action is established, then it is unlikely to occur on a widespread basis.

Gaps in the skills of public health staff were identified by several key informants, particularly in the areas of community engagement, mobilization and development. However, there are limited training opportunities to increase health determinant-related competencies. A recent examination of online training options found that a comprehensive online course on the topic of the determinants of health oriented to front-line public health professionals in Canada is not available at this time.⁴¹ At senior levels of organizations, the knowledge and skills required to take action involve domains that public health leaders may not have required previously (e.g., complex adaptive systems).

PUBLIC HEALTH ENGAGEMENT WITH COMMUNITIES

A number of key informants commented on the extent of engagement of public health organizations and their staff with communities. It was observed that the more an organization was focused on service delivery and harder outcomes, the less time and support was available for the development of strategic relationships with other service providers and the community. Some key informants hypothesized that the rigidity in program based orientations had led to a loss in the sense of 'place' and coordinated action among staff.

Several key informants commented on the nature of many public health organizations being overly bureaucratic and controlling. Some organizations appear to function as three separate organizations (i.e., senior leadership, middle management, front-line staff), each with their own perspectives towards communities and action on health determinants. Depending on the organization, one or more of these groups could be barriers to the others taking action. It was also observed that governance structures for public health may not be structured with sufficient breadth that would more likely support action on health determinants.

The regionalization process in many parts of the country appears to have hindered the traditional linkages between public health and municipalities. This is particularly problematic for work on health determinants since so many are influenced by the work of local governments.^{42,43} In England, where regionalization of health systems predated their occurrence in Canada, multiple efforts are occurring to support and formalize linkages between public health and local governments.

LEADERSHIP

For public health organizations to take action on health determinants and inequities, “local public health leadership needs to be intimately engaged in this work.”³⁴ This is critical since they influence priority setting and allocation of resources, as well as modeling of desired behaviours. If that support is not in place, then it will be very difficult to make progress. Taking action on health determinants and inequities likely requires a change in organizational and individual practices. This may involve reallocation of staff and other resources to better address the needs of a priority population, shifting from education-based interventions to greater community development and policy perspectives, and other types of reorientation (e.g., organizational structure, staff skills, type of interaction with community, more intensive interventions with harder to reach populations, etc.) . As such, resistance to change can be anticipated and needs to be managed.

COMMUNICATION

Action on health determinants and inequities requires the strategic use of information and its communication. In some instances, strategic use of a health status report and policy recommendations can be pre-planned, but there are also instances where nimbleness is required to take advantage of a current event. For example, in recent years there have been multiple high profile reports released related to health determinants and inequities. Some key informants expressed concern that public health organizations did not seem to effectively utilize those opportunities by adding local data and context to promote relevant policies and action. Such practice was the norm for local and provincial public health tobacco control efforts. As one commentator has suggested, public health needs to apply the comprehensive approaches it has used for health behaviours such as tobacco, healthy eating and physical activity, and apply these to other health determinants to address inequities.³³

An additional concern expressed by several key informants is that public health professionals are spending too much time speaking to other (convinced) public health professionals and need to achieve greater public engagement.

THE CAPACITY OF PUBLIC HEALTH ORGANIZATIONS

The capacity of public health organizations is highly variable and will impact their ability to address health determinants. For example, assessment/surveillance capacity is extremely important to inform deliberations and guide action. However, some regional health authorities and public health units have no or very limited epidemiologic capacity. The ability to engage with communities requires staff with community development skills, but this skill set may not be prevalent among staff. Pressures to provide traditional services and respond to health protection emergencies distract from broader, sustained action on health determinants.

The existing capacity within organizations will affect their receptivity towards new concepts and activities. The extent of existing implementation (i.e., whether an innovator versus newly starting) will affect the type of information required. For example, an organization already taking action on health determinants will have needs for more detailed evidence and be interested in more complex interventions. Organizations beginning to reorient themselves to action on health determinants will have greater interest in examples of effective practices and how to foster organizational change. Consideration needs to also be given to the needs of staff at different organizational levels (i.e., front-line, manager, executive).

An important consideration is that the current practice of some leading organizations reflects development activities that have been occurring over a period of many years. Attempting to duplicate a practice from such a setting into one with less capacity and readiness will not likely generate the same result. In such circumstances, it will be more important to identify the principles underlying the example and how they relate to existing evidence, in order to allow their tailoring to the local context of another organization.

POLITICAL ENVIRONMENT

Several aspects of the political environment were identified as challenges by the key informants. In some settings, the prevailing political ideology can make it extremely difficult to openly address the concept of inequalities/inequities or priority populations. At a minimum, there is a need to tailor messages to the audience and context (e.g., speak of 'health gain' versus 'inequities'). Many key informants observed that public health leaders engage in self-censorship due to the fear of consequences. In some settings, the political agenda may be lifestyle focussed and emphasizing personal responsibility versus the social context for lifestyle and behaviour choices. Public health can also be faced with opposition when there is an attempt to reallocate resources serving middle/upper class populations to address the needs of priority populations.

Opportunities (Reasons for Optimism)

PAST EXPERIENCE

The public health sector has achieved many successes in the past 100 years.⁴⁴ The experience of the sanitarians and tobacco control are but two examples. At their onset, both faced daunting challenges. As previously mentioned, Chadwick's work was not universally embraced and he had to use his own funds to even get the report printed. When tobacco control efforts began, it was normal practice for the majority of the population to smoke and the tobacco industry was extremely powerful and politically connected. The public health response in both instances was to make heavy use of structural (i.e., policy) change and certainly for tobacco, the public health sector learned (i.e., developed the evidence) while doing.

IPPH'S STRATEGIC PLAN

CIHR-IPPH has identified that supporting research in this area is a key priority. Its five-year strategic plan entitled "Health Equity Matters" includes four strategic research priorities:

- Pathways to equity – to further our understanding of pathways to health equity
- Population health interventions – to examine the impact of complex population health interventions on health and health equity
- Implementation systems for population health interventions in public health and other sectors – to examine how implementation systems for population health interventions may strengthen or weaken the impact of population health interventions on health and health equity
- Theoretical and methodological innovations – to stimulate theoretical and methodological innovations in knowledge generation, knowledge synthesis, and knowledge integration for population and public health.⁴⁵

Pursuit of these strategic research priorities will be extremely informative for the work of the NCCDH and its audiences. It is directly targeting the expansion of the knowledge that will address many of the foregoing described challenges to public health action. With the NCCDH's focus on knowledge synthesis, translation and exchange in this area, the IPPH's strategic research priorities provide a tremendous opportunity for synergy. The NCCDH should therefore, strive to work closely with the IPPH.

EXPERIENCE IS INCREASING

While the public health practice evidence base is limited, it is being expanded by a number of innovative organizations across the country. As part of this scan, multiple examples were encountered across the country including a growing list of frameworks and tools. For example, the Sudbury and District Health Unit conducted an extensive search of the literature for the evidence for public health interventions.³⁴ Their review identified 10 promising practices for local public health action, which are shown in the following text box.

10 Promising Practices to Reduce Social Inequities in Health in Local Public Health

TARGETING WITH UNIVERSALISM

- » Need a balance of targeted approaches with universal strategies to disproportionately improve the health of more disadvantaged groups while at the same time improving the health of the entire population

PURPOSEFUL REPORTING

- » On the relationships between health and social inequities in all health status reporting
- » Presenting publicly and intentionally the evidence about health inequities may be considered part of a strategy for change (e.g., stratify findings by socio-economic status (SES) versus controlling for it)
- » Can also help track changes over time (i.e., are the disparities getting better or worse over time?)

SOCIAL MARKETING

- » Tailoring of interventions to disadvantaged populations
- » Change the understanding and behaviour of decision makers and public to take or support action to improve social determinants of health (SDOH)

HEALTH EQUITY TARGET SETTING

- » Some promise as part of strategy for reducing inequities - focus on targets for remediable areas
- » Target setting as part of community engagement process connects target setting to other identified aspects of health inequity practice.

EQUITY-FOCUSSED HEALTH IMPACT ASSESSMENT

- » HIA is a structured method to assess potential health impacts of proposed policies and practices
- » Equity focussed HIA applies an equity lens to assess impact on inequities
- » Challenges include resources, competencies and institutional nature of public health agencies
- » HIAs are a tool – interpretation of the evidence lies with decision makers and their values

COMPETENCIES/ORGANIZATIONAL STANDARDS

- » Individual level
 - Skills base required to work effectively on social inequities include community planning, partnership and coalition building
 - While these are reflected in the public health core competencies, they are not necessarily common knowledge or experience for most public health staff
 - Implications for recruitment, training, professional development, position descriptions
- » Organizational
 - Making social inequities a priority - commit to work intersectorally and with community engagement
 - Likely require an enabling change to the “bureaucratic/structural model upon which public health is built” (versus need for greater community engagement, consultation, participation)

CONTRIBUTION TO EVIDENCE BASE

- » The burgeoning knowledge base on addressing social inequities through local public health action be strengthened by intentional distribution of knowledge.

EARLY CHILDHOOD DEVELOPMENT

- » Comprehensive continuum of approaches is required in order to reduce health inequities
- » Combination of services and policies designed through intersectoral collaboration and involve communities, especially vulnerable communities, in the program planning-implementation cycle.

COMMUNITY ENGAGEMENT

- » Key cross-cutting strategy - best practice recommendations stress importance of consultation, involvement, support and/or engagement
- » Nevertheless, there is a dearth of rigorous evaluations of social interventions aimed at reducing health inequalities

INTERSECTORAL ACTION

- » Many of the solutions to SDOH lie outside the health sector
- » Building strong and durable relationships between public health and other sectors will be necessary for effective action.

Source: Sutcliffe, Snelling, Laclé. Implementing local public health practices to reduce social inequities in health. EXTRA/FORCES Intervention Project. Sudbury & District Health Unit, 2010.

In Saskatoon, documenting inequities was a preliminary step followed by a comprehensive set of community consultations to discuss the findings, an extensive literature review of potential policy actions, and further consultations to assess support for particular policies.³⁹ This public health organization is now co-chairing an initiative with the United Way to pursue those policy options with the greatest level of community support. To systematically tackle how programs are planned and delivered, public health units in Waterloo and Sudbury have been developing frameworks to support the review of public health programs to strengthen their action against inequities.^{46,47} Additional examples of promising public health actions, frameworks and tools are listed in Appendix 12.

EXISTING MODELS OF WEB-BASED DETERMINANTS OF HEALTH AND HEALTH INEQUITY PORTALS

There are several existing online toolkits/portals in the U.S., Europe, and Australia that provide a range of conceptual frameworks, case studies/profiles, training modules, tools and other resources to support action on health determinants (see Appendix 12). Their existence provides several opportunities:

- Provide links to these sites from the NCCDH's website highlighting what they have to offer (i.e., their strengths)
- Select the best, most relevant and easiest items to adapt to the Canadian context
- Analyze the strengths and experiences of these sites and adapt these for improving the NCCDH's website.

EXTENT OF INTEREST WITHIN PUBLIC HEALTH

There are several reasons to believe that there is considerable interest in taking action on the health determinants to reduce inequities: the examples of innovative practice occurring across the country; increasingly explicit expectations for public health action; the new CIHR-IPPH strategic plan; and, the extent of response to this environmental scan. Some key informants indicated that the turnover in public health managers and leaders in upcoming years will provide an opportunity to groom a new cadre of future leaders with the knowledge and skills and orientation to address determinants.

EXTENT OF INTEREST OUTSIDE PUBLIC HEALTH

Public health is one of many potential actors to address health determinants. As evidenced by the range of recent reports from a variety of sources, there appears to be widespread interest in these issues. These various sectors represent potential partners that public health could collaborate with for broader action. Examples include, but are not limited to:

- Senate Sub-Committee on Population Health of the Standing Senate Committee on Social Affairs' report on population health¹⁸
- Conference Board of Canada's report on the case for business action on the socio-economic determinants of health²⁰
- Canadian Policy Research Networks analysis of the economic case for financing action on SDOHs⁴⁸
- Business case for early childhood education and care⁴⁹
- Provincial governments' anti-poverty initiatives⁵⁰⁻⁵²
- Community-level development efforts⁵³
- Business-led anti-poverty/prosperity initiatives^{54,55}
- Canadian Institute for Health Information (CIHI) – recent report on inequities in health care.⁵⁶

Some key informants suggested that there may be the beginning of a 'sea change' as more sectors become engaged.

Summary

There are many challenges facing the public health sector that have been impeding greater public health action on health determinants and inequities. However, there are also many opportunities. The challenge for the NCCDH is how best to take advantage of the opportunities and support public health to address these challenges. The next chapter of this report will pursue the implications of these findings regarding the future priorities and actions of the NCCDH.

4. ANALYSIS AND IMPLICATIONS FOR FUTURE NCCDH ACTIONS

Overview

In reflecting upon the information gathered during this environmental scan, what is particularly striking is that from the perspective of public health's history, as well as the conceptual thinking of recent decades, action on the health determinants and inequities is not 'new'. Yet, it seems to be. Either application of these concepts was never universally institutionalized throughout public health or enough time has passed and pressures exerted upon the public health sector that they have been lost. The impression from the key informant interviews is that both of these scenarios have been at play. An analysis of why this has occurred is beyond the scope of this report, but is relevant if the NCCDH intends to influence the status quo through its knowledge translation activities. Possible contributing factors may include, but are unlikely limited to: the extent of public health involvement in clinical primary care service delivery; gaps in primary care; the extent of formal public health training of staff; budget restrictions; biomedical hierarchies of evidence; and, insufficient evaluations of public health programs.

Based on the findings of this environmental scan, there are two inter-related challenges facing the field of public health. The first is that action on health determinants and health inequities is not widespread. There are pockets of considerable activity occurring across the country, but these organizations do not appear to be the norm. Based on the literature and key informant input, there is little doubt that analysis and action on health determinants and inequities should be an integral part of the normal practice of public health organizations and staff. Stated more strongly by one senior key informant whose organization has functioned in this manner for many years, "to not do so would be malpractice". The second overall challenge is that there appears to be considerable misunderstanding of key concepts that need to be applied to address determinants and inequities.

If the NCCDH did not exist, then it is possible that the innovation that is occurring in some organizations and the evidence that will be generated by the IPPH's research priorities would have gradual uptake by public health organizations. The challenge and opportunity for the NCCDH is to consider how it might speed up the spread of thinking and practices across the field of public health through knowledge synthesis and translation. This is not a small undertaking since accomplishing this goal is not simply providing the evidence, improving the practice of individual practitioners or of a particular program or even adding a new 'health inequities' program. Rather, addressing health determinants to reduce health inequities potentially involves every aspect of how an organization operates. At the program level, it involves how needs are assessed, how programs are planned and implemented, and how their performance is assessed. At an organizational level, it involves the culture of the organization, how priorities are established, how resources are allocated, how partnerships are viewed and pursued, and how leadership and management are enacted. Underlying these processes is an understanding of the evidence, conceptual frameworks and public health roles and approaches.

The following sections will consider the future focus and vision for the NCCDH, public health roles for action on determinants and inequities and implications for future activities of the NCCDH.

What Should be the NCCDH's Focus?

One of the questions that the NCCDH has struggled with since its inception has been, considering the breadth of the health determinants, what to focus upon. In the early years, the NCCDH focused on health literacy and more recently on early child development – particularly public health home visiting programs. To a large degree therefore, it appears that the NCCDH has been attempting to focus its work through a particular determinant or intervention. In other words, the NCCDH's efforts at knowledge synthesis, exchange and translation appears to have been guided by the following type of question:

“Which determinant(s) should the NCCDH's knowledge synthesis and translation efforts focus upon?”

However, one of the challenges with selecting a specific determinant is that they tend to cluster for disadvantaged populations so that it is often difficult to address a particular determinant in isolation of others.⁵⁷ In addition, while some of the key challenges facing the public health sector are organization-wide, focusing on one determinant risks marginalizing action to a particular program of a public health organization and not affecting the preoccupation with behavior and lifestyle determinants. Individual public health organizations will also select priorities for action based on their analysis of local and organizational contexts. The resulting priorities will likely vary from one location to another and may not align with a particular determinant chosen by the NCCDH for its focus. For maximal impact, the work of the NCCDH should be relevant to as many public health organizations and to as many aspects of public health practice as possible.

An alternative to the NCCDH focusing on a particular determinant is to look more broadly at the relationship between determinants and health. This might include the overall health of the population or downstream outcomes such as reduced health care costs, improved productivity and prosperity, etc. The potential downside of this option is that it does not actually provide a specific area of focus, which has been the major challenge for the NCCDH. In addition, improving the population's health through a shift of population distributions of determinants has under-pinned public health's thinking for decades. While tremendous progress has been made in a number of population health outcomes on average, there continue to be considerable gradients and inequities observed,³⁸ as well as increasing recognition that some existing types of interventions may be exacerbating inequities.⁵⁸ While addressing inequities is intrinsic to a population health approach,¹⁶ it requires focussed effort in the analysis of health issues and in the planning, delivery and evaluation of interventions. Several key informants stressed that what was required was for the NCCDH's focus to be less about specific determinants and more about critical thinking and reflective practice to incorporate consideration of inequities in all of the actions of the organization. It is also noteworthy that the leading public health organizations have not been focusing on a specific determinant, but are often addressing multiple roles and approaches for a variety of determinants and issues.

The foregoing alters the potential guiding questions for the NCCDH's efforts at knowledge synthesis, translation and exchange to the following type of questions:

“How can the NCCDH's knowledge synthesis and translation efforts best support public health action on the health determinants to reduce health inequities?”

“How will the knowledge synthesis and translation efforts of the NCCDH improve public health practices in order to reduce health inequities?”

While there are clear advantages to a focus on health determinants with respect to reducing health inequities, there are two potential risks that need to be considered and managed. The first is having the target audience mistakenly equate action on inequities as being equivalent to solely targeting priority populations. Wholescale shifts of efforts to priority populations ignore the nature of gradients. It is an appropriate balance of universal and targeted approaches that is required. Addressing this risk is part of the improved conceptual clarity that is required. The other risk associated with a focus on reducing health inequities is that, depending upon the context, it may be unpalatable for some settings/audiences. While the primary audience for the NCCDH is the public health community, there will likely be a need for the NCCDH to provide examples or suggestions of how issues have been successfully framed for different external audiences (i.e., prosperity vs. anti-poverty; health gain/gaps vs. reducing inequities; economic benefit of targeting an issue; etc.).

Table 1 summarizes the relative advantages and disadvantages of the potential areas of future focus for the NCCDH.

TABLE 1: POTENTIAL FUTURE AREAS OF FOCUS FOR THE NCCDH

| Focus Options | Pros | Cons |
|--|---|---|
| Focus on determinants broadly (e.g., improve population health) | <ul style="list-style-type: none"> » Potentially encompass any population health-related evidence, approach | <ul style="list-style-type: none"> » Does not really provide a focus – appears to broaden the area of potential action |
| Focus on specific determinant (e.g., early child development) | <ul style="list-style-type: none"> » Strong link between determinant and outcomes » Existing centre for knowledge development » Core program area for public health across the country | <ul style="list-style-type: none"> » Only a portion of public health practice involves maternal/child health » Limited impact on prevailing focus on behaviours and lifestyles » There are existing sources of knowledge for specific determinants » Priorities chosen for action locally will depend upon local context and might not be child development (housing, poverty, equity of services, education, etc.) » Determinants tend to cluster |
| Focus on reduction in health inequities | <ul style="list-style-type: none"> » Need for greater conceptual clarity » Opportunity to influence organization-wide practices » Practice examples and tools/supports will, over time, support a range of roles, determinants, populations, regions, etc. » Synergy with research focus of IPPH » Alignment with recent major documents and reports | <ul style="list-style-type: none"> » Less depth on any one determinant » Risk misinterpretation as equivalent to solely/ mainly targeting priority populations » Language may 'turn-off' or have little traction with some audiences |

For both key informants and survey participants, an attempt was made to identify the preferred list of health determinants to guide the work of the NCCDH. Among key informants, there was very little interest in selecting a particular list of determinants and some observed that individual jurisdictions often had different lists. Many key informants urged a focus on social determinants of health (SDOH), but not the use of a specific list of determinants. Several informants referred to the WHO Commission's report, which viewed the SDOH holistically as the social conditions in which people live and work.¹⁹ Similarly, while almost half (47%) of the 51% of survey participants responding to the question favoured the SDOH as the framework that would best support the actions of public health, narrative comments warned against being too rigid in applying a particular list. In those selecting the SDOH as the framework of choice, the majority (66%) supported a focus on all of the determinants.

Some key informants questioned whether health care services as a health determinant should be included in the work of the NCCDH. Their argument was that the SDOH were important modifiers of access and use of the health care system. While they would not want public health to be swamped by or solely focused on the health care system, their advice was that there was a potential public health role in participating in health care equity audits. The main arguments for including analysis and action in this area includes: health care is a significant health determinant; considerable societal investment in health care and its budget size will increasingly impact available funding to address other determinants; particularly in regionalized health systems, public health has potential access to health care partners and decision-making processes; and, this analysis will tend to direct focus to inequities in community settings. The contrary view is that the health care system already receives too much attention as a determinant of health and is far from as important as other determinants.

Some key informants and focus group participants expressed interest in the NCCDH being a source of information on specific interventions, particularly for priority populations (e.g., nurse home visiting; smoking cessation in pregnant women; community gardens; etc.). The challenge is that the concept of priority populations could be applied to every aspect of public health practice. While NCCDH could be a link to existing evidence/reviews on these topics, there will quickly be feasibility issues if the NCC attempts to be a source of expertise and knowledge synthesis for specific approaches for every public health issue. In addition, one would not wish to lose sight of the potential strength of structural interventions that may reduce the need for priority population approaches (e.g., water fluoridation vs. fluoride supplementation in priority populations). There is also the more proximal analysis required in seeking the optimal balance between universal and targeted approaches, although the evidence for effectiveness for each would presumably influence that analysis.

Identifying a focus for the NCCDH's work is clearly an important and challenging issue that the NCCDH has had to grapple with. Based on the input to this environmental scan, the following guidance regarding the NCCDH's future focus is provided:

- Recognize that individual public health organizations are going to choose their priorities for action depending upon their local context – in order to be relevant to the majority of organizations, the NCCDH's focus should be cross-cutting in nature

- It is the institutionalization of the critical thinking and analysis to inform public health action on health determinants to reduce inequities that should be the focus:
 - *Support application of SDOH in a holistic fashion to analysis and decision-making*
 - *Avoid focusing on a particular determinant, specific list of determinants, or specific intervention*
- Through a series of knowledge translation products and activities (e.g., syntheses, conceptual frameworks, case studies, tools, training, etc.), the NCCDH can, over time, address a cross-section of determinants, issues, populations, and settings.

What is the Emerging Vision for the NCCDH?

Key informants and focus group participants were asked about a future vision for the NCCDH. There was considerable consensus that there was a clear need for a body such as the NCCDH to conduct the necessary knowledge synthesis, translation and exchange to foster evidence-informed public health practices to reduce health inequities.

There was widespread agreement that the NCCDH should be the 'go-to' hub for information and assistance on public health action on health determinants to reduce inequities. The NCCDH should be the lead source of current knowledge and thinking in this area and work to improve the understanding of public health practitioners regarding what is known, what we may know, and what continues to be unknown. Considering the existing pockets of innovation, the NCCDH should capture and build on these promising practices and integrate their experience with existing knowledge and evidence. Since public health action addressing health determinants to reduce health inequities affects all aspects of programming, the work of the NCCDH needs to be informed by a strong understanding of the public health practice context at individual, organization and system levels.

The action of the NCCDH needs to be strategic in order to foster linkages between the practice and research communities. The IPPH's focus on health equity is highly synergistic with the proposed vision for the NCCDH and there are many potential areas for collaboration. Just as it is desirable for public health organizations to critically reflect on how their practices are contributing to a reduction in inequities, the NCCDH should work closely with the other NCCs to support consideration of inequities in their work. This is similar to the expectation that the knowledge translation tools developed by NCCMT would be utilized by the other NCCs. It is also similar to the approach by England's National Institute for Health and Clinical Excellence, which routinely and explicitly queries within its guidelines whether there are interventions to reduce inequalities for the topic being addressed. Recognizing the cross-cutting nature of NCC foci, there will be a continuing need to determine which NCC should take the lead on particular issues, seeking opportunities to collaborate, and avoiding duplication of efforts.

What Are the Public Health Roles for Action on Health Determinants to Reduce Inequities?

The scan of the literature encountered various descriptions of public health roles for addressing health determinants to reduce health inequities. The most succinct list⁵⁹ outlines four key roles for public health action:

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

There was widespread agreement among key informants and focus group participants regarding these four roles. There was also strong support among online survey respondents. Table 2 shows that among survey participants responding to questions regarding agreement with these roles for public health, over 90% strongly or somewhat agreed with each of the public health roles. However, the non-response rate was 43% for each of the role questions.

TABLE 2: AGREEMENT WITH SUGGESTED PUBLIC HEALTH ROLES AMONG ONLINE SURVEY PARTICIPANTS

| Public Health Role | Among Those Responding to Question | | | | No Response |
|---|------------------------------------|-------|----------|-------------------|-------------|
| | Strongly Agree | Agree | Disagree | Strongly Disagree | |
| Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities | 85.3% | 10.3% | 0.6% | 3.8% | 43% |
| Modify public health interventions to meet the unique needs and capacities of priority populations | 83.0% | 10.9% | 1.3% | 4.2% | 43% |
| Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs | 85.3% | 7.1% | 2.2% | 4.8% | 43% |
| Support community and other stakeholders in policy advocacy for improvements in the determinants of health | 84.0% | 10.3% | 1.3% | 4.2% | 43% |

There is growing experience with each of these roles. Table 3 provides examples of existing public health actions and associated tools/frameworks for each role. The examples are provided for illustrative purposes and are not intended to be exhaustive in nature. More information on these and other examples is provided in Appendix 12.

TABLE 3: EXAMPLE ACTIONS AND TOOLS FOR PUBLIC HEALTH ROLES/FUNCTIONS FOR ACTION ON HEALTH DETERMINANTS

| Public Health Role/Function | Example Actions* | Example Tools* |
|---|--|--|
| Assess and report on health of populations describing existence and impact of inequalities/inequities and effective strategies to address those inequalities/inequities. | <ul style="list-style-type: none"> » Local/Regional: Montreal; Interior BC; Saskatoon; Toronto » Provincial: Health inequities in BC; BC PHO report on Aboriginal health » National: CPHO reports; Social Determinants – Canadian facts (Raphael); UPHN/CPHI report; Aboriginal health report (NCCAH) » International: WHO Commission on Social Determinants of Health | <ul style="list-style-type: none"> » Deprivation indices (INSPQ, CPHI/UPHN report) » Early Development Index » Quality criteria for routine monitoring of population health inequalities by socio-economic position » GIS » Improving access to local data (e.g., Community Accounts (NL); Public Health Observatories) |
| Modify/orient public health interventions to reduce inequities | <ul style="list-style-type: none"> » Saskatoon – immunization coverage rate disparities among neighbourhoods » Sudbury – each program team reviewing their plans » Waterloo – several programs piloting planning framework » Montreal – presentations and working group review of programs | <ul style="list-style-type: none"> » Program planning path (Sudbury) » Program planning framework (Waterloo) » Health equity assessment tools (e.g., Interior Health; HEAT) |
| Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs | <ul style="list-style-type: none"> » Sudbury – mapped 20 child determinants to identify best (neediest) location for establishing Best Start centre » Saskatoon – quality of care for people with diabetes showing disparities in identification and disease control in ambulatory settings | <ul style="list-style-type: none"> » Health care equity audit process (Saskatoon) » Community health impact assessment (PATH) » Strengthening Chronic Disease Prevention and Management (CPHA) |
| Lead/participate and support other stakeholders in policy analysis, development and advocacy | <ul style="list-style-type: none"> » Montreal – Casino development » Saskatoon – community consultations on policy options for addressing inequities » Quebec – Section 54 of Act » Saint John – neighbourhood development » Prosperity/Anti-Poverty community initiatives (Hamilton, Saint John) | <ul style="list-style-type: none"> » Health impact assessment tools (NCCHPP) » Advocacy toolkit (Ireland) » Nutritious food basket (ON) » Saint John neighbourhood intervention video profile (Health Council of Canada) |

*Illustrative – not intended to be exhaustive

The first listed role of assessing and reporting on inequities and the strategies to address them underlies action on the other three roles. Information is critical in order to identify the problem, inform action and assess impact. For the latter, there needs to be a measurement component as part of the other three roles in order to assess impact.

While most of the examples in the Table are from local public health organizations, the roles can also be applied at provincial/territorial and federal levels recognizing their differences in context. For example, Section 54 of Quebec's *Public Health Act* provides the authority for the provincial public health department to conduct health impact assessments on all new provincial government legislation and regulations,²³ and is an example of public health leading and supporting policy analysis. Also, these levels do not just engage in direct practice, but also provide system leadership and supports for practice at other levels.

Public health action on health determinants and health inequities is often framed externally since most of the policy levers are held by other sectors. Potentially, three of the four roles address this perspective. However, the second listed role focuses on whether the design and delivery of public health programs and services are reducing health inequities. Including an examination of its own programming equips public health with an opportunity for action negating the 'outside our mandate' concern, fosters the necessary critical thinking and analysis for all of the roles, and potentially builds credibility with other partners (i.e., lead by example). This self-examination is encouraged in the recent WHO Commission's report on social determinants and public health programmes stating:

Effectively addressing inequities in health involves not only new sets of interventions, but modifications to the way that public health programmes (and possibly WHO) are organized and operate, as well as redefinition of what constitutes a public health intervention.⁶⁰

The wording of the third role is unique in starting with the phrase "*Engage in community and multi-sectoral collaboration.*" While this phrase only appears in the third role, the reality is that community engagement, partnership and inter-sectoral collaboration are key principles of public health practice and apply to all of the roles. For example, the *Ontario Public Health Standards* state the following:

Public health programs and services involve extensive partnerships within the health sector and other sectors. Public health promotes community capacity building by fostering partnerships and collaborating with community partners, including the voluntary sector, non-governmental organizations, local associations, community groups, networks, coalitions, academia, governmental bodies, the private sector, and others. Public health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management, and evaluation of programs and services. This will support improved local capacity to meet the public health needs of the community.²⁴

The implication is that while explicit in the third role, these principles underlie public health practice for all of the roles. For example,

ROLE 1 *(assessing and reporting on health status and what could be done to improve it):*

- Using data collection methods to ensure the needs of marginalized and priority populations are identified
- Engaging the community to seek meaning and understanding of the findings
- Providing results to foster community discussion, problem solving and action

ROLE 2 *(modify/re-orient public health programs):*

- Requires an understanding of needs among populations, which itself requires engagement with community
- Requires an understanding of existing services available in the community, which requires engagement with other providers

ROLE 3 *(engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs):*

- Requires an understanding of needs among populations, as well as services from other providers
- Requires collaboration with other service providers to prioritize gaps and identify steps to address them

ROLE 4 *(lead/support/participate with others to address policies):*

- Requires community and multi-sectoral collaboration.

Several concerns were expressed for the fourth listed role, which had initially been worded as “*Supporting community and other stakeholders in policy advocacy participate and support.*” The criticism was that public health should lead action on determinants and this word has now been added as an option reflecting the input of several scan participants who observed that whether public health should lead or participate was context specific. In some instances it may be appropriate for public health to be a participant and contribute its expertise to an inter-sectoral table and it would be inappropriate for public health to come to an existing process that may have been ongoing for some time and expect to take charge. This understanding of when it makes sense to lead and when it makes sense to participate requires well-developed leadership/strategic competencies.

While these four roles/functions highly resonate with environmental scan participants (key informants, online survey respondents and focus group participants), several suggestions for additional public health ‘roles’ were made including: leadership, educating the public and broader decision-makers, research and evaluation, improving staff and other service provider skills, etc. The challenge is that these are not stand-alone roles, but apply to all of the existing set of four roles (and most other public health activitiesⁱⁱ). For example, for all four roles, leadership is required to first state that taking action on health

ⁱⁱ If one picks any core public health programmatic area, whether chronic disease prevention, communicable disease control, environmental health, or healthy development, public health approaches and capacity building will invariably include leadership, education, research and evaluation, and skill development.

determinants to reduce health inequities is a priority. Then, leadership is required to pursue that public health role, to champion it internally, and in many instances, champion the findings/actions externally. Education and awareness raising can similarly be applied to all of the roles whether it is raising awareness about the existence of inequities, garnering support to reallocate public health resources or to foster support for policy change at a relevant system level. Similarly, skill development of staff is a consideration for fulfilling any of the roles.

The overall point is that there are a series of approaches and areas for capacity building that are the means by which the organization strengthens and fulfills these four roles. For example, the DETERMINEⁱⁱⁱ consortium has produced a *Menu For Capacity Building and Awareness Raising Action to Address the Social Determinants of Health and to Improve Health Equity*,⁶¹ which includes many of these concepts. Although developed for their European partners, the authors of the menu hoped that it would “also serve as a useful resource to bodies beyond the DETERMINE partnership that aim to build capacities on the social determinants of health and health equity.”⁶¹ Similarly, many of these same concepts also appear in a more broadly focused capacity building framework from Australia.⁶² As indicated by these frameworks, these additional suggested ‘roles’ are the means to foster achievement of the four public health roles to address health determinants to reduce inequities. Accordingly, Table 4 provides a mechanism for linking these suggested additional approaches with the four roles for public health action. For the individual public health organization, this table provides a potential aide to assessing the extent to which it is taking action across the four public health roles and what opportunities or limiting steps there may be with respect to current approaches and capacity building.

This table may also assist the NCCDH to conceptualize the various options it has to inform and improve public health action on health determinants to reduce health inequities. It will likely facilitate more focused questions than simply how can NCCDH support public health action since consideration of each cell of the framework will generate potential questions (e.g.):

- What is the evidence for how best to engage/support public health leaders to foster greater action on health determinants?
- What is the evidence for how best to assess the impact of inequities in small populations (neighbourhoods, rural)?
- What is the evidence for how best to balance a combination of universal and targeted interventions?
- What is the evidence for choosing what type of partnership to pursue? When should an organization lead versus be a participant?
- What skills do public health staff need in order to better engage communities?
- What is the evidence for how best to re-orient a public health team/organization to engage in reflective practice regarding inequities?
- Etc.

A potential disadvantage of this table is that a 4x6 table with 24 cells could risk overwhelming the NCCDH and lead to a scatter of activities. Subsequent sections will address the issue of priorities.

ⁱⁱⁱ DETERMINE is a European Union (EU) wide initiative to stimulate action to address the social and economic determinants of health and to improve health equity in the EU and its Member States.

TABLE 4: LINK BETWEEN PUBLIC HEALTH ROLES, APPROACHES AND CAPACITY BUILDING

| Components to Public Health Action* (How public health achieves/strengthens these roles) | | | | | | |
|--|--|---|--|---|--|--|
| Leadership | Develop/Apply Information & Evidence | Education & Awareness Raising | Organizational and System Development | Skill Development | Partnership Development | |
| Public Health Roles (What public health can do to address inequities) | Required for internal and external action (establish priorities, resource allocation, structural change, engaging others, modeling behaviours) | Require clear understanding of existing situation and effectiveness of policies and interventions | Willingness and ability to act (internally and externally) requires ongoing process of informing and sensitizing stakeholders, decision-makers and the public. | Addressing the policies, structures, procedures and practice of an organization (or system) to be in place to address inequities and managing the required change | Knowledge, skills and attitudes to adopt and implement new strategies, approaches and techniques. While internal, also potentially external as well. | Critically important for community engagement, development and action. |
| Assess and report on health of populations describing existence and impact of inequities/inequities and effective strategies to address those inequities/inequities. | | | | | | |
| Modify/orient public health interventions to reduce inequities | | | | | | |
| Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs | | | | | | |
| Lead/support and participate with other stakeholders in policy analysis, development and advocacy | | | | | | |

*Influenced by: DETERMINE's Menu for Capacity Building⁶¹ Monograph; New South Wales' Framework for Capacity Building⁶²

Implications for NCCDH Practice - Principles and Approaches

Position the NCCDH as the 'Go-To' Source for Information on Public Health Action on Health Determinants to Reduce Health Inequities

The NCCDH needs to raise its profile and credibility as the 'go-to' site for best advice on how to take action on the health determinants to reduce health inequities. The widespread perspective among environmental scan participants is that this is not currently the case. The NCCDH needs to provide ready access to the conceptual thinking and evidence, practice examples, frameworks and tools to equip the public health field to effectively take action on the health determinants to reduce health inequities. This is not a passive process and the NCCDH needs to strategically use a variety of mechanisms to engage its target audiences and provide information and advice tailored to their needs. Existing portals in other countries illustrate how others have tackled this challenge.

A key aspect of credibility is the quality of the material provided through the NCCDH. The best available evidence needs to drive the materials provided with transparency of how this was established.

Recognize that the 'Unit of Adoption' is Primarily the Public Health Organization

While public health action inherently involves individual practitioners, the roles for public health action on health determinants to reduce health inequities reflect organizational level processes and outputs. Whether to measure and report to the public about inequities among neighbourhoods or critically examine how programs are planned and implemented or engaging community partners to strategically address prosperity, these actions are not within the direct control of front-line staff. The knowledge, skills and attitudes of those staff are important enablers of action, but the decision-making authority regarding organizational priorities and practices rests ultimately with the management layers of organizations. Focussing primarily on front-line practitioners is unlikely to foster progress towards public health organizations taking greater action on health determinants to reduce inequities and doing so will set up front-line staff for frustration as they attempt to take action that is not aligned with their organizational context.

A CRITICAL DRIVER FOR ORGANIZATIONAL ADOPTION IS LEADERSHIP

One of the key differences between the adoption of innovation by individuals versus organizations is that for the latter, buy-in and leadership from the organization's senior management are essential. The reason is that leadership is essential for establishing action on health determinants as a priority, allocating resources, modelling desired behaviours, and overseeing implementation.

Recognizing the importance of this leadership, targeting of efforts to support leaders at various levels within organizations should be considered. Peer opinion leaders can be used to influence and model desired decisions. Formal system leaders such as Chief Medical Officers of Health and provincial and federal public health agencies can reinforce and support decisions towards adoption.

STUDY AND SUPPORT THE ADOPTION PROCESS

Pursuing the identified four public health roles will likely involve a change in the way a public health organization conducts business. Whether it is reflecting on values and attitudes, critically reflecting on existing practices, or reallocating resources, resistance and tension should be anticipated. The capacity building framework provided earlier in this report is a starting point for assisting analysis and provision of supports. Currently, there are many existing examples of approaches being pursued in this and other countries including:

- Reorienting ‘health promotion’ staff from a behaviour focus to a determinants focus
- Staff education and dialogue – show staff the data showing inequities of current practice and provide concrete options for action
- Use of PBS documentary *Unnatural Causes* to facilitate conversation among workforce
- Use of a working group to review practices and recommend changes
- Use of knowledge brokers to work with program managers and planners
- Establishment of an organizational unit to serve as a catalyst for internal and external change.

There is a need to learn more about how and why particular approaches have been implemented and the extent to which they were successful. Identifying critical success factors for adoption and implementation is an area of active research and those findings, when they become available, will need to be translated for use by the practice community.

Demonstration project funding may also assist consideration of adoption and provide a mechanism to document the process and its impacts.

**Provide the Information and Tools to Support Public Health Action
on Determinants of Health and Inequities**

IMPROVE THE CONCEPTUAL CLARITY ABOUT PUBLIC HEALTH ACTION

The current challenge regarding the uncertainty of what public health should or could do needs to be addressed. Tracing the historical roots of public health through to the landmark documents of recent decades (e.g., Ottawa Charter, population health promotion cube, etc.) could provide a foundation for current action.

To solidify the foundation, there is a need to synthesize the existing evidence to clearly articulate “what we know, what we may know and what we do not know.” This includes health gradients within Canada, the inter-relationships and pathways among determinants, and the generalizability of findings from other countries. Priorities for evidence synthesis need to be established and pursued. If high quality syntheses already exist, then they do not need to be duplicated. Where there is insufficient high quality evidence to support synthesis, then those areas should be flagged for future research.

Much greater clarity is required for public health audiences regarding the comprehensive application of a population health approach including the potential tension between overall population improvement versus reduction in inequities, structural versus information-type interventions, balancing universal versus targeted approaches, as well as the approaches to address the complexity of action across multiple sectors. The recent dialogue in the published literature among Canadian researchers addressing some of these concepts is foundational to conceptualizing and planning public health interventions.^{58,63-65} Such a dialogue should be highlighted if not enabled through a body such as the NCCDH.

Recognizing that there is a range of target audiences, the NCCDH should also package the principles highlighted by this debate for broader consumption as has been done in a summary paper on health inequalities in Scotland.³⁶ In that paper, the author provides guidance regarding which interventions would tend to worsen inequities versus those that would tend to lessen them (see following boxes).

Characteristics of Policies More Likely To Be Effective in Reducing Inequalities in Health

- » Structural changes in the environment: (e.g. area wide traffic calming schemes, separation of pedestrians and vehicles, child resistant containers, installation of smoke alarms, installing affordable heating in damp cold houses)
- » Legislative and regulatory controls (e.g. drink driving legislation, lower speed limits, seat belt legislation, smoking bans in workplaces, child restraint loan schemes and legislation, house building standards, vitamin and folate supplementation of foods)
- » Fiscal policies (e.g. increase price of tobacco and alcohol products)
- » Income support (e.g. tax and benefit systems, professional welfare rights advice in health care settings)
- » Reducing price barriers (e.g. free prescriptions, school meals, fruit and milk, smoking cessation therapies, eye tests)
- » Improving accessibility of services (e.g. location and accessibility of primary health care and other core services, improving transport links, affordable healthy food)
- » Prioritizing disadvantaged groups (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless)
- » Offering intensive support (e.g. systematic, tailored and intensive approaches involving face to face or group work, home visiting, good quality pre-school day care)
- » Starting young (e.g. pre and post natal support and interventions, home visiting in infancy, pre-school day care)

Source: Macintyre S. Inequalities in health in Scotland: what are they and what can we do about them? MRC Social & Public Health Sciences Unit: Glasgow, 2007.

Characteristics of Interventions Less Effective in Reducing Inequalities in Health

- » Information based campaigns (mass media information campaigns)
- » Written materials (pamphlets, food labelling)
- » Campaigns reliant on people taking the initiative to opt in
- » Campaigns/messages designed for the whole population
- » Whole school health education approaches (e.g. school based anti smoking and alcohol programmes)
- » Approaches which involve significant price or other barriers
- » Housing or regeneration programmes that raise housing costs

Source: Macintyre S. Inequalities in health in Scotland: what are they and what can we do about them? MRC Social & Public Health Sciences Unit: Glasgow, 2007.

Several key informants warned about putting effort into creating specific tools or checklists. Instead, they stressed that it was more important for the NCCDH to establish the knowledge base, and foster critical reflection about public health practices and inequities based on existing evidence since it is only possible to properly apply a framework or tool if one understands the underlying concepts. In many instances, there are multiple existing tools or checklists and the NCCDH could provide guidance on which to use and in what circumstances.

STUDY AND SHARE EXISTING PRACTICES

A key challenge is that those wishing to take greater action to reduce health inequities lack the tangible strategies and actions for this work. During the course of this environmental scan, a number of promising public health actions on health determinants were encountered. Some appear to be clear priorities for further study and dissemination. Examples include:

- Documentation of large disparities in child immunization rates by neighbourhood in Saskatoon. This led to internal work to modify allocation of resources in order to increase coverage in the low coverage neighbourhoods, which is now being achieved.
- Systematic approaches to examining existing public health practices across multiple programs to identify program plan modifications in order to reduce health inequities (Sudbury, Waterloo).
- Response of the Montreal Public Health Department to the planned movement of a casino to an area with populations that would be more vulnerable to the adverse effects of increased access to gambling.
- Community development approach to improve a neighbourhood in Saint John.

Appendix 12 provides a more detailed list of potential practice examples for further study. Selecting which practice examples to prioritize for write-up should consider the extent of demonstrable impact, as well as, achieving a mix of interventions by public health role, determinants involved, population, and regional perspectives. Careful attention will need to be given regarding not just capturing what happened, but clearly identifying the thinking and analysis that the organization went through to choose their course of action and the generalizable principles/learning for others, particularly considering the unique aspects of context and organizational readiness. Examples should be critically assessed how they illustrate or expand our understanding of the evidence. IPPH's experience developing casebooks may be valuable and that organization could also be asked for assistance with the peer review process.

Consideration should also be given as to how to best provide descriptions of practices. Many of the existing portals, including the Health Council of Canada, use a mix of methods including both written and video profiles of interventions. An example from Saint John is available at:

http://www.youtube.com/healthcc#p/u/9/Je_Vuw6dwUs

SUPPORT THE PRACTICE OF THOSE COMMITTED TO ADDRESS HEALTH INEQUITIES

Those organizations that have been working in this area for many years need to be not only studied, but also need to be supported to continue to advance their practices. These organizations have requirements for more detailed and technical syntheses and other supports. Examples suggested during this environmental scan included business cases, economic analyses, modelling of different combinations of universal and targeted approaches, and effective policy options stratified by level of government. More specific information gathering and prioritizing needs from these sites is likely warranted.

PROVIDE LINKS TO EVIDENCE REGARDING SPECIFIC INTERVENTIONS

It was previously acknowledged that attempting to conduct knowledge syntheses for every type of public health intervention to address inequities, including targeting priority populations, will be overwhelming. Providing a link to quality syntheses, where they exist, could be a potential NCCDH contribution. Several key informants encouraged a willingness to highlight evidence challenging prevailing thinking regarding practices historically intended to reduce inequities. The Scottish discussion paper by Macintyre provides multiple international examples of well-intended interventions that had adverse effects.⁶⁶

FOSTER ENGAGEMENT AND DIALOGUE IN THE PUBLIC HEALTH COMMUNITY

Considering the current state of practice, dialogue throughout the public health community is needed to increase understanding, to encourage examination of values and attitudes, to discuss public health roles, and to encourage reflection on current practices. To achieve this, a variety of possible approaches were raised by environmental scan participants including:

- Workshops: experience of other NCCs has been that engagement of the audience is an important predecessor to their using the organization's materials
- Webinars: need to reduce the geographic distance barrier through technology. Not everyone can come to conferences, but there is a huge interest in learning more. Within Canada, there are many leading practitioners and researchers who could share their thinking and experiences.
- Video: there are a range of uses of video from profiles of interventions and tools to more sophisticated documentaries such as PBS' *Unnatural Causes*. Many Canadian organizations have been using it internally and externally to foster dialogue, although would prefer one with a Canadian context.
- Practice Network: there is an interest among practitioners to be able to share experiences and problem solving. In fact, some focus group participants hearing of what others were doing spontaneously arranged sharing of tools and contact information.
- Organizational Networking: there are many organizations with an interest in this area (e.g., NCCDH, other NCCs, CIHI-CPHI, CIHR-IPPH, PHAC, etc.). There is a need for organizations to periodically come together to share what they are doing and identify opportunities for action.

FOSTER TRAINING OPTIONS

Practitioners at all levels need opportunities to develop needed competencies. As previously discussed, there are limited opportunities for developing the necessary knowledge and skills, and efforts to address this gap will need to be tailored to different groups of staff. Training will need to foster critical analysis and reflective practice (e.g. self assessment tools), integrating assessment of inequities into each step of the program planning cycle, as well as addressing how to seek a balance of universal and targeted interventions. Among front-line staff, skill development for community development, capacity building, and mobilization were identified by key informants as priorities.

The NCCDH does not necessarily have to create the training themselves, but could encourage, promote and/or partner with others to achieve this. Examples include: PHAC's Skills Online program, summer schools, conferences and the growing number of Masters in Public Health programs and Schools of Public Health.

STRENGTHEN SYSTEM REINFORCEMENT

The fundamental underlying perspective is that public health analysis and action on health determinants to reduce health inequities is simply good practice that should be the norm. This normalization of practice therefore needs to be embedded throughout the structures and processes of public health systems. Considering the work on public health system infrastructure conducted this past decade,⁶⁷⁻⁶⁹ this would include, but not be limited to, public health system legislation, core programs, protocols, accreditation criteria and their application, accountability mechanisms, etc. The NCCDH could encourage relevant partners to strengthen public health system structural components to support public health action on health determinants to reduce health inequities. Some specific examples emerging from scan participants include:

- Advising more explicit wording to addressing health determinants to reduce inequities when the core competencies are reviewed and updated
- Assessing how accreditation standards for public health/health organizations are being applied
- Encourage accountability mechanisms for organizations to include processes and actions that address inequities
- Encouraging discipline continuing professional development credits for training options that are developed.

Engage in Strategic Partnerships for Broader Public Engagement

As with all NCCs, the mandate of the NCCDH is to promote and improve the use of scientific research and other knowledge to strengthen public health practices – in this instance regarding action on health determinants to reduce health inequities. It is therefore beyond the mandate of the NCCDH to engage in direct advocacy efforts with the public or non-public health policy-makers. However, since effective

policy analysis, development and advocacy by public health organizations is a desired action, then providing the necessary evidence, frameworks and tools to support that to occur is within the sphere of action of the NCCDH. Public health organizations and associated professional organizations need to achieve greater public engagement regarding determinants and health inequities. Many existing examples were encountered during this scan:

- Inter-sectoral presentations to municipal leaders and other government departments by Vancouver Coastal Health Authority
- Public consultation on policy options to address documented health inequities in Saskatoon
- Public awareness raising about health inequities in Sudbury
- Public challenging of moving casino to a neighbourhood with more vulnerable populations in Montreal
- Public presentations of PBS' *Unnatural Causes* in Halifax.

There are also broader public health engagement strategies that are possible that could be led by public health associations and coalitions. Examples include the development of a Canadian documentary on health determinants and health inequities; as well as public consultations that could be facilitated across the country. The NCCDH could be a participant in such endeavours providing evidence to inform discussions and actions and being a conduit for findings generated by such engagement to inform practice.

Potential Early Actions

Key informants were asked what actions the NCCDH could take in the short term to have positive impact. Suggested examples include:

- Begin to clarify the conceptual foundation of this work:
 - *Thread of development through key documents (Ottawa Charter, etc.)*
 - *What does population health approach mean? Does public health only target the 'general population'? Concepts of priority populations, structural interventions, etc.*
 - *Synthesize the evidence to clarify what we know, may know and do not know (e.g., gradients, inter-relationships, pathways)*
- Write up case studies of promising practice examples integrating key messages/learning with existing understanding/evidence
- Canadianize existing quality materials from other countries
- Provide links to key international portal sites
- Launch a Webinar series with practice leaders and researchers
- Plan a leadership institute for public health leaders (e.g., state of existing knowledge; state of practice; inter-sectoral action in the face of complexity; complex adaptive systems; organizational change).

CONCLUSION AND NEXT STEPS

The purpose of this environmental scan was to inform the NCCDH's future direction, priorities and activities through an analysis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health. Over a 10-week period, a focused scan of the literature, key informant interviews, focus group teleconferences, and an online survey were conducted.

There is widespread interest in having a strong and visible NCCDH to support effective public health action on the determinants of health. As outlined in this report, the field of public health faces numerous challenges and barriers to action. Based on the information collected, an area of focus, vision and implications for future NCCDH actions have been proposed.

This environmental scan is but a preliminary step. There are a multitude of required next steps to discuss this report, make decisions about future priorities and actions, and establish the necessary capacities to achieve them. Suggested next steps include the following:

1. *Discuss the suggested future direction of the NCCDH between the NCCDH, the NCCDH National Advisory Committee, and PHAC. Items to be addressed include:*
 - a. Extent of agreement with the findings, analysis and implications
 - b. Extent that further validation of the findings and their analysis should be pursued – considering the extent of input and consistency of themes, it is suggested that it is more important to move forward
 - c. Extent that the report and associated materials will be disseminated to the field –at a minimum, the NCCDH should accompany any such dissemination with a statement of what has and will be done in response to this report
 - d. Development of a multi-year strategic plan and annual workplan including immediate priorities for action
 - e. Development of a transition plan to address the work done to-date, as well as raising the issue of who might take the lead on such issues in the future (e.g., nurse home visiting programs).

2. *Establish the necessary structure, capacities and processes to fulfill the described vision and priorities. Careful attention will be required to:*
 - a. Establish clarity of roles between the NCCDH, the NCCDH National Advisory Committee, and PHAC
 - b. Foster the necessary orientation of the NCCDH between the practice and research fields
 - c. Have an in-depth understanding of, and linkages with, public health practice community including:
 - The ability to effectively interact with the leaders of public health organizations
 - Understanding of structure and functioning of public health systems
 - d. Understanding of the adoption of practices from an organizational perspective and how this can be effectively influenced
 - e. Provide leadership to identify what is important and effectively articulate this to build a team and a variety of partnerships (e.g., researchers, other NCCs, other public health-related bodies, etc.), and interact with advisory and funding bodies
 - f. Oversee the implementation of complex tasks that achieve the strategic vision and are tailored to the various target audiences (i.e., strong project management).

APPENDIX 1

ENVIRONMENTAL SCAN DELIVERABLES

The Request for Proposals lists the following deliverables for the environmental scan:

1. Environmental scan report, including:
 - Documentation and synthesis of current activities, public health leaders/stakeholders and an analysis of promising areas in the determinants of health for public health
 - Synthesis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health
 - Identification of knowledge translation tools and strategies which are already developed or need to be developed (such as case studies; fact sheets of key opportunities; fact sheets of successful public health interventions; determinants of health lenses; or webinars)
 - Identification (if appropriate) of a cluster of priority determinants of health, promising areas and priority interventions for public health practice and policy, focus and action
 - List of the “go to” people (leaders/champions/priority stakeholders) with contact information
 - List of key resources in the area of the determinants of health for public health.
2. Executive summary report (stand alone) on promising areas and priority interventions in the determinants of health for public health.
3. Executive summary report of needs, gaps, and opportunities in the determinants of health for public health.
4. Information package to facilitate the validation of the environmental scan.

APPENDIX 2 FURTHER DETAILS REGARDING METHODOLOGY

Information Gathering Roles

As indicated in the main body of the report, with the addition of the focus group teleconferences and an online survey, there was an agreement that NCCDH staff would contribute to the information gathering processes. Role delineation for each of the information gathering steps included the following:

| Information Gathering Component | Consultant | NCCDH |
|---------------------------------|--|---|
| Scan of the literature | Conduct searches, review and extract information | Identify 'not-to-miss' reports |
| Key informant interviews | Provide advice on selection Draft key informant questionnaire Conduct key informant interviews | Identify list of key informants Advise on key informant questionnaire Recruit and schedule key informants |
| Online survey | Advise on survey questions | Create, translate, and pilot survey Arrange for survey to be online Promote survey Analyze results and provide to consultant |
| Focus group teleconferences | Prepare background material (summary of themes, discussion questions) Conduct teleconferences | Recruit and schedule participants Provide teleconference capacity |

Organizations' Websites Included in the Scan of the Literature

The following websites were included as part of the primary search strategy.

- Public Health Agency of Canada (PHAC)
- WHO Commission on Social Determinants of Health
- Canadian Reference Group on Social Determinants of Health
- Other NCCs
- Urban Public Health Network (UPHN)
- Institute of Population and Public Health (CIHR-IPPH)
- Canadian Population Health Initiative (CIHI-CPHI)
- Public health associations – national and provincial
- Accreditation bodies for public health organizations
- Health-evidence.ca.

Additional sites were included based on information provided by key informants/focus group participants.

APPENDIX 3 LIST OF KEY INFORMANTS

| Key Informant | Position and Organization |
|---------------------|---|
| Lorraine Adam | Executive Director, Public Health Programs and Strategies, Division of Public Health and Primary Health Care, Manitoba Health and Healthy Living, Winnipeg, Manitoba |
| John G. Abbot | CEO and Chair, Health Council of Canada (Alternate for Dr. Jeanne Besner), Toronto, Ontario |
| Lex Baas | Director of Population Health, Interior Health , Nelson, British Columbia |
| Dr. Bill Bavington | Faculty of Medicine, Division of Community Health and Humanities, Memorial University, St. John's, Newfoundland |
| François Benoit | Lead, National Collaborating Centre for Healthy Public Policy (NCCHPP), Institut national de santé publique du Québec, Montréal, Québec |
| Ted Bruce | Executive Director, Population Health, Vancouver Coastal Health, Victoria, British Columbia |
| Dawn Marie Buck | Executive Director, St. Joseph's Community Centre, Saint John, New Brunswick |
| Dr. Donna Ciliska | Scientific Director, National Collaborating Centre for Methods & Tools (NCCMT), McMaster University, Hamilton, Ontario |
| Connie Clement | Executive Director, Social Venture Partners Toronto at Centre for Social Innovation, Toronto, Ontario |
| Dr. Benita Cohen | Associate Professor, Faculty of Nursing, University of Manitoba |
| Erica Di Ruggiero | Associate Director, Canadian Institutes of Health Research (CIHR) - Institute of Population and Public Health, Toronto, Ontario |
| Dr. Margaret Fast | Scientific Director, National Collaborating Centre for Infectious Diseases (NCCID), International Centre for Infectious Diseases, Winnipeg, Manitoba |
| Dr. John Frank | Senior Scientific Advisor to the National Collaborating Centres for Public Health Program, Chair, Public Health Agency of Canada (PHAC) National Collaborating Centres Advisory Council |
| Dr. Margo Greenwood | Academic Leader, National Collaborating Center for Aboriginal Health (NCCAHA), University of Northern British Columbia, Prince George, British Columbia |
| Dr. Trevor Hancock | Public Health Consultant, Ministry of Healthy Living and Sport, Victoria, British Columbia |

| Key Informant | Position and Organization |
|-----------------------|--|
| Jean Harvey | Director, Canadian Population Health Initiative (CPHI), Ottawa, Ontario |
| Dr. Clyde Hertzman | Director, Human Early Learning Partnership (HELP), Vancouver, British Columbia |
| Sandra Laclé | Director, Health Promotion Division, Sudbury and District Health Unit, Sudbury, Ontario |
| Lynn Langille | Coordinator, Health Disparities Chronic Disease and Injury Prevention, Nova Scotia Health Promotion and Protection, Halifax, Nova Scotia |
| Dr. Richard Lessard | Director of Public Health, Montréal Public Health, Montréal, Québec |
| Madonna MacDonald | Vice President Community Health, Guysborough Antigonish Strait Health Authority (GASHA), Antigonish, Nova Scotia |
| Dr. Lynn McIntyre | Professor and CIHR in Gender and Health, Department of Community Health Sciences, Faculty of Medicine, University of Calgary, Calgary, Alberta |
| Dr. John Millar | Executive Director, Population Health Surveillance and Disease Control Planning, Provincial Health Services Authority, Vancouver, British Columbia |
| Dr. David Mowat | Medical Officer of Health, Peel Region |
| Dr. Cory Neudorf | Chief Medical Health Officer, Saskatoon Health Region, Saskatoon, Saskatchewan |
| Dr. Alain Poirier | Provincial Public Health Director and Assistant Deputy Minister, Ministry of Health & Social Services, Québec, Québec |
| Dr. Louise Potvin | Professeure titulaire, Département de médecine sociale et préventive, Université de Montréal, Montréal, Québec |
| Daniela Seskar-Hencic | Manager, Health Determinants, Planning and Evaluation, Region of Waterloo Public Health, Waterloo, Ontario |
| Dr. Dawn Smith | Assistant Professor and Loyer DaSilva Research Chair in Public Health Nursing, University of Ottawa, Ottawa, Ontario |
| Dr. David Strong | Medical Health Officer, Surveillance and Health Status Assessment, Alberta Health Services, Edmonton, Alberta |
| Margot Suttis | Registered Lactation Consultant, Public Health Nurse, Dept of Health and Social Services, Iqaluit, Nunavut |

APPENDIX 4

KEY INFORMANT INTERVIEW GUIDE

Introduction

The focus of the National Collaborating Centre for Determinants of Health (NCCDH) is the factors that influence the health of Canadians. The NCCDH is undertaking an environmental scan regarding the actions of formal public health organizations and their staff to address the determinants of health. The scan's findings will be used to help shape future direction and the knowledge translation priorities and activities of the NCCDH over the next five years (2010 – 2015).

Key Informant Questions

1. Imagine a future five (5) years from now in which the NCCDH is optimally supporting public health action on the determinants of health (DOH). What does that future look like to you? (i.e., what does success look like?)
2. To what extent do you agree that the following are roles for public health organizations and their staff in taking action on the DOHs?
 - Assessing and reporting on the DOHs in populations including the existence and impact of health inequalities and inequities
 - Modifying public health interventions to meet the unique needs and capacities of priority populations
 - Engaging in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs
 - Supporting community and other stakeholders in policy advocacy for improvements in the DOHs
 - Other?
3. What would you identify as the best examples of public health activities (practice, policy, and/or research) addressing the DOHs in your (or other) organization/system? (please provide specific example(s))
 - Are there any particular practice tools, strategies or other resources that we should be aware of or that you would recommend?

4. What do you see as the key challenges/needs/gaps for public health in addressing the DOHs?
5. What opportunities are there for improving public health action in addressing the DOHs?
6. Considering the current state of public health actions on the DOHs, what could the NCCDH do to have the greatest impact on strengthening public health action on the DOHs?
 - To what extent should the NCCDH's focus be...
 - *On specific roles (see list Question 2)?*
 - *On particular DOH(s). (see lists in Appendix)*
 - *All/some DOHs*
 - *All/some 'Social Determinants of Health' (& which list?)*
 - *Other?*
 - *Specific populations (e.g., Aboriginal, immigrant/refugee, persons with mental health challenges, persons with disabilities, etc.)*
 - *Other? (e.g., work through the other NCCs)*
 - What types of knowledge translation approaches would be most helpful? (e.g., summaries of evidence; case studies of public health actions; equity-based program planning framework; health impact assessment tool; knowledge brokering; key messages for internal and external stakeholders, support structure for sharing of information and issues, etc.)
 - What are two things that the NCCDH could do that would have immediate impact to support public health action on the DOHs?
7. There are many well-known leaders and champions in this field. Who should we be aware of that may not be as well known, but is a leader in public health action to address the determinants of health?

APPENDIX 5 ONLINE SURVEY QUESTIONNAIRE

Introduction

The National Collaborating Centre for Determinants of Health is one of six Centres established by the Public Health Agency of Canada to support evidence-informed public health practice and policy-making. The mission of the Centres is to translate existing and new evidence produced by academics and researchers in public health into accessible and useful information. The focus of the National Collaborating Centre for Determinants of Health (NCCDH) is on the factors that influence the health of Canadians. The NCCDH is undertaking an environmental scan regarding the actions of public health organizations and their staff to address the determinants of health (DOH). The scan's findings will guide the future direction and the knowledge translation priorities and activities of the NCCDH over the next five years (2010 – 2015).

The purpose of this online survey is to gather information from a broad and diverse group of public health practitioners, policy-makers, managers, educators and researchers from across Canada to complement the other information being gathered. Your responses will be included in the analysis of the environmental scan data and in the environmental scan report and recommendations.

Please direct any questions about the survey to Hope Beanlands, Scientific Director, at 902-867-6137.^{iv}

IT IS ANTICIPATED THAT THE SURVEY WILL TAKE ABOUT 15-20 MINUTES TO COMPLETE.

Demographics

1a. *Which province/territory?*

(drop down box – of the provinces and territories and national)

1b. *Which best describes the setting in which you work?*

- rural
- remote
- urban

1c. *Which best describes the type of organization for which you work?*

- Public health organization
 - Local/regional
 - Provincial/territorial
 - Federal
- Other government department/organization
- Non-governmental organization
- Community Health Centre
- Professional association
- Academic institution
- Other: _____

^{iv} Hope Beanlands has since left the NCCDH. Inquiries about the survey can be directed to NCCDH at nccdhd@stfx.ca.

1d. *Which best describes your public health role:*

- Front-line public health practitioner (e.g., public health nurse, public health inspector, health promoter)
- Technical expert (e.g., epidemiologist, program consultant)
- Policy/Decision-maker (e.g., director, executive head of organization, Medical Officer of Health)
- Researcher
- Educator of public health practitioners
- Other: _____

Determinants of Health

The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions. These factors are referred to as the 'determinants of health', and together they play a key role in determining the health status of the population as a whole. Addressing the determinants of health is fundamental to public health.

2a. *To what extent do you agree that the following are roles for public health organizations in taking action on the determinants of health (DOH)?*

(4-point scale: strongly agree; somewhat agree; somewhat disagree; strongly disagree)

- Assess and report on the determinants of health in populations including the existence and impact of health inequalities and inequities
- Modify public health interventions to meet the unique needs and capacities of priority populations
- Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs
- Support community and other stakeholders in policy advocacy for improvements in the determinants of health

2b. *Are there additional important roles for public health organizations in taking action on the DOHs?*
(Y/N – If yes, please describe)

3. *What would you identify as the best examples of public health action (practice, policy, and/or research) to address the DOHs? These examples could include action that addresses the determinants of health as a whole, the framework, or individual determinants alone or in combination*

Please provide specific example(s) – (e.g., name of organization, name/type of initiative, name of project leader, name of report, etc.) *(narrative response space)*

4. *Please list any practice tools, strategies or other resources that you are aware of and think would be helpful to other public health organizations' work to address the DOHs? (where possible - include the name and how to access) (narrative response space)*

5. *What are the key challenges/needs/gaps for public health organizations/staff to better address the DOHs?*

(4-point scale: strongly agree; somewhat agree; somewhat disagree; strongly disagree)

- Stronger organizational/system leadership? (e.g., explicit expectations for public health organizations to address DOHs; identification of DOH action as priority; resource allocation targeted to DOH work)
- Education/training/skill development of the existing and future workforce? (e.g., in applying DOH-based frameworks and tools; conducting DOH-based analysis; establishing priorities)
- Develop external partnerships? (e.g., skills to engage partners; areas for joint action)
- Establish organizational routines to address DOHs in program planning cycles? (e.g., application of equity lens to steps of planning cycle; integrating DOH activities into organization)
- Other: _____

6a. *In order to best support the actions of public health organizations and their staff to address the determinants of health, which DOH framework should be the focus of the NCCDH's work?*

- Determinants of Health (PHAC)

Determinants of Health

- » Income and Social Status
- » Social Support Networks
- » Education and Literacy
- » Employment/Working Conditions
- » Social Environments
- » Physical Environments
- » Personal Health Practices and Coping
- » Healthy Child Development
- » Biology and Genetic Endowment
- » Health Services
- » Gender
- » Culture

Source: Public Health Agency of Canada

- Social Determinants of Health

Social Determinants of Health

- » Income and Income Distribution
- » Education
- » Unemployment and Job Security
- » Employment and Working Conditions
- » Early Childhood Development
- » Food Insecurity
- » Housing
- » Social Exclusion
- » Social Safety Network
- » Health Services
- » Aboriginal Status
- » Gender
- » Race
- » Disability

Source: Raphael

- Selected Determinants -
Chief Public Health Officer Report
(Addressing Health Inequalities)

CPHO Report - 2008

- » Income
- » Employment & working conditions
- » Food security
- » Environment & housing
- » Early childhood development
- » Education & literacy
- » Social support & connectedness
- » Health behaviours
- » Access to health care

Source: CPHO Report 2008: Addressing Health Inequalities

- Other framework (please identify) _____

6b. *For the selected framework, should the focus of the NCCDH be on all or specific determinants?*

- All determinants in the framework
- Some determinants in the framework (if so, which ones?) *(framework items as checklist)*

7. *From the list below, identify the top three items which would be of greatest assistance to strengthen public health organizations'/systems' actions to address the DOHs?*
- a. Case studies of public health organization's actions to address DOHs
 - b. Summaries of existing evidence
 - c. Tools/checklists for addressing DOHs (e.g., Health Impact Assessment; program planning framework; conducting situational/needs assessments)
 - d. Knowledge brokering service (provision of best practice advice tailored to local context)
 - e. Mentoring by experienced peers
 - f. A support structure for sharing of information and issues among public health staff/ organizations (e.g., networks; communities of practice)
 - g. Key messages/tools for engaging internal and external stakeholders
 - h. Other _____
8. *There are many well-known leaders and champions in this field. Who should we be aware of that may not be as well known, but is a leader in public health action to address the determinants of health? (narrative space)*
9. *Are you interested in receiving the environmental scan report?*
Y/N
10. *Are you interested in receiving other information from and /or participating with the NCCDH in the future?*
Y/N

APPENDIX 6 ADDITIONAL ONLINE SURVEY RESULTS

This appendix provides additional results from the online survey. A more detailed technical report has also been produced by the NCCDH.

Demographics

TABLE 5: NUMBER AND PERCENTAGE OF RESPONDENTS BY PROVINCE AND TERRITORY OF RESIDENCE

| Province or territory | Frequency | Percent |
|------------------------------|-----------|---------|
| BC | 214 | 35 |
| ON | 164 | 27 |
| NS | 101 | 16.6 |
| AB | 52 | 8.6 |
| MB | 28 | 4.6 |
| NL | 12 | 2.0 |
| SK | 12 | 2.0 |
| YT | 5 | .8 |
| QC | 5 | .8 |
| NT | 2 | .3 |
| NB | 2 | .3 |
| NA – (location not provided) | 10 | 1.6 |
| Total | 607 | 100.0 |

TABLE 6: NUMBER AND PERCENTAGE OF RESPONDENTS BY SETTING

| Setting | Frequency | Percent |
|---------|-----------|---------|
| Urban | 379 | 64.3 |
| Rural | 199 | 33.8 |
| Remote | 11 | 1.9 |
| Total | 589 | 100.0 |

TABLE 7: NUMBER AND PERCENTAGE OF RESPONDENTS BY TYPE OF ORGANIZATION

| Type of Organization | Frequency | Percent |
|--|-----------|---------|
| Local/Regional public health organizations | 272 | 45.8 |
| Community Health Centre | 83 | 14 |
| Provincial/Territorial public health organizations | 68 | 11.4 |
| Academic institution | 55 | 9.3 |
| Non-governmental organization | 49 | 8.2 |
| Other | 30 | 5.1 |
| Other government department/organizations | 17 | 2.9 |
| Federal public health organizations | 9 | 1.5 |
| First Nations Health Agency | 5 | .8 |
| Professional Association | 3 | .5 |
| Student | 3 | .5 |
| Total (answering the question) | 594 | 100.0 |

TABLE 8: NUMBER AND PERCENTAGE OF RESPONDENTS BY PUBLIC HEALTH ROLE

| Role | Frequency | Percent |
|---|-----------|---------|
| Front-line public health practitioner (e.g., public health nurse, public health inspector, health promoter) | 333 | 57.4 |
| Technical support (e.g., epidemiologist, program consultant) | 45 | 7.8 |
| Other | 42 | 7.2 |
| Policy/Decision-maker (e.g., director, executive head of organization, Medical Officer of Health) | 35 | 6.0 |
| Researcher | 41 | 7.1 |
| Educator of public health practitioners | 32 | 5.5 |
| Administrative Support | 23 | 4.0 |
| Manager | 19 | 3.3 |
| Student | 10 | 1.7 |
| Total | 580 | 100 |

Additional Public Health Roles

Almost 23 % (138) of respondents answered positively to the question of 'other' roles for public health organizations in taking action on the determinants of health. The main themes that emerged included:

- Education (e.g., public, health system, practitioners)
- Advocacy (e.g., for policy, funding and programs; on behalf of clients and populations, lobbying of governments and politicians; and political action)
- Research and evaluation (e.g., leadership and active participation in research and evaluation on the determinants of health and effective interventions).

Challenges for Public Health Organizations and Staff

TABLE 9: THE KEY CHALLENGES/NEEDS/GAPS FOR PUBLIC HEALTH ORGANIZATIONS/STAFF TO BETTER ADDRESS THE DETERMINANTS OF HEALTH

| Challenge/Need/Gap | Among Those Responding to Question | | | | No Response |
|---|------------------------------------|-------|----------|-------------------|-------------|
| | Strongly Agree | Agree | Disagree | Strongly Disagree | |
| Stronger organizational/system leadership? (E.g., explicit expectations for public health organizations to address DOHs; identification of DOH action as priority; resource allocation targeted to DOHs work) | 74.6% | 21.5% | 0.9% | 3.0% | 45.5% |
| Education/training/skill development of the existing and future workforce? (e.g., in applying DOH-based frameworks and tools; conducting DOH-based analysis; establishing priorities) | 74.0% | 22.1% | 1.8% | 2.1% | 44.8% |
| Develop external partnerships? (e.g., skills to engage partners; areas for joint action) | 67.4% | 27.8% | 2.7% | 2.1% | 45.5% |
| Establish organizational routines to address DOHs in program planning cycles? (e.g., application of equity lens to steps of planning cycle; integrating DOH activities into organization) | 69.7% | 26.6% | 1.5% | 2.1% | 46.1% |

Focus – Health Determinant Framework

TABLE 10: PREFERENCE FOR WHICH DETERMINANT OF HEALTH FRAMEWORK THE NCCDH SHOULD UTILIZE

| Framework | Frequency | Percent |
|---|-----------|---------|
| Social Determinants of Health | 151 | 47.5 |
| Determinants of Health (PHAC) | 94 | 29.6 |
| Selected Determinants - Chief Public Health Officer Report (Addressing Health Inequalities) | 55 | 17.2 |
| Other | 18 | 5.7 |
| Total | 318 | 100.0 |

Of the 151 that chose the SDOH framework, the majority (66%) supported a focus on all of the determinants versus specific ones.

Type of Knowledge Translation Preferred

TABLE 11: ITEMS WHICH WOULD BE OF GREATEST ASSISTANCE TO STRENGTHEN PUBLIC HEALTH ORGANIZATIONS'/SYSTEMS' ACTIONS TO ADDRESS THE DETERMINANTS OF HEALTH (N=338)

| Knowledge Translation Approach | Percent |
|---|---------|
| Tools/checklists for addressing DOHs (e.g., Health Impact Assessment; program planning framework; conducting situational/needs assessments) | 18.4 |
| A support structure for sharing of information and issues among public health staff/organizations (e.g., networks; communities of practice) | 17.6 |
| Knowledge brokering service (provision of best practice advice tailored to local context) | 14.6 |
| Summaries of existing evidence | 13.0 |
| Key messages/tools for engaging internal and external stakeholders | 13.5 |
| Case studies of public health organization's actions to address DOHs | 10.2 |
| Mentoring by experienced peers | 9.4 |
| Other | 2.9 |
| Total | 100.0 |

APPENDIX 7 FOCUS GROUP PARTICIPANTS

| Participant | Position and Organization |
|--------------------|--|
| Wendy Bruins | Clinical Nurse Educator, Health Promotion and Prevention, Fraser Health, Burnaby, British Columbia |
| Katie Dilworth | Professional Practice Consultant and Professional Practice Leader (Policy), Toronto Public Health, Toronto, Ontario |
| Ken Diplock | Ontario Branch President, Canadian Institute of Public Health Inspectors (CIPHI), Waterloo, Ontario |
| Leila Gillis | Director, Prevention & Promotion Programs and Nursing Leadership, First Nations and Inuit Health Atlantic Region, Halifax, Nova Scotia |
| Jennifer Gratix | Epidemiologist, Health Protection/Communicable Disease Control, Alberta Health Sciences, Edmonton, Alberta |
| Stefane Gravelle | Regional Manager, Environmental Health Branch, Manitoba Health, Brandon, Manitoba |
| Maryann Kusmirski | Newborn Metabolic Screening Project Coordinator, Sexual and Reproductive Health Team, Health Promotion, Disease and Injury Prevention Population and Public Health, Alberta Health Services, Edmonton, Alberta |
| Michelle LeDrew | Manager, Health Promotion, Public Health Services, Halifax, Nova Scotia |
| Stephanie Lefebvre | Policy and Planning Specialist, Sudbury & District Health Unit, Sudbury, Ontario |
| Ann Manning | Regional Director Public Health, Eastern Health, Mount Pearl, Newfoundland |
| Alysha McFadden | Public Health Nurse, Government of Yukon, Whitehorse, Yukon |
| Mary McIntyre | District Manager - Public Health Calgary Zone (Policy), Alberta Health Sciences, Edmonton, Alberta |
| Mary Lou Murphy | Public Health Nurse, Government of Northwest Territories, Yellowknife, NWT |
| Susan O'Neill | Public Health Nurse, Niagara Region Public Health, Thorold, Ontario |
| Nancy Trotter | Public Health Nurse, Government of Northwest Territories, Yellowknife, NWT |

APPENDIX 8

FOCUS GROUP FEEDBACK

Four focus group teleconferences were conducted in order to discuss/validate emerging themes from the literature review and preliminary key informant interviews, and to provide an opportunity to collect additional information.

This summary provides a listing of key points made during these teleconferences.

Feedback on Emerging Vision

- 'Go-To' hub makes sense
 - *NCCDH seems unknown – needs to be more visible*
- Should focus on 'inequities'/social justice
 - *Unclear impact of changing focus to inequalities versus focus on DOHs overall*
 - *Is inequity any more focussed?*
 - *Impact on existing home visiting focus – does not have to be NCCDH, but who?*
- Collaboration important between NCCs
- Need 'sounding board' to share ideas
- 'Foster institutionalization' is too technical – need plainer language – suggest 'normalization'
- At end of the day, need to be practical

Feedback on Emerging Themes

- Roles: agreement overall; additional comments:
 - *Support whole-of-government approaches (note difficulty of addressing First Nations issues with multiple levels and departments of government)*
 - *Need to take action when do health status reports*
 - *If address roles at too high a level, could be useless*
 - *There is a summary of PH roles in poverty prepared in NS – should compare with 4 key roles*
 - *Appears that some of these are support and enabling factors (e.g., capacity building, sociocultural shift, leadership, R&D/KT, etc.)*
 - *More holistic approach to considering DOHs makes sense*
 - *How set priorities addressing inequities?*
- Challenges with analysis:
 - *Need to be able to analyze small areas and small populations and seek meaning/ understanding*
 - *Disparity in capacity – if local data is powerful, how do this if no infrastructure?*
- New? Not really but been a large enough gap since was done that is essentially new
 - *Note that have learned long ago that need to segment the audience to target messaging – why wouldn't we do that for public health interventions?*
 - *Tendency to get focussed on own work – not part of every day job*
 - *Problem in PHN practice of shifting from generalist to program – ? impact on DOH work? How foster community assessments when in program?*

- How is public health accountable for this work? (e.g., standards, mechanism for accountability):
 - *Need to have mandate to do this work – with limited resources, if outside mandate won't get done*
- Evidence/guidance required:
 - *What partnership models can public health use; effectiveness in engagement*
 - *How best to utilize social marketing – targeted and community wide; evidence?*
 - *What are the tools to move this forward?*
 - *Know what DOHs are and how to create partnerships, not clear how to make change in priority population (e.g., pregnant smokers in high risk population)*
 - *Importance of cost-benefit analysis*
 - *Need some type of framework to guide our conceptual thinking (i.e., NOT a list of DOHs, but rather the web/hierarchy of factors and spots for intervention) – likely need to consider various frameworks since some work better for different issues*
- Resonance of opportunities and challenges; love of pamphlets since easier; difficulty for PHIs with their enforcement role to do some types of engagement
- Agreement that organization is unit of adoption/change:
 - *System is also the unit of adoption – need provincial participation (e.g., CMOH)*
 - *Also useful to consider approaches that front-line staff could use to influence/inform their manager*
- Underlying issue that targeting of harder-to-reach populations will often be more resource intensive – what are the tradeoffs? Potential role for modelling
- Need to think of the distances involved for training and support – Skills Online; webinars; videos, etc.
- Political environment can be a challenge:
 - *May make it difficult to introduce controversial interventions*
 - *May reinforce continuation of interventions less likely to be effective*
 - *Options when not politically possible to advocate*
 - *There is self-censorship, but also opportunities to work through professional associations (CPhi, OPHA/CPHA, COMOH, etc.)*

APPENDIX 9

ADDITIONAL DISCUSSION OF INFORMATION GATHERING APPROACHES

This environmental scan used a variety of approaches to acquire information from the public health community. The experience with these approaches should inform future information gathering activities of the NCCDH.

Scan of the Literature

Targeting key organizations' websites to retrieve existing syntheses was an efficient means to assess the state of current thinking and practice. However, considerably more information and sources were subsequently identified during the key informant interviews.

Key Informant Interviews

The key informant questionnaire had been designed to be open-ended with a limited number of questions and to function as a guide to a conversation allowing the expert key informants the flexibility to provide the input that they thought was most important. In creating the interview guide, considerable attention was given to crafting questions regarding the desired focus of the NCCDH with respect to which determinants and which list of determinants. The reason was that this had been questions for which the NCCDH and its advisory committee and funder had struggled with since its inception. To this end, existing lists of determinants from various sources were provided with the information guide. However, none of the key informants were interested in this aspect of the issue and a key finding of the environmental scan was that this was probably not the right strategic question for the NCCDH to be addressing. Because of the open-ended nature of the key informant interviews, the inclusion of this supplementary material did not appear to detract from the interviews themselves.

Focus Group Teleconferences

The intent of the focus group teleconferences was two-fold:

- Provide an early check-in/validation step for the emerging themes from the scan of the literature and preliminary key informant interviews – primary objective
- Provide an opportunity to identify additional pertinent information (e.g., additional themes, practice examples, tools, etc.) – secondary objective.

The initial plan was to have a focus group for each of the main target audiences of the NCCDH: decision-makers; front-line practitioners; and, researchers. However, the focus groups were comprised of a mix of predominantly front-line practitioners with some managers and no researchers. This latter gap was addressed by including additional researchers to the key informant interviews.

Overall, the flow and level of discussion during the different teleconferences was variable. One challenge was that some participants could only participate for the first hour of the teleconference. A greater challenge was that the extent of participants' previous involvement in health determinants work was highly variable. Those with greater experience had greater ease addressing the questions. In contrast,

those staff with neither previous knowledge of the work of the NCCDH nor direct involvement in health determinant work experienced greater challenges in participating in the focus groups. Since the themes for discussion in the focus groups were generated by interviews with practice and research experts and key concepts from the literature, attempting to validate them with predominantly front-line staff created significant misalignment issues.

Online Survey

The intent of the online survey was to gather broader input into the environmental scan. Since the survey instrument was developed shortly after the key informant questionnaire, its content was heavily influenced by that questionnaire. As previously noted, some of the initial thinking that guided the key informant questionnaire changed as more was learned from the key informants. In addition, the key informant questionnaire was designed for practice and research experts, however, the survey was marketed to a predominantly front-line practitioner audience with over half of the survey respondents self-classified as front-line staff.

For ease of completion and analysis, surveys typically use close-ended type questions. However, creating such questions is only possible when there are clearly formulated questions and a known set of possible responses. For example, a survey could be used to seek feedback on a list of priority issues or interventions that was generated through previous key informant work. The timelines for this project did not allow sequencing of this nature and the nature of the questions facing the NCCDH made crafting questions difficult. While there was a desire to seek broader input on examples of practices and champions, and a considerable number of suggestions were received, the challenge is that a survey does not provide the opportunity to seek the rationale for those suggestions.

Implications for Future Information Gathering

Overall, the information gathered during this environmental scan is sufficient to fulfill the project's purpose. However, considering the available timelines and resources for this project, the scope of information gathering components was overly optimistic. The intent in several instances was for one component to inform another such as the online survey to inform the selection of additional key informants. Since many of the components were 1-3 weeks behind schedule, the intended sequencing among components was not achievable especially when the entire project had an extremely tight timeline of 10 weeks.

A key learning for future efforts should be to seek greater alignment among: the complexity of the subject; the target audience; and, the chosen approach to acquire information. While the literature scan and key informant interviews most closely achieved this alignment, this was not the case for the other components. Focus groups can be an effective approach to gather information. However, individuals who cannot participate for the entire scheduled time should not be included; more homogeneous groups should be utilized; and the content and process should be more tailored to the audience. Online surveys should be utilized to generate feedback around a defined set of questions and potential responses rather than to generate information regarding complex and inconsistently understood concepts.

APPENDIX 10

PUBLIC HEALTH LEGISLATION AND CORE PROGRAMS

Legislation

Quebec Public Health Act

The object of this Act is the protection of the health of the population and the establishment of conditions favourable to the maintenance and enhancement of the health and well-being of the general population. (1)

Other measures in this Act pertain to the prevention of disease, trauma and social problems having an impact on the health of the population and the means of exerting a positive influence on major health determinants, in particular through trans-sectoral coordination. These measures are intended to maintain and promote physical health and the mental and social capacities of persons to remain active within their environment. (3)

The Minister shall, in developing the components of the program that relate to prevention and promotion, focus, insofar as possible, on the most effective actions as regards health determinants, more particularly 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. (8)

The Minister, public health directors and institutions operating a local community service centre may, each at the appropriate level of intervention, for the purpose of preventing disease, trauma and social problems that have an impact on the health of the population and influencing population health determinants positively,

- (1) organize public information and awareness campaigns;
- (2) promote and support preventive health care practice among health care professionals;
- (3) identify and assess situations involving health risks within the population;
- (4) establish mechanisms providing for concerted action between various resources able to act on situations that may cause problems of avoidable morbidity, disability and mortality;
- (5) promote health and the adoption of public social policies capable of fostering the enhancement of the health and welfare of the population among the various resources whose decisions or actions may have an impact on the health of the general population or of certain groups;
- (6) support actions which, within a community, foster the creation of a living environment conducive to health and well-being. (53)

Source: Quebec Public Health Act.²³

Public Health Core Programs

Ontario

The delivery of public health programs and services occurs in diverse and complex geographic, physical, cultural, social, and economic environments that differ significantly across Ontario. There are systemic differences in health status that exist across socio-economic groups (i.e., health inequities). Thus, there are both common and diverse factors that influence and shape the public health response required to achieve a desired health outcome. Effective public health programs and services take into account communities' needs, which are influenced by the determinants of health. As well, an understanding of local public health capacity and the resources required, including collaboration with partners to achieve outcomes, is essential for effective management of programs and services. To ensure that boards of health assess, plan, deliver, manage, and evaluate public health programs and services to meet local needs, while continuing to work towards common outcomes, boards of health shall be guided by the following principles: Need, Impact, Capacity, and Partnership and Collaboration.

In order to be successful in achieving outcomes, boards of health shall continuously tailor their programs and services to address needs that are influenced by differences in the context of their local communities. The Ontario Public Health Standards allow for flexibility in local public health programming by emphasizing the importance of population health assessment and surveillance to inform program planning and service delivery. Public health

programs and services must consider the health needs of the local population. Need is established by assessing the distribution of determinants of health, health status, and incidence of disease and injury.

The determinants of health will often inform the needs of a community. It is evident that population health outcomes are often influenced disproportionately by sub-populations who experience inequities in health status and comparatively less control over factors and conditions that promote, protect, or sustain their health. By tailoring programs and services to meet the needs of priority populations, boards of health contribute to the improvement of overall population health outcomes. Boards of health shall also ensure that barriers to accessing public health programs and services are minimized. Barriers can include, but are not limited to, education; literacy levels; language; culture; geography; economic circumstances; discrimination (e.g., age, sexual orientation, race, etc.); social factors, including social isolation; and mental and physical ability.

Many of the requirements can be more optimally achieved through partnerships with community partners, non-governmental organizations, governmental bodies, and others. The attainment of desired population outcomes, as identified in the Ontario Public Health Standards, is dependent upon the degree of integration of public health programs and services with broader community goals. Collaboration among boards of health, their local community partners, academic institutions, and government is integral to the interpretation and prioritization of needs. Shared knowledge can assist in leveraging resources and aligning community goals and objectives.

As a sector, public health not only acknowledges the impact of the determinants of health but also strives to influence broader societal changes that reduce health disparities and inequities by coordinating and aligning its programs and services with those of other partners. Public health has a leading role in fostering relationships to support broader health goals to achieve the best possible outcomes for all Ontarians.

Source: Ontario Public Health Standards.²⁴

Quebec

The program defines the activities to be implemented over the coming years in order to act on the determinants that have an impact on the physical and psychosocial aspects of health. In this way, it strives to promote health and prevent the onset and development of health and psychosocial problems in the Québec population.

Through its objectives, the program strives to change the determinants of health and well-being, enhance health and well-being, and reduce health or psychosocial problems and injuries.

The following highly interrelated health determinants all provide analytical vantage points or perspectives, either direct or indirect, to help guide public health action:

- biological and genetic predispositions;
- lifestyles and other health-related behaviours;
- living conditions and social settings;
- physical environment;
- organization of health and social services as well as access to resources.

It has been known for a long time that socio-economic status, educational level, housing quality and employment situation are linked to many physical health and psychosocial problems. The enormous influence of these factors on health and well-being must be mentioned, despite the fact that the most powerful levers to change these living conditions are in the hands, not of the health and social services sector, but of other sectors. They are also indissociable from the social settings in which people evolve and which constitute, in turn, important health determinants. The family, child care setting, school, workplace and community are all social settings that, according to the values and standards which they convey, influence people's health practices. Social stability, safety, recognition of diversity, harmonious interpersonal relations and social cohesion make up a set of conditions that have a protective effect on health. In particular, the protective effects of social support, based on characteristics such as the quality and diversity of available support, should be mentioned. Numerous studies conducted in recent years have revealed the important impact of these "social" determinants on many health and psychosocial problems.

Source: Quebec Public Health Program: 2003-2012.²⁸

British Columbia

The Government of British Columbia believes that public health has the following fundamental tasks:

- to improve the overall health and well-being of the population;
- to prevent diseases, injuries, or disabilities that may shorten life or impair health, well-being and quality of life; and
- to reduce inequalities in health between different groups and communities in society (this task cuts across the other tasks.)

For the most part (except for those that have a biological cause) inequalities have their roots in the social, economic, cultural, and environmental determinants of population health. These determinants do not fall within the mandate or jurisdiction of the public health sector, and therefore are not directly amenable to public health interventions. At the same time public health has a duty, as one of its fundamental tasks, to work to reduce inequalities in health. This can be accomplished in several ways:

- by documenting inequalities, reporting on them so as to draw public attention to them, and analyzing the factors that contribute to these inequalities;
- by working with communities to change the conditions that contribute to inequalities in health in their community; and
- by advocating for healthier public policies and changes in social, economic, cultural, and environmental conditions that will reduce inequalities in health.

There are also some actions that health authorities may want to consider that contribute directly to reducing inequalities in health. One example is to ensure that those in greatest need of public health services, or those most vulnerable or at-risk, receive more attention. This involves:

- directing programs to high-risk/disadvantaged groups;
- improving access/removing barriers to public health programs;
- forging partnerships with other organizations to address multiple barriers and/or issues in a coordinated and comprehensive manner;
- using community development as a means to support self-advocacy and self-reliance; and
- ensuring that the core programs provided by the health authorities reflect the priorities of the people with greatest need.

Source: Framework for Core Functions in Public Health.²⁵

APPENDIX 11

ACCREDITATION CANADA STANDARDS

Within its 2010 standards, expectations for organizations include:

- Organization's leaders understand the changing needs and health status of the community it serves including trends and changes in the environment, including demographic information, the impact of the determinants of health (e.g., housing conditions and socioeconomic status) on the community served, the presence of risk factors (e.g., smoking, overweight/obesity) that may lead to health issues; and feedback from clients and the community about their health needs.
- Organization's leaders support and participate in ongoing community development to promote health and prevent disease (e.g., advocating for healthy public policy affecting determinants of health).
- The governing body plays an advocacy role in the community. Examples include supporting healthy public policy to address the determinants of health (e.g., smoking bans in public places, environmental health legislation, and raising community awareness about issues).

The public health specific standards state that the organization is to:

- Regularly monitor health status to identify health issues affecting the population including determinants of health (including socioeconomic, education, and environmental factors that affect health). The report also is to describe population health resources and assets needed to address population health needs.
- Monitor current healthy public policy in the community and act as an advocate for healthy public policy in the community. Policy development activities include issuing policy briefs, giving public testimony, participation in local, provincial, national, or international boards, participating in advisory panels, meeting with elected officials and contributing to regional, national or international healthy public policy initiatives. Activities are focused on identifying and addressing barriers to the adoption of healthy public policies in non-health sectors.

APPENDIX 12

LIST OF PRACTICE FRAMEWORKS, PRACTICE EXAMPLES, TOOLS AND OTHER RESOURCES

Frameworks and Background Documents

TACKLING HEALTH INEQUALITIES – A PROGRAMME FOR ACTION

This report described England's national strategy to address inequalities. It addresses areas where action will have greatest impact, key interventions to close the life expectancy and infant mortality gaps, as well as a series of themes and principles. While a national strategy and acknowledging that "action will be taken nationally, the main contributions will be made locally. This Programme encompasses local solutions for local health inequality problems given that local planners, front-line staff and communities know best what their problems are, and how to deal with them." Further analysis and recommendations are provided in the initiative's final (2007) status report.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

INEQUALITIES IN HEALTH IN SCOTLAND: WHAT ARE THEY AND WHAT CAN WE DO ABOUT THEM

In this 2007 paper, Sally Macintyre succinctly reviews the thinking and recommendations regarding action on inequalities. Key points include the following:

- The existence and extent of social gradients varies by the condition or determinants being examined – some are relatively steep, whereas there are some in which there is no gradient
- The health gaps between social groups indicates what might be possible for the whole population, and gives us goals to which we can aspire
- Lack of evidence about the effectiveness and cost effectiveness of policies, programmes, and projects in reducing inequalities in health. The lack of information is related to the lack and limitations of evaluations of interventions
- Lack of robust evidence of effectiveness is not a justification for inaction. Need to learn more about what works by encouraging generation of knowledge (evaluation)
- Improving population health and reducing health inequalities may sometimes conflict – one can potentially improve the population average while increasing the extent of inequalities. Value judgements may have to be made about the relative priority to be given to creating aggregate health gain as compared to reducing inequalities.

Based on what is known to-date, characteristics of the intervention will be more or less likely to reduce inequalities, although may be effective in themselves.

<http://www.sphsu.mrc.ac.uk/reports/OP017.pdf>

EQUITY LENS: CORE PUBLIC HEALTH FUNCTIONS FOR BC EVIDENCE REVIEW

The core public health function framework explicitly includes an equity lens. This evidence review provides a comprehensive description of key concepts for a public health audience. It discusses promoting health equity within the health care system; policy options and strategies; health equity and Aboriginal populations; and, potential roles of a health authority.

http://www.phabc.org/pdfcore/Equity_Lens-Evidence_Review.pdf

REACHING FOR A HEALTHIER LIFE: FACTS ON SOCIOECONOMIC STATUS AND HEALTH IN THE U.S.

This report from the MacArthur Foundation Research Network on Socioeconomic Status and Health uses U.S. data, but outlines how social determinants influence health. It uses the analogy of a ladder to illustrate differences in opportunities and outcomes among populations and that policy choices affects the ladder's steepness.

http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_Life.pdf

WHO COMMISSION – EQUITY, SOCIAL DETERMINANTS AND PUBLIC HEALTH PROGRAMMES

This 300+ page report was released in 2010 and provides a SDOH-based analysis of public health programmes. An important implication of these questions is that while addressing social determinants requires inter-sectoral action, there are crucial programmatic tasks that need to be undertaken within the health sector before asking other sectors to do their part. The authors' multi-level analytic framework was applied to 12 public health programmes providing a discussion of potential interventions, possible entry-points and potential barriers. While valuable, an implicit requirement is presumably a team/organization that is approaching program planning and implementation from a SDOH perspective. The final chapter is particularly useful in discussing achievement of 'synergy for equity.'

http://www.who.int/social_determinants/en/

Practice Examples

Public Health Role – Assess and Report on Inequalities and Inequities and Strategies to Reduce Inequities

There are multiple examples of health status reports providing stratified analysis by socio-economic measures. These reports typically incorporate analysis of what strategies could be utilized to reduce inequities. Selected examples from international, national, provincial and regional levels are outlined.

WHO COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

This landmark report documents the health inequalities among and within countries. It proceeds to describe that these inequalities reflect to a large degree inequities since they "arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces." Following an extensive review of the evidence, the Commission identifies three principles of action:

1. Improve the conditions of daily life
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action.

http://www.who.int/social_determinants/en/

REPORT ON THE STATE OF PUBLIC HEALTH IN CANADA (2008): ADDRESSING HEALTH INEQUALITIES

This inaugural report from Canada's Chief Public Health Officer (CPHO) focuses on the health inequalities among Canadians. Following presentations of health status information and the relationship with SDOH, the report identifies five priority areas for intervention: social investment; community capacity; inter-sectoral action; knowledge infrastructure; and, leadership.

<http://www.phac-aspc.gc.ca/publicat/2008/cphorsphc-respcacsp/index-eng.php>

REPORT ON THE STATE OF PUBLIC HEALTH IN CANADA (2009) - GROWING UP WELL: PRIORITIES FOR A HEALTHY FUTURE

In the CPHO's second report on the state of public health in Canada, the focus is on child development with many influences identified. Four priority areas for action on issues affecting Canadian children include: better collection and sharing of data and information; improved and ongoing education and awareness; healthy and supportive environments; and co-ordinated, multi-pronged and sustained strategies.

<http://www.phac-aspc.gc.ca/publicat/2009/cphorsphc-respcacsp/index-eng.php>

REDUCING THE GAPS IN HEALTH: A FOCUS ON SOCIO-ECONOMIC STATUS IN URBAN CANADA

This report prepared by CPHI presents analyses of health in urban Canada by measures of both low income as well as deprivation showing consistent links between SES and health. The report also provides a high-level overview of what seems to be working, both within Canada and abroad, to reduce gaps in health linked to SES. It concludes with a discussion regarding improving the evidence base for the development of applicable and actionable interventions.

http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1690_E&cw_topic=1690&cw_rel=AR_2509_E

SOCIAL DETERMINANTS OF HEALTH: THE CANADIAN FACTS

This latest analysis published in 2010 utilizes a 14-item SDOH model that Dennis Raphael developed in 2002. For each of the determinants, this report provides a description of why it is important, illustrative data, and policy implications. In a final section on 'what you can do', the authors urge public health units and other system actors to:

- Educate themselves and their clients on how social determinants influence health
- Urge governments and policy-makers to create and implement health promoting policies.

The final section provides additional recommendations about what Canadians can do to support action.

<http://www.thecanadianfacts.org/>

HEALTH INEQUALITIES AND SOCIAL DETERMINANTS OF ABORIGINAL PEOPLES' HEALTH

A recent report from the NCCAH describes health inequalities experienced by Aboriginal peoples in Canada. The findings are organized around SDOH with their categorization into proximal, intermediate and distal levels. The authors describe how inequalities in SDOH act as barriers to addressing health disparities presenting an Integrated Life Course and Social Determinants Model of Aboriginal Health.

http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAH-Loppie-Wien_Report.pdf

HEALTH INEQUITIES IN BRITISH COLUMBIA

This report from the Health Officers Council of BC provides background information on the concept of health inequity and the existence of health inequities in BC. It provides information regarding the case for addressing health inequities and provides a set of guiding principles and key policy considerations:

- Guiding Principles
 - *Levelling up, not down*
 - *Not making the inequities worse – helping the worst-off first*
 - *Using a combination of regulatory and structural interventions for greatest impact*
 - *Recognizing that complex problems require complex solutions; health inequities must be addressed on many fronts, through multiple, interrelated strategies.*

- Key Policy Considerations:
 - *Making the reduction of health inequities a government and societal priority and allocating resources accordingly*
 - *Developing a multi-sectoral approach involving cooperation across all levels and areas of government and across the public, private, NGO and community sectors*
 - *Setting clear goals and targets for all initiatives and tracking progress on specific measures related to health inequity as part of a continuous improvement process*

The report also provides a series of policy options, mainly at a societal level for individual SDOH: income and food security; education and literacy; early childhood education; housing and build environments; and, health care.

http://www.bchealthyiving.ca/sites/all/files/HOC_Inequities_Report.pdf

PATHWAYS TO HEALTH: 2ND REPORT ON THE HEALTH AND WELL-BEING OF ABORIGINAL PEOPLE IN BRITISH COLUMBIA

This comprehensive report from BC's Provincial Health Officer provides chapters discussing determinants of health, pregnancy, infants and children, diseases and injuries, physical environment, and health services. A chapter devoted to recommendations on improving the health of the Aboriginal population in BC.

<http://www.health.gov.bc.ca/pho/pdf/abohlth11-var7.pdf>

SOCIAL INEQUALITIES IN HEALTH – MONTREAL

This 1998 annual report from Montreal's Department of Public Health documents the extent of disparities across the life course. Describing the extent of poverty within the region, it states "when we know that poverty is often associated with poorer health, this situation must be recognized as a critical public health issue." Grounded by the legislative responsibility to inform the public about its health and health problems and the most effective responses, this report focuses predominantly on the extent and impact of poverty on different age groups. It states that the extent of poverty is a problem the Department of Public Health cannot ignore and "is joining other social actors on the Montreal scene as a partner, who, armed with its specific brand of expertise, is determined to commit its forces to the common struggle."

http://www.dsp.santemontreal.qc.ca/index.php?id=523&tx_wfqbe_pi1%5buid%5d=1013

BEYOND HEALTH SERVICES AND LIFESTYLE: A SOCIAL DETERMINANTS APPROACH TO HEALTH – INTERIOR HEALTH, BC

This 2006 health status report from the Interior Health Authority in BC provides background information on the concept of SDOH and their relevance, local data to show extent of existing inequities, and a discussion of future actions. It identified the following next steps for action:

- Highlight the work already being done to strengthen the SDOH and address health inequities
- Support a public conversation on the issue of SDOH and what we can do together
- Increase access to local and integrated information on health and social determinants to support local action
- Develop a strategy to support healthy community planning across the Interior Health region.

http://www.interiorhealth.ca/uploadedFiles/Choose_Health/Pop_Health/PopHealthReport2006.pdf

HEALTH DISPARITY IN SASKATOON: ANALYSIS TO INTERVENTION

This comprehensive report addresses the following objectives:

- Describe the extent of health disparity in the Saskatoon community
- Determine the causes of health disparity
- Explain that health disparity is mostly preventable
- Use evidence from other jurisdictions to present policy options for consideration.

In addition to the description of disparities within the region, particular effort was made to engage the community:

- Over 200 community consultations initiated to transfer knowledge of vast disparity in health and gather opinion on what needs to be done to help alleviate this complex problem
- Telephone interviews with randomly selected residents to determine which interventions willing to support
- Literature review to examine evidence-based policy options
- Further 100 consultations to verify the statistics and ensure evidence-based policy options were realistic in the Saskatchewan context

The report presents 46 policy options to reduce health and social disparity in areas of income, education, employment, housing and health care. More recently, public health will be co-chairing with the United Way an initiative to pursue those policy options most feasible and acceptable to the community.

http://www.saskatoonhealthregion.ca/your_health/documents/PHO/HealthDisparityRept-complete.pdf

THE UNEQUAL CITY: INCOME AND HEALTH INEQUALITIES IN TORONTO

This 2008 report documents inequalities of several health outcomes across income gradients. In addition, the proportion of census tracts classified as low income has steadily increased since 1970. The report's recommendations include regular reports to the Board of Health on key inequality indicators; incorporating strategies to reduce inequalities in the next strategic plan; urge the provincial government to maintain its commitment to poverty reduction; and strengthen monitoring of SDOHs.

http://www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf

Public Health Role – Modify/Orient Public Health Practices

SASKATOON PUBLIC HEALTH SERVICES

In Saskatchewan, public health is responsible for providing all immunizations. Examination of childhood immunization rates by neighbourhood in Saskatoon found large disparities. Six low income neighbourhoods had 43.7% of children immunized for MMR, whereas five affluent neighbourhoods had coverage rates of 90.6%.⁷⁰ Engaged in process within health unit to discuss findings with staff, discuss options, and eventually re-allocate resources. Have increased coverage rates in these less affluent neighbourhoods – report to be published later in 2010.

Saskatoon has also restructured their unit that traditionally addressed lifestyles and is now organizing it by determinants.

SUDBURY AND DISTRICT HEALTH UNIT

The Sudbury and District Health Unit (SDHU) has been working to apply evidence-informed practices to reduce social inequities in health within its organization. Their EXTRA program report³⁴ outlines their multi-faceted approach:

- Extensive literature search to identify evidence-informed practice to reduce social inequities in health. This yielded 10 promising practices.
- Assessed their organization for readiness to adopt practices to reduce inequities
- Identified potential strategies for transferring knowledge to action:
 - *Knowledge brokering meetings with managers and planners to implement promising practices into planning and logic models*
 - *Community-wide social marketing initiative through newspaper advertisements to enable organizational change.*

In early 2010, the organization developed an equity-focussed planning path for implementation of the new OPHS. <http://www.phred-redsp.on.ca/Docs/Reports/OPHSPlanningPath.pdf> It is being piloted in 2010 with the intent to assess the extent to which program plans (e.g., logic models) will have changed due to the interventions. Results are expected in late 2010.

WATERLOO REGION PUBLIC HEALTH

The Region of Waterloo Public Health Unit has been developing a framework for equity-based population health assessment and planning. It incorporates equity-based queries at each step of the assessment/ planning cycle. They have piloted it internally with several public health programs and are in the process of updating the framework.

[http://www.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/\\$file/EPPF_maindoc.pdf?openement](http://www.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?openement)

http://www.chnet-works.ca/index.php?option=com_phocadownload&view=category&id=7%3Afireside-chat-presentations-2010&download=211%3A182-march-24-2010-bringing-health-inequities-from-the-fringes-to-the-mainstream&Itemid=13&lang=en

Public Health Role – Partnering with Other Service Providers to Collectively Address Health Inequities

SASKATOON PUBLIC HEALTH SERVICES

Saskatoon public health has begun the process of conducting, in partnership with other components of the health care system, health care equity audits. The concept originates from the UK and was also pursued in a recent CIHI report. These audits are assessing the extent to which the quality of service/care is equitable across socio-economic determinants. A diabetes equity audit has been completed and found that in-hospital care was similar regardless of SES, identification and care in ambulatory settings showed disparities. Public health is finalizing work assessing several surgical procedures.

SUDBURY AND DISTRICT HEALTH UNIT

In working with local partners, this health unit mapped 20 child determinants to identify the 'best' (i.e., neediest) location for establishing a Best Start centre.

Public Health Role – Policy Analysis, Development and Advocacy

LEGISLATING HEALTH IMPACT ASSESSMENTS – SECTION 54 OF QUEBEC'S PUBLIC HEALTH ACT

Section 54 of Quebec's Public Health Act requires all ministries and agencies to consult with the Ministry of Health and Social Services when they are formulating laws and regulations that could have an impact on the health and well-being of the residents of Quebec. The main mechanism is a health impact assessment and the public health department of the Ministry has the lead role for implementation of this Section. A 2005 assessment observed that while there had been modest implementation of the HIA provisions, "a general lack of understanding of the mechanism itself and of the factors that contribute to health and well-being remained key obstacles to greater implementation."⁷¹ Overall, it was considered too early to draw any conclusions about the Section's impact and recommendations were made for strengthening future efforts.

PROSPERITY/ANTI-POVERTY COLLABORATIVES

Community-based prosperity/anti-poverty collaboratives have been formed in Hamilton and Saint John. The former involves a group of community leaders, including public health, who are committed to promoting Hamilton's prosperity through job creation and retention. They have embraced the vision to be the best city in Canada to raise a child, promote innovation, engage citizens and provide diverse economic opportunities. In Saint John, their initiative was initiated by a group of local businesses whose work has been guided by an analysis of local needs. Public health is part of some of the working groups. Nine priorities have been identified and the group has issues a report card tracking its progress for each priority area, as well as poverty rates.

Saint John: <http://www.bcapi.ca/>

Hamilton: <http://www.jpchamilton.ca/>

NEIGHBOURHOOD RENEWAL – SAINT JOHN

The community development worker of the Community Health Centre began to become engaged with the renewal of a Saint John's neighbourhood that was experiencing multiple challenges. An attempt to burn down the community policing station led to widescale interest and a comprehensive set of interventions. According to the Health Council of Canada's video profile, one measure of success to-date has been a reduction by 50% of calls to police.

http://www.youtube.com/healthcc#p/u/9/Je_Vuw6dwUs

COMMUNITY CONSULTATIONS ON HEALTH STATUS FINDINGS AND POLICY OPTIONS

As part of its major report on health disparities, Saskatoon Public Health Services conducted over 200 community consultations to transfer knowledge of the vast disparity in health and gather opinion on what needs to be done to help alleviate this complex problem. This was supplemented with telephone interviews with randomly selected residents to determine which interventions they were willing to support. There were a further 100 consultations to verify the statistics and ensure evidence-based policy options were realistic in the Saskatchewan context. The final report presents 46 policy options to reduce health and social disparity in areas of income, education, employment, housing and health care. More recently, public health will be co-chairing with the United Way an initiative to pursue those policy options deemed most feasible and acceptable to the community.

http://www.saskatoonhealthregion.ca/your_health/documents/PHO/HealthDisparityRept-complete.pdf

ADVOCATE FOR THE VULNERABLE – RELOCATING MONTREAL'S CASINO

The Montreal Department of Public Health raised concerns that relocating a casino to a neighbourhood with precarious socio-economic conditions that problem gambling would likely increase in the nearby neighbourhood and there would be a rise in related social and health problems. Neither the Department nor the provincial public health level specifically recommended not instituting the relocation, they provided specific recommendations to reduce the negative impact of the casino move.

http://www.finances.gouv.qc.ca/documents/Autres/en/rapport_casino_eng.pdf

Tools and Resources

Public Health Role – Assess and Report on Inequalities and Inequities and Strategies to Reduce Inequities

DEPRIVATION INDICES

Deprivation measures “identify those who experience material or social disadvantage compared with others in their community”. The recent CPHI report on urban Canada includes a brief description and analysis of different indexes and utilized one developed by INSPQ as the basis of its analysis.

http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1690_E&cw_topic=1690&cw_rel=AR_2509_E

EARLY DEVELOPMENT INDEX

The Early Development Instrument (EDI) is a population-based early child development assessment tool used to measure the state of children's development in Kindergarten. Completed by Kindergarten teachers, it is a holistic measure of children's development across five areas: physical health and well-being; social competence; emotional maturity; language and cognitive development; and, communication skills. The results are grouped by neighbourhood, school district, health area, and provincial levels to understand patterns in vulnerability at the population level. This measurement can provide a baseline to prioritize areas for intervention and an outcome measure to assess impact.
<http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/>

QUALITY CRITERIA FOR MONITORING OF INEQUALITIES

In a soon-to-be-published paper from Scotland, Frank and Haw provide guidance on criteria for monitoring health disparities at the population level combining both epidemiological and communication characteristics.

PUBLIC HEALTH OBSERVATORIES (UK)

Public health observatories (PHO) have been established in the UK to produce information, data and intelligence on people's health and health care for practitioners, policy-makers and the wider community. Within England, each serves a specific geographic area and has a particular area of strength. Routine products include health profiles, interactive maps, and tools. The latter includes health inequalities toolkit and a poverty index. There is current interest within Canada to begin to build a network of emerging PHOs.
<http://www.apho.org.uk/>

Public Health Role - Modify/Orient Public Health Practices

SDHU

Recognizing the greater focus on health inequities and priority populations in the OPHS, as well as the experience gained through Extra project, SDHU established an OPHS Planning Path that would be piloted for 2010. The Planning Path contains a set of 11 guiding principles, which include:

- Ensuring each community or priority population has access to public health programs and services and a healthy and safe environment that optimizes their health
- Improvement in knowledge about current and emerging health determinants (including social determinants) and risks are vital to effective public health efforts
- Public health efforts should aim for levelling up, that is bringing "up the health status of less privileged socioeconomic groups to the level already reached by their more privileged counterparts".

"Central to the planning pathway model is an intentional focus on the social inequities in health or health equity." For each of the four major steps in the planning cycle, specific questions are provided, to incorporate inequities into routine planning. Included in the framework is an *OPHS Planning Assessment Tracking Form* that has been developed to prompt consideration of the questions and the managers' responses. An equal access checklist is also included as a guide for activity planning.
<http://www.phred-redsp.on.ca/Docs/Reports/OPHSPlanningPath.pdf>

WATERLOO REGION PUBLIC HEALTH

Waterloo Region has been preparing a planning framework with a focus on health inequities. For each of the program planning stages, it identifies a series of questions to be considered. The framework has been piloted in several programs and is in the process of being revised.

[http://www.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/\\$file/EPPF_maindoc.pdf?openelement](http://www.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?openelement)

HEALTH EQUITY ASSESSMENT TOOLS

A Health Equity Assessment Tool (HEAT) was originated in New Zealand and adaptations are currently being used in a number of public health organizations across Canada, including the above program planning frameworks. The tool was designed to be used with health services, particularly those for general populations.

The 10 basic questions of the HEAT include the following:

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Maori health outcomes and reduce health inequalities experienced by Maori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

<http://www.moh.govt.nz/moh.nsf/0/13F2B20B719809C2CC257491000F7C15>

Public Health Role - Partnering with Other Service Providers to Collectively Address Health Inequities

STRENGTHENING CHRONIC DISEASE PREVENTION AND MANAGEMENT

This tool was developed to assist public health, primary care and the community to work together to prevent and manage chronic disease in health regions across the country. Its intent is to help these sectors think about, discuss and assess current practice, capacities and opportunities for action. A 'focus on determinants' is included as one of the 8 critical success factors of this tool.

<http://www.cpha.ca/en/portals/cd.aspx>

HEALTH CARE EQUITY AUDIT

A health care equity audit is a process to “identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. (This may include resources such as services, facilities, and the determinants of health). The overall aim is not to distribute resources equally but, rather, relative to health need, otherwise inequities occur which lead to health inequalities.” England’s national strategy, Tackling Health Inequalities: A Programme for Action, identified these audits as a key tool to embed evidence on inequalities into mainstream health system activity such as planning, commissioning and service delivery. Saskatoon has been applying this process to an increasing number of health services in their regional health authority.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138

Public Health Role – Policy Analysis, Development and Advocacy

HEALTH IMPACT ASSESSMENT

According to the WHO, health impact assessment (HIA) is “a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of the population, and the distribution of those effects within populations.” The NCCHPP has taken a lead role in this area and its website provides a wide range of information and tools.

http://www.ncchpp.ca/54/Health_Impact_Assessment.ccnpps

PUBLIC HEALTH ADVOCACY TOOLKIT

This toolkit was prepared by an alliance of public health organizations in Ireland and is intended to those working to improve health to think through, plan and undertake advocacy work. The toolkit provides a model for the advocacy process and can be used to identify training needs, point to resources for developing skills and competencies and provide a framework for action.

<http://advocacy.phaii.org/>

COMMUNITY HEALTH IMPACT ASSESSMENT – PEOPLE ASSESSING THEIR HEALTH (PATH)

This variant of the HIA has been developed in rural Nova Scotia and incorporates a “highly inclusive and participatory health development process in the discussion of health decision-making and the development of healthy public policy.” [Coady] A facilitated process is used to engage a community in developing its own unique community HIA tool. The process has been used in a variety of community settings.

<http://www.mystfx.ca/coady-library/path.html>

NUTRITIOUS FOOD BASKET

A “Nutritious Food Basket (NFB) is a survey tool that is a measure of the cost of basic healthy eating that represents current nutrition recommendations and average food purchasing patterns. Food costing is used to monitor both affordability and accessibility of foods by relating the cost of the food basket to individual/family incomes.” A protocol and guidance documents have been produced to support the OPHS’ requirements in this area.

http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/nutritious_food_basket.pdf

NEIGHBOURHOOD RENEWAL – SAINT JOHN

An initiative to renew a neighbourhood in Saint John is profiled in a Health Council of Canada video.
http://www.youtube.com/watch?v=Je_Vuw6dwUs

Existing Comprehensive Health Inequality/Inequity Portals

There are several existing online toolkits/portals in the U.S., Europe, and Australia that provide a range of conceptual frameworks, case studies/profiles, training modules, tools and other resources to support action on health determinants:

PREVENTION INSTITUTE

"A national non-profit organization, the Institute is committed to preventing illness and injury, to fostering health and social equity, and to building momentum for community prevention as an integral component of a quality health system." It is funded by numerous governments, foundations and organizations. Its website includes a variety of toolkits, initiative profiles, and series of online training modules ("Health Equity and Prevention Primer").

www.preventioninstitute.org

UNNATURAL CAUSES – IS INEQUALITY MAKING US SICK?

This seven part series from PBS explores racial and socioeconomic inequalities in health. As US-based, it is highly influenced by the US context, however, it is an example of professional media that can be used as a component to an overall set of comprehensive actions. The associated website (www.unnaturalcauses.org) is a very rich source of related tools, resources in the US and internationally, and a campaign (overview, toolkit, resources, handouts and discussion guide).

HEALTH EQUITY AND SOCIAL JUSTICE – NACCHO

The goal of NACCHO's Health Equity and Social Justice initiatives is to advance the capacity of local health departments to tackle the root causes of health inequities through public health practice and their organizational structure. The website provides links to a national coalition of LHDs, a state-based campaign, toolkit, and NACCHO's new publication *Tackling Health Inequalities Through Public Health Practice: Theory to Action*.

<http://www.naccho.org/topics/justice/>

DETERMINE

Determine is an EU Consortium for action on the SDOH that aims to take forward the work of the WHO Commission on the SDH in an EU context. It brings together over 50 health bodies, public health and health promotion institutes, governments and various other organizations from 26 European countries. This comprehensive European portal provides a wide range of materials (frameworks, good practice directory, video profiles, national policies, etc.). To assist visitors to pursue their particular area of interest, the portal provides a 'sign-post' on its main webpage.

<http://www.health-inequalities.eu/>

VICHEALTH

This Australian health promotion foundation provides a list of health inequalities-related publications. <http://www.vichealth.vic.gov.au/en/Publications/Health-Inequalities/Fairer-health---Case-studies-on-improving-health-for-all.aspx>

Training Opportunities

As noted in a recent analysis commissioned by the NCCDH, there are limited training opportunities to increase health determinant-related competencies and according to a recent examination of options, found that “what does exist is not directed to front-line public health professionals working in a Canadian context.” Five online courses are profiled in that report and the reader is directed there for further details. It should be noted that the author located most of these courses through personal contact with those involved and many were not readily locatable through general web searches.

Some additional training opportunities were identified over the course of this environmental scan.

HEALTH EQUITY AND PREVENTION PRIMER

The U.S.-based Prevention Institute has recently developed a “Health Equity and Prevention Primer” <http://www.preventioninstitute.org/tools/focus-area-tools/health-equity-toolkit.html>. Each of the 7 modules is about 15 minutes in length and is comprised of an audio presentation and links to additional resources. The primer includes the following modules: (ADD EN ANGLAIS)

- *Achieving Equity in Health and Safety through Primary Prevention* describes how Primary Prevention is a key strategy for eliminating inequities in health and safety. It provides an overview of Primary Prevention and previews material that will be covered later in the series
- *Take Two Steps to Prevention* describes the Two Steps to Prevention Framework and the Trajectory of Health Inequities. These tools can be used to describe why a focus on the environment is essential for health equity efforts
- *Community Factors & How They Influence Health Equity* explores eighteen community factors. These eighteen factors are linked to health equity. Each factor is part of a community and provides tangible opportunities for achieving equitable health and safety outcomes
- *The Spectrum of Prevention: A Framework for Addressing Health Equity*, introduces the Spectrum of Prevention. It provides a step by step explanation of how the Spectrum can be used to develop a mutually supportive set of actions as part of a comprehensive primary prevention strategy to change environments for equity
- *Enhancing Effective Partnerships for Health Equity* explores the power of partnerships for improving equity. It introduces the Eight Steps to Coalition Building, which can be used to launch and stabilize effective equity-focused coalitions
- *The Importance of Local Policy for Achieving Equitable Outcomes* looks at why policy—at the city and county levels, in particular—is important to health equity efforts. It provides an overview of key strategies in the policy development process
- *Good Health Counts: Measurement and Evaluation for Health Equity* describes how community health indicators can be used to assess and monitor conditions that influence health and safety. It highlights a number of indicator reports that have been used to advance health equity efforts.

CULTURAL COMPETENCIES

The Canadian Healthcare Association, in association with the Aboriginal Nurses Association of Canada, has developed a course to provide training to health service professionals who work in aboriginal settings and with First Nations, Inuit and Métis peoples. The program includes seven home study units, a major paper or project, and a mandatory, four-day intramural session in Ottawa. By becoming familiar with these concepts, health professionals can add a cultural competence component to their foundations of skills.

<http://www.learning.cha.ca/CourseDescriptions/Management/CulturalCompetenceandCulturalSafetyinHealth.aspx>

SPRING/SUMMER SCHOOL COURSES

Examples of spring/summer school courses were retrieved for two locations:

University Central London (UCL)

Social Determinants of Health (July 12-16, 2010)

Combination of lectures and seminars – 5 full days

Sir Michael Marmot opening and closing speaker

The equivalent link for 2011 is http://www.ucl.ac.uk/iish/LEAFLET_20FINAL.pdf

University of Minnesota School of Public Health

Social Determinants of Health: Moving Upstream with Community (May 2010)

Combination of lectures, small and large group exercises, daily assignments, final project – 4 half days

<http://www.sph.umn.edu/ce/trainings/coursepage.asp?activityId=9317>

Additional Tools and Resources

Videos and Other Tools to Engage Staff, Partners and the Public

UNNATURAL CAUSES

This seven part series from PBS explores racial and socioeconomic inequalities in health. While highly influenced by its U.S. context, however, it is an example of professional media that can be used as a component to an overall set of comprehensive actions. The associated website (unnaturalcauses.org) is a very rich source of related tools, resources and a campaign (overview, toolkit, resources, handouts and discussion guide). It has been used as an initial prompt for further discussion among staff, as well as to foster dialogue within communities (i.e., view with community stakeholders and then discuss). Many Canadian public health organizations have utilized it in this fashion as well.

<http://www.unnaturalcauses.org>

CANADIAN DOCUMENTARIES

Two Canadian documentaries were mentioned by focus group participants.

- Poor No More - <http://www.poornomore.ca/>; documentary by Mary Walsh looking at the working poor in Canada and other countries' policies
- Four Feet up - <http://films.nfb.ca/four-feet-up/>; NFB documentary on child poverty in Canada from a child's perspective.

SNAKES AND LADDERS

As described in the BC Council of MOHs' report, Dr. Michael Hayes at Simon Fraser University uses the concept of 'the game of snakes and ladders' to illustrate how the game boards of some individuals are filled with more opportunities (i.e., ladders) and some have few ladders but many snakes (i.e., traps/ barriers to health).

http://www.nfhs-pg.org/fasd-toolkit/Working%20with%20Participants/Activities/IH_SnakeLadders_Version1.pdf

THE LAST STRAW

Developed by two public health graduate students, the Last Straw has been used with students in medicine and public health; government policy analysts and community workers. Its objectives are:

- To promote discussion about the social determinants of health
- To help players build empathy with marginalized people and gain an awareness of players' own social location
- To encourage learning in a fun and supportive environment.

A youtube video 'training manual' for facilitators is also available.

www.TheLastStraw.ca

Complexity-Related Resources

- Tamarack Institute for Community Engagement
 - <http://tamarackcommunity.ca/>
- Getting to Maybe: How the World Changed
 - *A 2006 publication by Westley, Zimmerman and Patton.*
- The Power of One the Power of Many - Bringing Social Movement Thinking to Healthcare Improvement
 - *Publication of NHS Institute for Innovation and Improvement*
 - http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=580

Additional Examples

The following selected items were encountered during the scan and may warrant consideration for future information gathering efforts.

- Reorienting Public Health Programming in Montreal: This health department has been providing presentations to staff and using a working group to review programs. The perception is that a greater population perspective is being achieved
- Winnipeg – Age and Opportunity <http://www.ageopportunity.mb.ca/>
- Food Security Initiatives http://www.smartfund.ca/current_cfa.html
- Calgary homelessness <http://www.calgaryhomeless.com>
- Healthy Communities Networks <http://www.ohcc-ccso.ca/en> ;
<http://www.bchealthycommunities.ca/content/home.asp>
- Provincial anti-poverty initiatives
- Built in environment initiatives (e.g., Interior Health, BC)
- Peterborough County-City Health Unit – social marketing, training initiatives
- Vancouver Coastal Health – work with municipal and other officials.

Note: it is likely that there are other practice examples worthy of consideration that were not identified during this scan. For example, online survey respondents provided a number of suggestions that could be pursued in the future – see the survey technical report for further details.

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