National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

COMMON AGENDA FOR PUBLIC HEALTH
ACTION ON HEALTH EQUITY

CONTENTS

ACKNOWLEDGEMENTS

THE NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

The National Collaborating Centre for Determinants of Health (NCCDH), hosted by St. Francis Xavier University, is one of six National Collaborating Centres (NCCs) for Public Health in Canada. Funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases and health inequities. The NCCDH focuses on the social and economic factors that influence the health of Canadians and applying knowledge to influence interrelated determinants and advance health equity. Find out more at nccdh@stfx.ca. The other centres address aboriginal health, environmental health, healthy public policy, infectious disease, and methods and tools. Find out more about all NCCs at www.nccph.ca/en/home.aspx

1 Introduction

Why a common agenda?

Health inequities refer to differences in health outcomes that are systematic, unfair and avoidable.[1-3] These differences in health outcomes are rooted in unequal power relationships and structures across society. Persistent social inequities are observed in who gets sick and who dies earlier across the population. For example, people with low incomes have significantly poorer health than those with high incomes; there are significant differences in life expectancy among geographic regions; and decreased life expectancies and poorer health exist among indigenous peoples compared to non-indigenous peoples.[4-8] The public health sector has been concerned with reducing these health inequities through action on the social, economic, cultural and political conditions that influence health and related inequities. Despite this concern, there is a need to further strengthen and amplify public health action.[9-12] Opportunities exist to deepen public health's commitment to a more equitable and fair society, increase the coherence of existing efforts, and amplify innovations for greater impact.

This agenda contributes to increased alignment of Canadian public health action through the identification of common health equity priorities, goals, objectives, and approaches. The purpose of the Common Agenda for Public Health Action on Health Equity is to encourage action to improve health for all. It contributes to, and builds upon, existing momentum to improve health equity in the Canadian context. It is designed to support policy makers, practitioners and organizations at all levels to influence the social determinants of health by identifying objectives, approaches and entry points. It can be used to help identify areas of common interest, priority issues, and evaluate the potential success of various types of interventions across organizations and sectors.

While this document is developed for public health, working collaboratively with health and non-health partners - including a range of community stakeholders - is an essential component. This document is a guide and tool for those who intend to drive a common agenda strategy; it does not replace the will and commitment to do so.

How to use this agenda

This document provides a guide to actions that can drive a common agenda at all levels: local, provincial, territorial and national. It provides public health leaders and practitioners with approaches that are appropriate to their specific contexts to guide organizational and systems action directed towards improving health equity. Ideally, the agenda will be used to frame both internal organizational priorities as well as external partnerships and collaborations.

How the agenda was developed

The National Collaborating Centre for Determinants of Health (NCCDH) has collaborated with and engaged public health practitioners, researchers, and decision-makers across Canada on the question of how to strengthen the social determinants of health and improve health equity. Through various knowledge exchange, learning, and networking activities, these stakeholders have identified challenges they face, priorities they are already engaged in, and areas for more focus and collaboration.

This common agenda was developed through a synthesis of documents from these activities, including past NCCDH event reports, environmental scans, meeting notes, and staff observation through network development and consultations. These sources represent the voices of thousands of public health actors from every province and territory in Canada. We also reviewed high-level strategy documents from Canada and abroad to assess alignment and additional substantiated directions. A review of these sources shows a high level of coherence in priorities. See **Appendix 1** for a list of sources.

An advisory group comprised of leaders in the field provided direction and guidance for this agenda and selected readers provided comments to drafts (see acknowledgements).

2 Understanding the social determinants of health and health equity

A number of complex social, economic, ecological and political factors - commonly referred to as the **social determinants of health (SDH)** - interact in dynamic ways to influence health experiences and outcomes. At the most fundamental level, social determinants of health inequities consist of the social and political context as well as the **structural determinants of health**. Structural determinants generate social inequities across class, gender, race and ethnicity, education, occupation, and income (e.g., classism, sexism, racism, heterosexism and homophobia, ageism) and shape the distribution of power, prestige and resources in society.[13] **Intermediary or midstream determinants** of health are the material, behavioural, biological and psychosocial factors (e.g., housing conditions, employment, and food security) that influence health. **Downstream determinants** are the conditions that have an immediate impact on health (e.g., health-related knowledge, attitudes, beliefs, or behaviours). The social determinants of health influence and shape lifestyle choices and behaviors, which interact to produce health or disease.

The SDH are also shaped by public policy decisions and, as such, are modifiable through different policy choices and actions.

Specific determinants of health are interconnected and need to be understood in their specific socio-political and historical contexts. For example, there are strong links between education and income, with higher education associated with opportunities for better income. Additionally, racism and discrimination in the education system adversely affects Indigenous and racialized peoples resulting in poorer educational experiences and outcomes. Further, while racialized peoples have higher rates of high school completion, this does not translate into better employment and income prospects when compared to non-racialized people.[14]

Health inequities reflect deeply embedded patterns of social inequities in society. Differences in power, money and resources shape, and are shaped by, social hierarchies resulting in differences in health for various population groups.[13]

CONTEXT

Context is an important but under-explored element relevant to action to improve the social determinants of health inequities.

Context refers to *"a broad set of structural, cultural and functional aspects of a social system whose impact on individuals tends to elude quantification but which exert powerful formative influence on patterns of social stratification and thus on people's health."* [79 (p. 25)]

This includes the labour market, educations systems, and political institutions. Important elements of context are:

- Governance
- Macroeconomic policy
- Social policies (labour, social welfare, land, and housing)
- Public policy (education and health)
- Culture and societal values
- Epidemiological conditions

Health inequities are differences in the health of population groups – defined in social, economic, demographic or geographic terms – that are systematic, avoidable, unnecessary and unfair.[2,3] Social stratification (e.g., by gender, social class, race/ethnicity, and ability) results in differential exposures to health promoting and health damaging conditions and experiences, differential vulnerability, and unequal consequences of illness. Determinants of health interact across the life span, with disadvantage and privilege having cumulative effects over the life course and across generations. As such, a **life course approach** that considers how health is influenced from gestation through to elderhood is an essential lens for action on the SDH.[15-17]

RESOURCES

Canadian Council the Social Determinants of Health. (2015). *A review of frameworks on the determinants of health.* Retrieved from **http://ccsdh.ca/**

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts.* Retrieved from **www.thecanadianfacts.org/The_Canadian_Facts.pdf**

Reading, J. & Halseth, R. (2013). *Pathways to improving well-being for Indigenous peoples: How living conditions decide health.* Retrieved from **www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/102/pathways_EN_web.pdf**

McGibbon, E. (Ed). (2012). *Oppression: A Social Determinant of Health.* Halifax, NS: Fernwood Publishing.

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3 Health inequities in Canada

Health inequity is not a new concern for public health, but one that has been gaining in importance as social inequity increases in Canada and around the world. A recent report from the Organization of Economic Cooperation and Development (OECD)[18] shows how the level of income inequality in Canada, and the gap between the richest and poorest, is worse than in many European countries.

The Broadbent Institute[19] looked at wealth in Canada in order to get a better understanding of net worth, that is, the value of assets minus debts. In 2012, the top 10% of Canadians owned almost half (47.9%) of all wealth. In contrast, together, the bottom 50% of Canadians owned less than 6% of the wealth.

There are significant regional variations in Canada: the concentration of wealth for the top 10% is highest in BC (56.2%) and lowest in Atlantic Canada (31.7%) and Quebec (43.4%).

The Public Health Agency of Canada (PHAC) has reported on the connection between social inequity and health status at the national level.[5] For example, data from 2001 show more total years of life were lost to premature death (measured as "potential years life lost" or *PYLL*) in lower-income urban neighbourhoods than in the 20% of neighbourhoods with the highest incomes. In his report on the state of public health in Canada, the Chief Public Health Officer notes that if the rates from the highest-income quintile had applied to the entire population, the total PYLL for all urban neighbourhoods would have been reduced by approximately 20% – the equivalent of eliminating all premature deaths due to injuries in those neighbourhoods.[5(p. 27)]

Education provides another measure of social inequity, with low educational attainment related to higher levels of chronic disease.[5(p. 29)]

FIGURE 1: DISTRIBUTION OF WEALTH IN CANADA BY DECILE, 2012 (BROADBENT INSTITUTE, 2014)
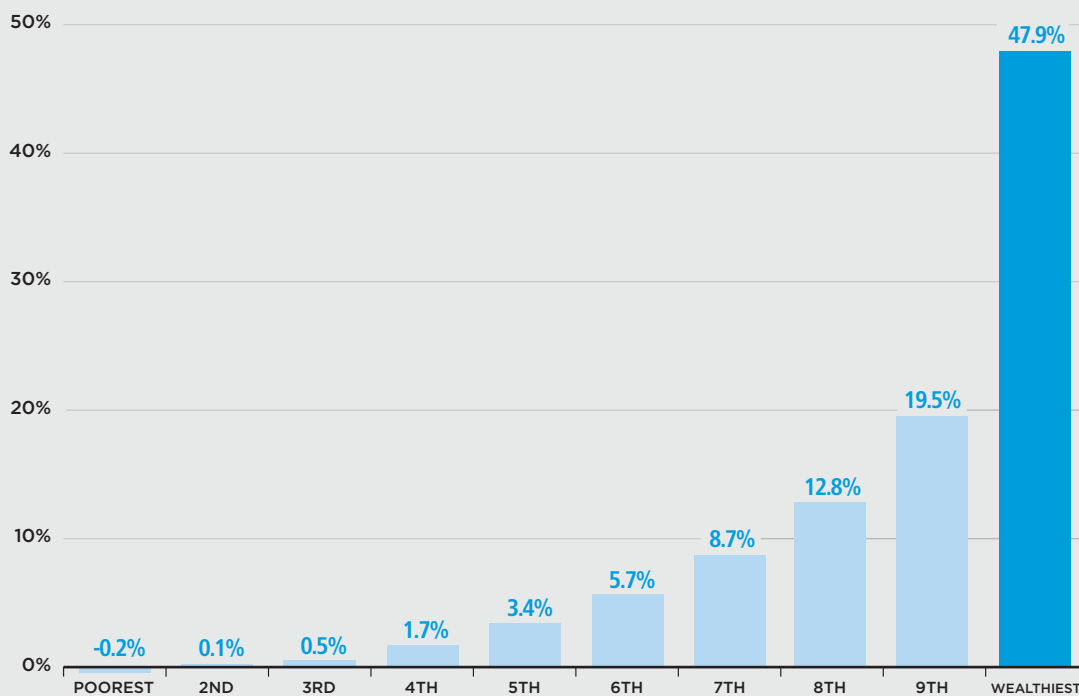
FIGURE 2: SELF-REPORTED HEART DISEASE BY EDUCATIONAL ATTAINMENT AND SEX, HOUSEHOLD POPULATION AGED 45-64 YEARS, CANADA, 2005 (PHAC, 2008, P. 29)
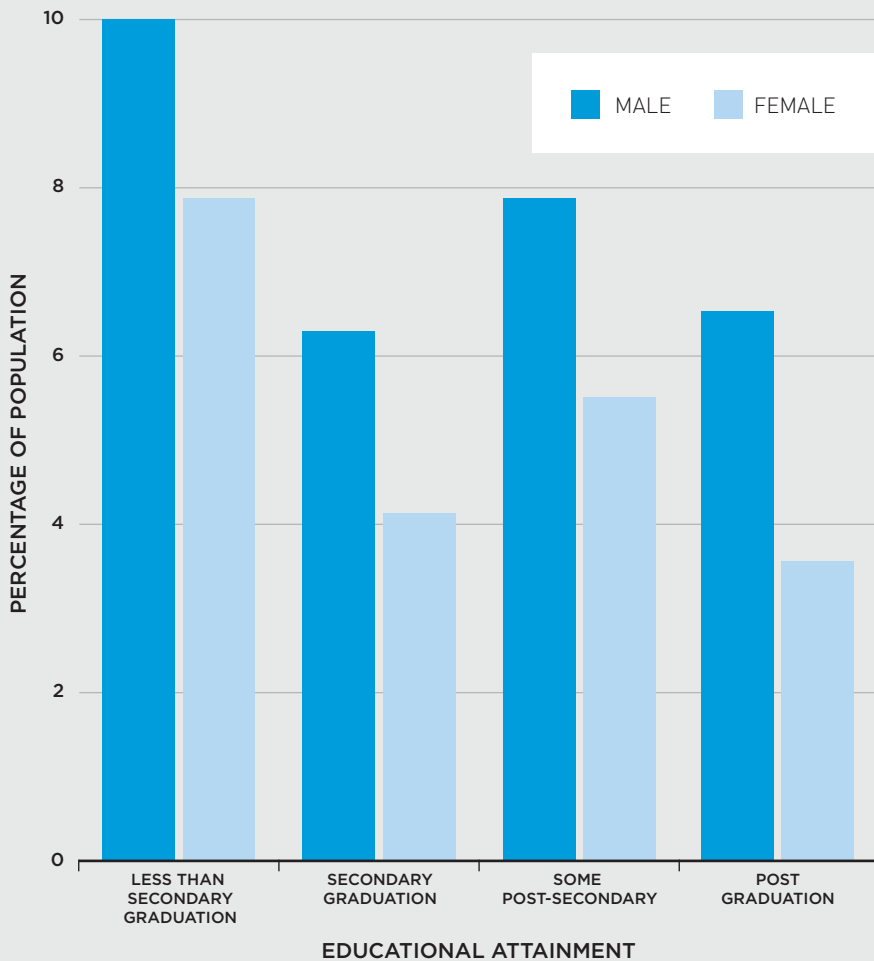
Spatial measures, such as geographic location, also increase the depth of our understanding of health inequities. Data specific to urban population health describe a health inequity gradient in hospitalization rates across socio-economic groups.[21] To truly understand this information at the local level, it is necessary to capture the significant contextual differences that can be found between metropolitan areas. For this reason, local analysis of national survey data is essential for understanding the nature of equity issues. A number of urban areas (i.e., Saskatoon, Montreal, and Quebec) have generated specific equity focused population health status reports in recent years.[4,6,7]

With respect to place, there is an equivalent need to understand the local context. For example, income and education tend to be lower in rural areas in Canada, but so do cancer rates. In addition, morbidity and mortality data indicate higher rates of mortality due to injury and poisoning for rural populations, and higher death and disability rates due to traffic incidents.[22]

Although we have sufficient data on the problem of health inequity in Canada to act, there are still serious gaps that limit our ability to track change over time, and develop and evaluate appropriate interventions. For instance, a report on racialization and health equity in Toronto[23] found inequities for members of some racialized groups on a number of health outcomes, but not others. Demonstrating the need for better data on racialization and health in the Canadian context, the report concluded that

We can also consider indigeniety as a critical lens for examining health inequities. For example, Aboriginal people are over-represented in HIV infection rates. While they comprised only 3.8 % of the total Canadian population in 2006, they accounted for 8% of people living with HIV and 12.5% of new infections in 2008.[20]
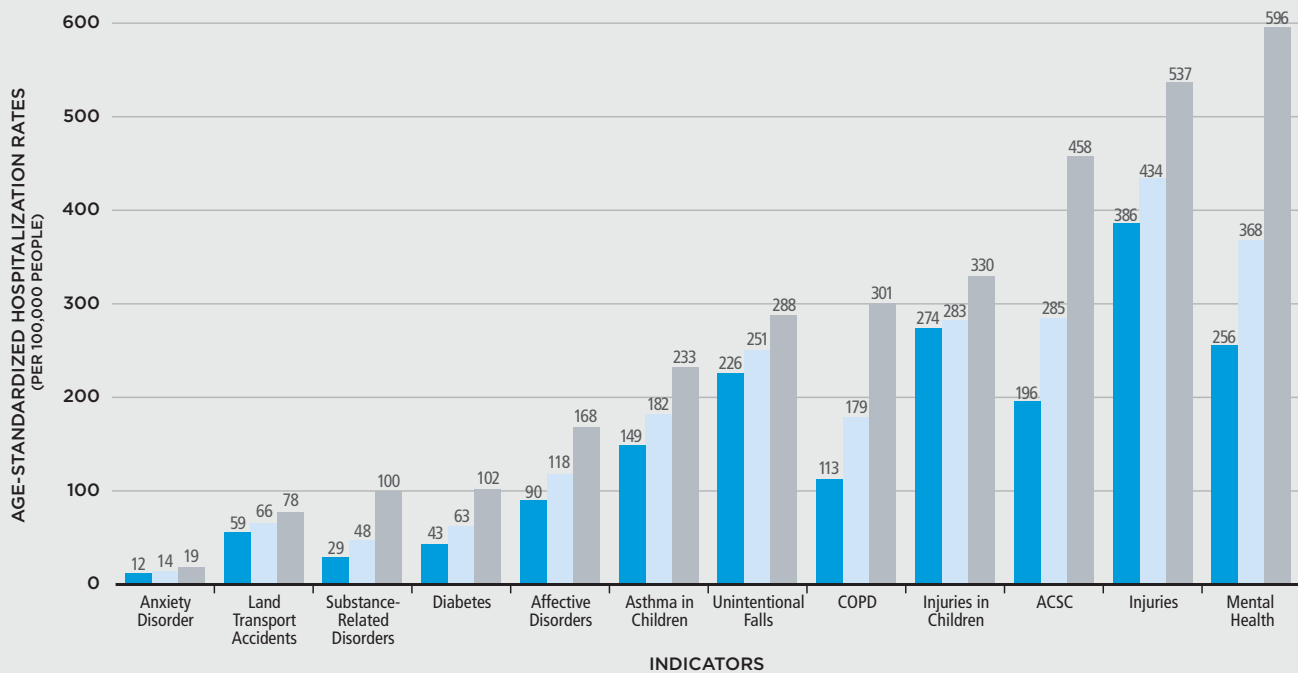
existing data do not allow for a comprehensive or conclusive exploration of racialization and health. This same problem can be found in data on indigenous people, due to data often not being collected on non-status First Nations and Metis or Inuit living in urban areas. In health administrative and surveillance data, ethnic identifiers of First Nation, Metis and Inuit status are inconsistent, making these groups invisible in the data.[20]

Despite these challenges, data on health inequity is improving. The *Trends in Health Inequalities in Canada* report was recently released by the Canadian Population Health Initiative at CIHI.[24] The analysis examines national and provincial/territorial trend data over time to show whether gaps between the highest and lowest income groups

are increasing, persisting or decreasing. The CIHI report analyzes several measures summarizing income-related inequality, along with income-specific rates for a range of health indicators, and showcases policies and interventions designed to reduce inequality. There is a second pan-Canadian health inequalities indicators report expected in 2016 which is being developed collaboratively by the Public Health Agency of Canada, Statistics Canada, CIHI, and the Pan-Canadian Public Health Network.

It is important to reiterate, however, that in spite of existing measurement and data challenges, we have sufficient evidence to act to improve health equity through concerted action on the social determinants of health.

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RESOURCES

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OECD. (2015). Health at a glance 2015 OECD Indicators. Paris: OECD Publishing. doi: 10.1787/health_glance-2015-en

Broadbent Institute. (2014). Haves and have-nots: Deep and persistent wealth inequality in Canada. Ottawa: Author. Retrieved from **www.broadbentinstitute.ca/haves_and_have _nots**

SELECTED LOCAL EXAMPLES

Toronto Public Health. (2015). The Unequal City 2015: Income and health inequities in Toronto. Toronto: Author. Retrieved from: **www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-79096.pdf**

Toronto Public Health. (2013). Racialization and health inequities in Toronto. Toronto: Author. Retrieved from **www.toronto.ca/legdocs/mmis/2013/hl/bgrd/background file-62904.pdf**

Lemstra, M., and Neudorf, C. (2008). Health disparity in Saskatoon: Analysis to intervention. Saskatoon: Saskatoon Health Region. Retrieved from **www.caledon inst.org/Special%20Projects/CG-COP/Docs/HealthDisparityRept-complete.pdf**

Direction de sante publique. (2011). Social inequalities in health in Montreal - Progress to date. Montreal: Agence de la sante et des services sociaux de Montreal. Retrieved from **http://publications.santemontreal.qc.ca/uploads/tx_asssmpublications/978-2-89673-119-0.pdf**

4 Current actions to reducing health inequities

In this section, we briefly review public health action on the social determinants of health and health equity. A comprehensive analysis of the state of action on the social determinants of health in Canada is beyond the scope of this document; instead, we provide a high-level overview.

Recent years have seen a renewed commitment by many public health organizations to influence the SDH.[10,11] At the national level, the Chief Public Health Officer of Canada's 2008 report[25] signaled the importance of reducing health inequities through public health practice. Coinciding with increased attention on the global stage,[13] the report emphasized five areas of action:

"**social investments**, particularly for families with children living in poverty and in early child development programs; **community capacity**, through direct involvement in solutions, enhanced cross-sectoral cooperation, better defined stakeholder roles, and increased measuring of outcomes; inter-sectoral action through integrated, coherent policies and joint actions among parties within and outside of the formal health sector at all levels; **knowledge infrastructure**, through a better understanding of sub-populations, the pathways through which socio-economic factors interact to create health inequalities, how best practices from other jurisdictions can be adapted to improve Canadian efforts, and through more advanced measurement of the outcomes of the various interventions undertaken; and **leadership** at the public health, health and cross-sectoral levels."[25(p. 3)]

Current actions on inequalities across Canada exist on a spectrum,[26] ranging from measurement of health inequalities to isolated initiatives; however, comprehensive and/or coordinated policies are absent. The NCCDH 2014 environmental scan noted that attention to health equity within the public health sector has grown over the last three years, with a variation across regions in terms of capacity and action.[11] This growth was observed through visible leadership commitments, incorporation of health equity into strategic priorities, investments in human resources, increased monitoring and reporting with a health equity lens, prioritizing intersectoral partnerships, advocating for health-in-all policies and the initiation of research projects. The most significant area of growth appeared to be in the development of guidance documents and organizational capacity.[11]

In the research domain, the Canadian Institutes of Health Research - Institute for Population and Public Health (CIHR-IPPH) identified health equity as a strategic priority and earmarked research funding for health equity.[27] In addition, the Canadian Institute for Health Information – Canadian Population Health Initiative, the Public Health Agency of Canada, and Statistics Canada have actively contributed to the knowledge infrastructure through initiatives like the recently released report *Trends in Income–Related Health Inequalities in Canada*.[24]

Organizations like the National Collaborating Centres (NCCs) for Aboriginal Health, Determinants of Health, and Healthy Public Policy are working to bridge research and practice and have emphasized the social determinants health, indigenous health and health equity as key areas of intervention. Through a range of knowledge translation activities, these NCCs play a key role in moving research into action.[10] Emergent organizations like Upstream[28] are bringing together voices from the health and non-health sectors to increase public dialogue on the social determinants of health.

Organizational standards and professional competencies contribute to the integration of health equity into practice. The core public health competencies for Canada[29] provide some support for health equity action as they explicitly name some competencies that are relevant to action on the social determinants of health (e.g., leadership, advocacy and communications). The competencies have, however, been critiqued for not effectively integrating a determinants of health approach[30] and a social justice lens,[31] which is essential for supporting equity action in a more comprehensive manner. To date, three provinces have included a health equity approach in their public health standards or core functions.[32-35] Nonetheless, public health organizations continue to identify gaps in knowledge, skills and attitudes required to improve health equity.[11]

Public health organizations are incorporating health equity into strategic plans and priorities at all levels. The identification and documentation of health inequalities is increasingly common at the local and regional level[7,36-38] with equity being more apparent in the vision, mission and values statements of health regions than in the interventions they offer.[11,39]

To examine how public health policies and programs improve health equity through action on the social and structural determinants of health, it is helpful to consider five different levels related to how these programs are directed towards the improvement of daily living conditions and the redistribution of wealth, power and resources: [40,41]

a. Shifting social stratification (society - socioeconomic context and position)
b. Decreasing exposures to damaging factors (social and physical environment)
c. Decreasing vulnerability (population group)
d. Improving differential health and health care outcomes (individual)
e. Preventing unequal consequences of differential vulnerability (individual)

a. Shifting social stratification (society - socioeconomic context and position)

To reduce health inequities, public health must understand – and address – social stratification factors such as class, gender, race/ethnicity, education, occupation and income, all of which are, in turn, determined by governance, policies and societal values.

Strategies exist to improve a number of specific determinants of health, with public health playing varied roles. Income and health is an area of active engagement for many public health organizations, with involvement in a range of strategies related to poverty reduction and income security. While there is currently no federal poverty reduction strategy, all Canadian provinces and territories – with the exception of Alberta and British Columbia – have poverty reduction plans. Anti-poverty legislation exists in Manitoba, New Brunswick, Nunavut, Ontario and Quebec. At the local level, many public health organizations play a role in the development and implementation of poverty reduction initiatives through a range of intersectoral collaborations (e.g., Saskatoon Poverty Reduction Network and Peterborough Poverty Reduction Network). There are advocacy and policy initiatives for a living wage[42] and, more recently, a basic income guarantee.[43-45] In contrast, public health appears to be less engaged around other SDH like education, gender, race and disability.[11]

b. Decreasing exposures to damaging factors (social and physical environment)

Socioeconomic context and position are inversely related to exposure to many risk conditions: the lower a group's or individual's social status, the greater the probability of exposure to risk conditions such as unhealthy housing, dangerous working conditions, inadequate food access, social exclusion and availability of high quality and affordable recreational resources.

Decreasing exposure to damaging factors is a common public health strategy, but one which is highly context specific. At this level of intervention, housing and food security issues have received some attention from the public health sector. For example, in Nunavut, where nearly 70% of households experience moderate to severe food insecurity, public health is part of the Nunavut Food Security Coalition, which is leading activities to improve food security in the territory. The Coalition addresses four components of food security: availability, accessibility, quality and use.[46] Similarly, recognizing the higher exposure of lower income people to secondhand smoke, the Region of Waterloo enacted a smoke-free community housing policy.[47] This policy restricted indoor smoking in Waterloo Region Housing buildings and also recommended that public health implement smoking cessation support for tenants and those on the waiting list. Other public health initiatives include attention to healthy built environments to support physical activity or nurture age-friendly communities and focus on decreasing exposure to factors in the social and physical environment that are detrimental to health.

c. Differential vulnerability (population group)

Different groups experience varying levels of vulnerability and as such the same level of exposure may have different effects. This is typically as a result of groups being exposed to multiple risk conditions. Interventions at this level focus on mitigating vulnerability.

In Ontario for example, there has been a focus on addressing the unique needs of "priority populations"[38] through the modification of public health interventions. Interventions here are quite varied and can include initiatives that compensate for lack of opportunities, seek to empower communities, and enhance access to services for specific groups. Other examples include tailored employment opportunities for people living with disabilities and targeted public health interventions that are provided for free or at reduced cost (e.g., dental coverage for low income families). While public health programs usually have a focus to some extent on marginalized populations, approaches vary and do not always address processes that lead to marginalization.

d. Differential health care outcomes (individuals)

Social position, exposure and vulnerability are further compounded when the delivery of health care – and related public health interventions – does not address socially determined circumstances. Consequently, programs and services are not appropriate to, or are less effective for, certain populations.

Public health has used approaches that integrate cultural competence into program design to address this issue, such as developing educational materials with ethnically and culturally diverse

communities and eliminating discriminatory practices in the delivery of services. Another example is the provision of dedicated services for particular groups, such as an immunization program for people in deprived Saskatoon neighbourhoods.[37,48] Quality care initiatives in public health and across the health sector are reinforcing their focus on providing culturally appropriate care (e.g., indigenous health programs).

e. Differential consequences (individuals)

Advantaged groups in society are better protected from the social and economic consequences of ill health. As such, the consequences of illness and injury – such as loss of income, reduced ability to work, worsened social isolation, exclusion or survival – have a deeper negative impact for those who experience intersecting disadvantages at multiple levels (e.g., experience of social stratification, social and physical context, individual vulnerability and health care outcomes).

Differential consequences can be addressed through increasing social and political access, such as implementing workplace policies that maintain income as a result of illness or injury. We found fewer examples of public health action that relate to this level, although the literature analyses such consequences.[40] As one example from the field, Dr. Sheela Basrur, Ontario Chief Medical Officer of Health in Toronto during the 2003 SARS outbreak (personal communication, 2004), was struck by how quarantine regulations affected health care workers differentially. She noted that the nurses who were quarantined were more likely to work multiple part-time jobs, including a disproportionate number of immigrant nurses who in some cases had fewer social and family supports to help them through the isolation of quarantine.

While public health programs and policies can be found at each of these five levels, the increased interest and commitment within the public health sector in Canada has yet to lead to widespread, significant and concrete actions to improve health equity.[9-11,49] To date, there has been a lack of concerted attention to macro, historical and dynamic influences on health. Instead, emphasis has been placed on downstream determinants such as health behaviours.[49-51] Moreover, the majority of public health strategies do not explicitly recognize a social determinants of health and health equity approach and public health remains oriented towards lifestyle interventions.[52] According to a 2012 study, 25% of public health interventions addressed equity, with 16% of these interventions being structural in nature.[39] There is a need to move beyond largely biomedical and behavioural approaches, which are insufficient to reduce health inequities. This will require, in part, an acknowledgement of existing tensions around the legitimacy of public health's engagement in activities on the social determinants of health[53,54] as well as a reconfirming of the core purposes of the public health system.[49,55] A summary of public health equity action at the provincial and territorial level is presented in **Appendix 2**.

A continuum of action is required that fundamentally influences structural determinants of health and redistributes wealth, power and resources. This change needs to be systematic, systemic, and long-term and include activities that address social stratification. A holistic approach to analysis, planning, intervention and evaluation will allow for the consistent consideration of equity in programs and policies. Additionally, an

intersectional lens lends itself to a critical analysis of how unequal power relationships impact the SDH and equity across multiple forms of social exclusion and allows for the exploration of both social positions and social processes that lead to inequity.[56-59] Achieving health equity requires a proportionate universal response, i.e., improving health outcomes for all population groups, while seeking to reduce the excess burden of ill health among socially and economically disadvantaged populations.[60-63] Ultimately, improving health equity will be achieved through both reducing the gap in outcomes and experiences at the extremes and along the social gradient.

RESOURCES

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National Collaborating Centre for Determinants of Health. (2014). B*oosting Momentum: Applying Knowledge to Advance Health Equity.* Retrieved from **http://nccdh.ca/ resources/entry/boosting-momentum**

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5 Nurturing a culture of equity: goals and approaches for a common agenda

"No matter how sophisticated our population health interventions, they won't adequately address inequities if we exclusively focus on proximal determinants and tinker at the edges of structural disadvantage"

Nancy Edwards, Scientific Director
Canadian Institutes of Health Research Institute of Population and Public Health, 2011

This section outlines common goals and approaches for public health action to improve health equity. Working towards health equity requires that public health fully integrate and act upon values of fairness and social justice. Social determinants of health are shaped by social and economic policies, and as such, these policies have to be an explicit focus of intervention. Public health, in collaboration with partners from other sectors

and in the community, has a range of approaches available to intervene across the foci listed above. These approaches are organized under three main themes – build a foundation for action, establish a strong knowledge base, and collaborate with non-health sector partners (see Box 2)[64] – that are well-aligned with the four roles for public health action on health equity described in Figure 4.

FIGURE 4: PUBLIC HEALTH ROLES FOR ADVANCING HEALTH EQUITY (NCCDH, 2013, P.2)

ASSESS AND REPORT

Assess and report on a) the existence and impact of health inequities, and b) effective strategies to reduce these inequities.

MODIFY AND ORIENT INTERVENTIONS

Modify and orient interventions and services to reduce inequities, with an understanding of the unique needs of populations that experience marginalization.[a]

PUBLIC HEALTH ROLES

Partner with other government and community organizations to identify ways to improve health outcomes for populations that experience marginalization.[a]

PARTNER WITH OTHER SECTORS

Lead, support and participate with other organizations in policy analysis and development, and in advocacy for improvement in health determinants and inequities.

PARTICIPATE IN POLICY DEVELOPMENT

BOX 2

NURTURING A CULTURE OF EQUITY:
GOALS AND APPROACHES FOR A COMMON AGENDA

The three overarching themes were initially developed based on key informant interviews and small group discussions held with public health leaders from 20 jurisdictions at regional/local, provincial/territorial and federal levels. The resulting report, Toward Health Equity: Canadian Approaches to the Health Sector Role,[64] was presented at the World Health Organization's (WHO) 8th Global Conference on Health Promotion in 2013.

1 Build a foundation for action

- Strengthen public health leadership
- Increase social and political support (political will) and action
- Build organizational and system capacity

2 Establish and use a strong knowledge base

- Act on existing evidence and strengthen the knowledge base to support concerted action
- Incorporate equity considerations into regular monitoring, surveillance and reporting

3 Collaborate with non-health sector partners

- Participate in long-term multisectoral action
- Advocate for policy and structural change
- Allocate time and resources for meaningful sustained community engagement and political empowerment

Build a foundation for action

Strengthen public health leadership

Leadership is a cornerstone for public health action on health equity. Where supportive leadership is present, activities are more likely to be initiated and supported. Public health is called to:

- Build and strengthen visible support for health equity among organizational leaders (e.g., Medical Officers of Health, directors, policy makers).
- Grow the base of leaders who explicitly and publicly support the importance and legitimacy of public health action on the social determinants of health and equity.
- Develop and implement strategic organizational commitments to health equity that are cross-cutting and address all aspects of the organization's activities within the public health and broader health sectors.
- Profile and support the achievement of leadership commitments and priorities to bolster widespread community action.
- Make action to improve health equity a priority in public health leadership and management networks at local, provincial/territorial and national levels.

RESOURCES: LEADERSHIP

National Collaborating Centre for Determinants of Health. (2013). *What contributes to successful public health leadership for health equity? An appreciative inquiry: 14 interviews.* Retrieved from **http://nccdh.ca/resources/entry/leadership-app-inquiry**

Community Health Nurses of Canada. (2015). *Public health leadership competencies for public health practice in Canada: Leadership competency statements release 1.0.* Retrieved from **https://chnc.ca/documents/LCPHPC-EN/mobile/index.html#p=3**

Increase social and political support (political will) and action

Political will is based on the extent to which the public (government leadership and broader community) understands and supports a particular issue. This is a driver for investments across health and non-health systems for the implementation of wide ranging public policy to improve equity.

- Political will and commitment can be increased through a range of approaches. Strategies to influence political will and action include:
  - Using media advocacy to influence policy makers to act on social problems. Including conversations on health equity in the public arena helps frame the conversation in ways that support action.
  - Coordinating comprehensive communications and social marketing strategies that promote the importance of action on the social determinants of health to increase public awareness, understanding of the context in which health and wellbeing are created and support for specific policy solutions.
  - Using existing public concerns and policy priorities as levers for support. For example, the public consensus and pride over the importance of a universal health care system in Canada can be used to prime the conversation for health equity. Action to improve health equity can be framed as essential for the sustainability of the health care system.

- Raise awareness of, and leverage, international commitments such as human rights agreements and declarations. Some relevant international conventions include:
  - UN International Covenant on Economic, Social and Cultural Rights
  - UN Declaration on the Rights of Indigenous Peoples

RESOURCES

National Collaborating Centre for Determinants of Health. (2013). *Communicating the social determinants of health guidelines for common messaging.* Retrieved from **http://nccdh.ca/resources/entry/communicating-the-social-determinants-of-health-common-messaging-guidelines**

National Collaborating Centre for Determinants of Health & Canadian Public Health Association. (2014). *Communicating the social determinants of health: Income inequality and health.* Retrieved from **http://nccdh.ca/resources/entry/income-inequality-and-health**

Build and leverage organizational and system capacity

The ability for public health organizations and systems to adequately act on health inequities is related to the capacity within these structures to identify the problem and mobilize resources to address them. There is a need to further develop the capacity of public health organizations to take action on the SDH and improve health equity. For

a significant impact on health equity, interventions have to move beyond influencing downstream determinants to impacting structural determinants of health and social stratification. Strategies for building organizational and system capacity are listed below.

- Make health equity an integral component of all public health, population health and health sector strategic priorities and plans:
  - Review all existing public health sector plans and strategies, including issue and disease specific plans, and consistently integrate a SDH and health equity approach.
  - Specify how core public health programs (e.g., tobacco control, healthy eating, active living, immunization) will intervene on the SDH and reduce health inequities.
  - Use existing tools like health equity impact assessments, existing lenses and intersectionality-based policy analysis to assist in these endeavours.
- Integrate health equity in public health standards at the organization and system levels as well as in performance monitoring.
- Allocate adequate resources within the public health system to support equity-oriented action. Resources are needed for human resources as well as the infrastructure required to effectively reorient public health activities.
- Address the aspects of public health practice that produce and reproduce social inequities in health. This includes adopting a critically reflexive practice approach at the individual, organizational, and system levels that interrogates and transforms power relationships within the public health system.

- Invest in the development of organizational capacity and build the capacity of the multidisciplinary public health workforce to act on health equity. The required knowledge and skills can be acquired through educational programs responsible for training public health practitioners and ongoing professional development and training. Some required competencies include:[66,67]

  - knowledge of SDH and health equity
  - organizational change and development
  - systems change strategies
  - program development and evaluation with specific consideration to equity
  - advocacy
  - policy development
  - community engagement
  - intersectoral action
  - leadership

- The broader health system, of which public health is one component, is an important site of intervention for the reduction of health inequities through a stronger focus on prevention and acknowledging the health sector role as an employer and public policy lever. Health care organizations and researchers in Canada, and elsewhere, are analyzing the mechanisms through which health care influences health equity, paying attention to equity of access, equity within quality of care and equity of user outcomes. Public health can partner with care providers to better coordinate social and health interventions, such as by considering housing and built environment in diabetes prevention. Public health can also influence resource allocation within the health care system to increase upstream action.

Establish and use a strong knowledge base

Act on existing evidence and strengthen the knowledge base to support concerted action

The majority of research on health equity describes and explains the health equity problem, with a smaller proportion focused on what to do to improve health equity. As such, there is a gap in research evidence to help understand what action to take. Furthermore, where evidence for action and intervention exists, this is not always fully implemented. The links between evidence, policy and practice are non-linear and evidence is only one of many influencers. For example, the strength of the evidence may not be the most important driver for action; indeed Kelly and colleagues argue that "the definition of best evidence should be made on the basis of its fitness for purpose."[68(p.7)] Weighing existing evidence with community preferences, needs and aspirations are important considerations in decision-making with particular attention to processes that create or increase inequities.

RESOURCES

Hankivsky, O. (Ed). (2012). *The intersectionality-based policy analysis.* Retrieved from **www.sfu.ca/iirp/ibpa.html**

Mendell, A., Dyck, L., Ndumbe-Eyoh, S., & Morrison, V. (2012). *Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity: Comparative tables, November 2012.* Retrieved from **http://nccdh. ca/resources/entry/tools-and-approaches**

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The following actions support public health to act on existing evidence and strengthen the evidence base to support concerted action:

- Identify and implement effective and acceptable program and policy interventions to reduce health inequities that address a spectrum of issues across sectors, system levels and intervention types.
- Facilitate the use of existing evidence through knowledge mobilization that supports dialogue and exchange across research, practice and policy fields, disciplines, regions and sectors. Knowledge translation processes that enable action on the social determinants of health identify equity as an explicit goal, involve a range of stakeholders, prioritize multisectoral engagement, draw from multiple forms of knowledge, recognize the importance of contextual factors, and have a problem-solving approach.[69]
- Develop robust evaluation systems that are attentive to process and outcomes of health equity interventions to adequately capture the social and health impacts of interventions. This includes uncovering the mechanisms linking social and structural determinants, interventions, and context.
- Contribute and strengthen the knowledge of what works to improve health equity:
  - Partner with researchers to increase the capacity of public health organizations to actively contribute to the evidence base on which interventions work, how they work, who they work for, and under what conditions.

- Comprehensively document the processes and outcomes of innovative practices (including successes and failures).
- Develop methods and implementation systems to scale-up efforts alongside well-integrated knowledge translation processes that increase dialogue between research evidence, practice and policy. Processes to capture and share tacit knowledge on health equity action contribute to these efforts.
- Investigate and clarify the costs and benefits of action and inaction to society across sectors and system levels.

Incorporate equity considerations into regular monitoring, surveillance and reporting

Consistent high quality population data allows an assessment of trends and progress towards improving health equity. This assessment includes information on health inequities, the determinants of these inequities and existing action and strategies to address them. In collaboration with partners in the health sector, non-health sector, and community public health, engagement in the following activities supports this objective.

- Create and implement a comprehensive framework for health status reporting and surveillance that integrates indicators of health and social equity.
- Identify the social and economic conditions which exist in specific jurisdictions and the role these play in the generation or reduction of health inequities.

- Increase national reporting of health data by social gradient across multiple markers of social position and develop a common set of equity indicators across jurisdictions. These equity indicators should be integrated into routine surveillance and measurement in local, regional, provincial/territorial and national plans and systems. This includes consistent disaggregation of outcomes by equity indicators (e.g., income, race/ethnicity, gender, sexual orientation) for a range of health issues and SDH.
- Develop a process to sustain dialogue about the analysis of both surveillance data and experiential knowledge in understanding the causes of inequities and their solutions.

RESOURCES

Hosseinpoor, A., Bergen, N., & Schlotheuber, A. (2015). Promoting health equity: WHO health inequality monitoring at global and national levels. *Global Health Action, 8.* doi: 10.3402/gha.v8. 29034

National Collaborating Centre for Public Health and National Collaborating Centre for Determinants of Health. (2016). *Equity-integrated population health status reporting: Action framework.* Retrieved from **http://nccdh.ca/resources/entry/ equity-integrated-population-health-status-reporting-action-framework**

National Collaborating Centre for Determinants of Health. (2012). *Population health status reporting: The learning together series.* Retrieved from **http://nccdh. ca/resources/entry/population-health-status-reporting**

Collaborate with non-health sector partners

Participate in long-term multisectoral action

¨Achieving health equity will depend in large part on decisions made outside of the health care system, to address core social determinants of health, including income inequality and poverty, educational barriers and underemployment, unsafe working and living conditions, and systemic discrimination and racism.¨[70]

Given the interrelated and dynamic nature of the SDH, no one sector (government or non-governmental) can make a significant impact in redressing inequities on its own. Programs and policies across health and non-health sectors are integral to shifting the distribution of health generating assets, wealth, power and resources. Through active engagement with non-health sector partners, public health supports and amplifies action on key determinants of health. Intersectoral action on health equity is supported by:

- a powerful shared vision of the problem to be addressed and what success would look like;
- strong relationships among partners, as well as the most effective mix of partners;
- leadership, both in advancing shared purposes and sustaining the collaboration;
- adequate, sustainable and flexible resources; and
- efficient structures and processes to do the work of collaboration.[71]

As a partner in intersectoral action to reduce health inequities, the following strategies are relevant for public health:

- Use public health credibility, trust and ability to influence health and non-health partners.
- Adopt comprehensive health equity impact assessments of programs and policies in health and non-health sectors. Assessments should pay attention to how policies can create, reproduce or reduce structural inequities, with particular attention to the impact on already disadvantaged groups. Conversely, assessments should articulate who benefits from various policies and demonstrate if and how benefits may accrue and accumulate to groups with more power and resources.
- Promote approaches that support health and equity as a consideration across sectors. A health-in-all-policies approach and health equity impact assessments are supportive approaches and tools.
- Identify how health equity aligns with existing goals and mandates of other sectors and social outcomes that are beneficial to society at large.

RESOURCES

Freiler, A., Muntaner, C., Shankardass, K., Mah, C.L., Molnar, A., Renahy, E., O'Campo, P. (2013). Glossary for the implementation of Health in All Policies (HiAP). *Journal of Epidemiology and Community Health,* 67(12):1068-72. doi: 10.1136/jech-2013-202731.

Ministry of Health and Long-Term Care. (2012). *Health equity impact assessment tool.* Retrieved from **www.health.gov.on.ca/en/ pro/programs/heia/tool.aspx**

National Collaborating Centre for Healthy Public Policy. (2010). *Health impact assessment.* Retrieved from **www.ncchpp. ca/54/health_impact_assessment.ccnpps**

Advocate for policy and structural change

Public health has a clear role as an advocate for healthy public policy. The Public Health Agency of Canada (PHAC) lists advocacy as a core competency for public health and notes that "advocacy—speaking, writing or acting in favour of a particular cause, policy or group of people—often aims to reduce inequities in health status or access to health services."[29]

Advocacy is a critical population health strategy that emphasizes collective action to effect systemic change. It focuses on changing upstream factors related to the social determinants of health, and explicitly recognizes the importance of engaging in political processes to effect desired policy changes at organizational and system levels.[72-74] Advocacy is necessary, especially in an environment where improved equity requires policy and structural change that may go against the interests of powerful actors in society. Advocacy contributes to a policy-oriented approach to action on the SDH and health equity.

Public health is well positioned to frame issues and develop and propose policies, as well as to understand political barriers to change within public health, the broader health system, and beyond. Advocacy roles for public health include: framing the issue; gathering and disseminating data; working in collaboration and developing alliances; and using the legal and regulatory system.[75]

Priority actions for public health include:
- participating in and supporting coalitions and partnerships organized to advance specific policy issues;
- prioritizing advocacy and policy development for health equity within public health networks and professional associations; and
- using policy analysis theories and frameworks.

Allocate time and resources for meaningful sustained community engagement and political empowerment

The communities most affected by inequities are those with the least access to power and resources. Meaningful engagement of communities in decisions and actions ensures that these voices and experiences are centered in the conversation on improving health equity. However, community engagement and participation should not be seen as a substitute for the responsibility of governments to ensure that essential material resources and social goods are fairly distributed.13 Community engagement, participation and empowerment have to coincide with a change in the allocation of social and material goods that promote equity in health and wellbeing.

Meaningful engagement requires time, resources and a sustained commitment. The following actions are required:

- Incorporating participatory processes in the identification, analysis and generation of solutions.
- Involving communities in decision making and in the development, implementation and delivery of policies and interventions. This is essential to shifting processes of social stratification as well as increasing the relevance and acceptability of interventions.
- Working with specific populations and communities to address broad based structural inequities as they manifest in their lives.
- Using community development approaches to remove barriers to community participation, support and grow community leadership, capacity and decision-making capacity.

6 Moving the common agenda into action

This section builds on the shared vision for change articulated above. This vision includes an understanding of the problem and approaches to support coordinated action to improve health equity for public health stakeholders. The goals and approaches identified above can be applied to a range of SDH; selecting areas of focus will likely vary from community to community. Furthermore, the levers for change lie at different levels of government. For example, while living wage campaigns are developed locally, proposals for guaranteed minimum incomes typically require national level policy. As such, the agenda represents a basis for planning and prioritization. Through further discussion and engagement, organizations are called to use the strategies in this common agenda to develop comprehensive actions.

Especially at a time when public health in Canada is "under siege,"[76] it is essential that activities – including action to influence structural determinants of inequity – are well resourced by policy makers and political leaders at all levels. Whitehead[77] identifies four typologies of action to improve health equity, which provide a guide for identifying and focusing activities: strengthening individuals, strengthening communities, improving living and working conditions, and promoting healthy macro-policies. The extent to which these activities are supported or not supported is itself a reflection of the commitment to building a more equitable society. Previous research has identified a number of priority intervention areas. The World Health Organization[13] highlighted the need to:

- Improve daily living conditions - the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources - the structural drivers of those conditions of daily life – globally, nationally, and locally.
- Measure and understand the problem and assess the impact of action - expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

In the United Kingdom, Marmot and colleagues[62] recommended six policy areas to reducing health inequities:

1. Give every child best start in life
2. Create fair employment and good work for all
3. Enable all children and adults to maximize their capabilities and control of their lives
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen role and impact of ill health prevention

In addition, a recent paper[17] on guidance for a comprehensive approach to address health equity in Europe identified complementary priorities:

- Taking a life-course perspective, specifically to address disadvantages in maternal health, childhood, working life and old age. Priority actions include: ensuring a good start in life for every child, adequate social protection for young families, and universal, high-quality, and affordable early years education and childcare.
- Reducing inequities in SDH related to the conditions in which different groups within the population live and work.
- Building more equitable health care systems to address inequities in access to essential health services and ensure access for all groups of the population.

All of these sets of priorities resonate in the Canadian context. Some public health organizations are actively engaged on issues such as income support policies (e.g., living wage initiatives, basic income coalitions), affordable housing and homelessness policies, and poverty reduction strategies. However, as mentioned earlier, public health is largely silent about the fundamental drivers of social inequities. Attention is needed to redress systems and processes that create these social inequities as well as learning from, and joining with, communities actively engaged in resistance. For example, it is essential for public health to honestly and courageously interrogate colonialism and racism, as evidenced in structural policies and practices, in order to eliminate indigenous health inequities.

The public health sector has the opportunity to provide significant leadership to the work of improving health equity through the implementation of this agenda, and concerted political will. There are inspiring efforts being made across Canada; we now need to use this collective vision and commitment to tackle the gaps that still exist.

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APPENDIX 1: BACKGROUND SOURCES

EVENT	PARTNERS	AUDIENCE
Dialogue: multiple actors bringing diverse knowledge to improve health equity http://nccdh.ca/resources/entry/dialogue-bringing-diverse-knowledge-to-improve-health-equity-quebec February 4 and 5, 2015 Quebec City, QC	• Réseau de recherche en santé des populations du Québec • Institut national de santé publique du Québec	**70 participants** Public health practitioners and researchers, community based organisations from across Quebec.
Advancing provincial and territorial public health capacity for health equity http://nccdh.ca/resources/entry/advancing-provincial-and-territorial-public-health-capacity-for-health-equi May 29 and 30, 2014 Toronto, ON	• Department of Health and Social Services • Government of North West Territory • Dalhousie University • Department of Health and Wellness Nova Scotia • Chronic Disease and Injury Prevention, Public Health Ontario • Université de Montréal • Centre Léa-Roback sur les inégalités sociales de santé de Montréal • Faculty of Nursing, University of Manitoba and • Faculty of Nursing, University of Victoria	**35 participants** Representatives from all provinces and territories were invited as well representatives at the federal level. Only the Yukon was unable to participate. The majority of chief public health officers attended, as well as a mix of deputy chief medical officers, executive directors, assistant deputy ministers and, in the case of three provinces, regionally-placed medical officers.
Manitoba Regional Health Equity Forum June 4, 2013 Winnipeg, MB	• Manitoba Health, Public Health Agency of Canada Manitoba/Saskatchewan Regional Office and Public Health Association Manitoba; Health Child Manitoba, National Collaborating Centre for Aboriginal Health, Manitoba Healthy Living, Senior and Consumer Affairs, Winnipeg Regional Health Authority, University of Manitoba – Faculty of Nursing, Community Health Nurses of Canada, Canadian Institute of Public Health Inspectors	**111 Participants** Assistant Deputy Ministers, policy analysts, managers, directors, researchers, medical officers of health, public health practitioners, indigenous elders, board members.

EVENT	PARTNERS	AUDIENCE
Saskatchewan Heath Equity Agenda Summit May 13, 2013 Saskatoon, SK	• University of Saskatchewan • Canadian Council on Social Determinants of Health • Saskatoon Health Region	**63 Participants** Public health practitioners and decision-makers at the federal, provincial, territories, and municipal governments, regional health regions professional associations, non-governmental organizations, and academia. Attendees came from all provinces/territories except for Yukon, Quebec, Nunavut and Newfoundland.
PEI Regional Health Equity Forum April 9th, 2013, Charlottetown, PEI	• Atlantic Summer Institute on Healthy and Safe Communities, and the New Brunswick and PEI Branch of the Canadian Public Health Association	**65 Participants** Public health practitioners, community health leaders, policy developers and researchers, as well as people involved in education, safety, and social and economic development.
Nova Scotia Public Health Forum November 19th and 20th, 2012 Antigonish, NS	• Sponsored by St Francis Xavier University (Frank McKenna Centre for Leadership Encounter Series) • Guyburough Antigonish Straight Health Authority and the • Public Health Association of Nova Scotia	450-**500 participants** Students, faculty, public health staff and community members: • Guysborough Antigonish Straight Health Authority • Pictou County, Colchester East Hants, and Capital Health • Local community groups: the Anti-poverty Coalition; Antigonish Women's Resource Centre, Food Security Coalition; Antigonish and County Adult Learning Association • Members of the Paq'tnkek First Nation • Faculty and students at St FX

EVENT	PARTNERS	AUDIENCE
New realities, same determinants of health: Your role in advancing health equity in Newfoundland and Labrador. **October 16th and 19th, 2012 St John's, NL** **Teleconference from Corner Brook, involving Stephenville, Deer Lake and Norris Point via video**	• St. John's - Newfoundland and Labrador Public Health Association (NLPHA) • Corner Brook – NLPHA, National Collaborating Centre for Methods and Tools, Western Health Region	**110 participants** St. John's - public health practitioners, policy makers, researchers, educators, professional associations, community agencies and students. Corner Brook - front line primary health care, health promotion, and public health staff, managers, and senior staff from the health authority as well as representatives from the Western Regional School of Nursing.
Nunavut Regional Health Equity Forum **April 3 – 4, 2012 Iqaluit, Nunavut**	• National Collaborating Centre for Healthy Public Policy • National Collaborating Centre Aboriginal Health	**50 Participants** Public health practitioners and decision makers from the Kitikmeot, Kivalliq, and Qikiqtaaluk regions; Nunavut Tunngavik Inc.; the Government of Nunavut's Departments of Education, and Health and Social Services; the Nunavut Anti-Poverty Secretariat; the Quajigiartit Health Research Centre; the Hamlet of Cambridge Bay; and the Qulliit Nunavut Status of Women Council.
Researcher-practitioner health equity workshop: Bridging the gap http://nccdh.ca/resources/entry/ researcher-practitioner-health-equity-workshop-proceedings **February 14 – 15th, 2012 Toronto, ON**	• Canadian Institutes of Health Research Institute of Population and Public Health with support from • Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health, • National Collaborating Centre for Healthy Public Policy and • Canadian Institute for Health Information – Canadian Population Health Initiative	**50 Participants** Public health researchers, policy-makers, and practitioners working on the social determinants of health and health equity across Canada and globally.

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PROVINCE/TERRITORY	FOUNDATION FOR ACTION	KNOWLEDGE BASE	COLLABORATE WITH NON-HEALTH SECTOR PARTNERS
Alberta	• Online leadership discussion • Alberta Health Services (AHS) has dedicated team within Population, Public and Aboriginal Health for the promotion of health equity (HE) • AHS established the Aboriginal Health Program and Wisdom Council • AHS developed a Promoting HE Framework • Plan to engage Albertans in a discussion about wellness & SDH	• AHS resource development: HE glossary; Populations Vulnerable to Poor Health Outcomes Report • Surveillance and monitoring: AHS & Government of Alberta drafting a conceptual framework towards an Alberta deprivation index	• Government Social Policy Framework • Poverty & homelessness elimination strategies
British Columbia	• Development of First Nations Health Authority • *Public Health Act* requires medical health officer and provincial health officer reports • Guiding Framework for Public Health • BC Health Strategy to 2017 has focus on rural/remote & high needs populations • Core public health programs review. Equity is lens for developing programs, accountability • Conducted equity-focused health impact assessment of sexually transmitted disease and infection-related programs • Recognition at policy & decision-making levels that equity impacts health outcomes	• BC Surveillance Plan will include references to inequity • Equity Lens in Public Health research project in collaboration with U of Victoria & health authorities • Provincial support for Public Health Association of BC conference • Equity indicators identified for monitoring • Partnership between health authorities to increase awareness, develop tools	• Cross-government Ass't Deputy Minister committee on health • Ministries of Education & Agriculture partnership on school fruit & vegetable program, & food security • Healthy Families BC focuses on partnerships with local governments and NGOs
Manitoba	• HE is a strategic priority • Has a Population HE Unit • Winnipeg RHA has a HE position statement & report & staff with responsibility for HE	• Winnipeg RHA Authority resources	• Poverty reduction & social inclusion strategy • Housing First approach
New Brunswick	• Health & inclusive communities wellness strategy • HE a strategic priority • Capacity for HE work		

PROVINCE/ TERRITORY	FOUNDATION FOR ACTION	KNOWLEDGE BASE	COLLABORATE WITH NON-HEALTH SECTOR PARTNERS
Newfound-land & Labrador	• Population Health Branch established in 2011 • HE work initiated within regions through the Wellness Advisory Council	• RHA capacity for health promotion work • Surveillance & monitoring: Communicable Disease Control, & Newfoundland & Labrador Centre for Health Information	• Poverty reduction strategy
North West Territories	• Political will is high • Recognition that health starts at home • Focus on healthy children & families		• Planning process with communities; focus on community-identified priorities
Nova Scotia	• Position: *Coordinator, Health Disparities,* is part of Public Health's Healthy Communities team. Engages across Public Health, Department of Community Services & with other partners • Policy: HE is one of 5 cross-cutting protocols of the Nova Scotia Public Health Standards. The protocol is a deliberate articulation of the expectations for incorporating HE factors in all public health practice • Practice: piloting use of HE lens using the four public health roles for HE action	• Renewed efforts in population health status reporting at local level • Local work supported by the Understanding Communities Unit (new capacity in surveillance & epidemiology)	
Nunavut	• HE interwoven in work of the health department	• Social determinants of Inuit health • acculturation • housing • productivity	• The size of the territory allows for good partnerships across sectors. • Food Security Action Plan came out of Poverty Reduction Plan
Ontario	• Ontario Public Health Standards, 2008 • Make No Little Plans: Ontario's Public Health Sector Strategic Plan (2013) • SDOH nurses in each health unit • HE Impact Assessment Tool used widely • All health reports talk about inequities	• Renewal of Public Health Systems research project	

PROVINCE/ TERRITORY	FOUNDATION FOR ACTION	KNOWLEDGE BASE	COLLABORATE WITH NON-HEALTH SECTOR PARTNERS
PEI	• Public health staff passionate about HE (e.g., Public Health Association conference) • Clinics for newcomers & Aboriginal peoples • Needle exchange program	• Chief Public Health Officer Report & Health Trends has first-time mention of income & education • Reports about incidence of chronic diseases	Government attention to poverty reduction, early learning, & economic development
Quebec	• Public Health Act provides levers for action • HE part of Medical Officer of Health role	• Deprivation index • Monitor 18 deprivation indicators • Poverty reduction & mental health support policy scans by National Collaborating Centre for Healthy Public Policy	
Saskatch-ewan	• Integrated health system; thinking & acting as one • Flat structure • Reducing inequities part of Ministry's strategic plan • Equity champions in some regional health authorities (RHA) • Some RHAs have dedicated staff developing & using equity tools to change programs & policies	• Saskatoon's Public Health Observatory • Saskatchewan Population Health & Evaluation Research Unit does equity research, surveillance, knowledge translation, performance evaluation & HE audits • Health Promotion group focused on HE not lifestyles	• Saskatchewan Population Health Council includes First Nations • Provincial & regional inter-ministerial committees • Strong leadership at other human service ministries & organizations
Federal	• Focus on evaluation, science, grants & contributions • Health Portfolio partner commitments • PHAC Plan to Advance HE 2013-2016 • Health Equity Matters, strategic plan (2009-2014) from CIHR's Institute for Population and Public Health • First Nations and Inuit Health Branch Strategic Plan	• Data collection & analysis on 56 indicators & 13 dis-aggregators. • PHAC Best Practice Portal added equity consideration	• PHAC collaborations with federal departments, Canadian Council on the Social Determinants of Health, Pan-Canadian Public Health Network

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National Collaborating Centre
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Centre de collaboration nationale
des déterminants de la santé