Health Equity and Public Health in Ontario

A Scan of Health Equity Activities Taking Place in Ontario Public Health Units and the Identification of Enablers, Challenges, and Select Examples

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INTRODUCTION

Health equity refers to the concept that every person is entitled to an equal opportunity to achieve their optimal health. It recognizes that health is influenced beyond genetics, medical care, and individual health behaviours. Where a person lives, works, or goes to school, along with several other social factors, are described as the social determinants of health (1). These determinants can impact the health of certain populations in ways that are avoidable. The Ontario Ministry of Health and Long-Term Care (MOHLTC) defines health inequities as differences that are systematic, socially produced, unfair, and unjust (2).

Health Equity in a Public Health Setting

Public health professionals are well poised to advance work in health equity. Given their upstream impact on the health of broad populations, public health agencies must consider how their work can serve to either widen or narrow the gaps of health inequity. Under the modernized 2017 Ontario *Standards for Public Health Programs and Services* (2), released for consultation in February, 2017, Health Equity is identified as a Foundational Standard. Under the Health Equity Standard, four requirements for boards of health are listed. These requirements align well with the four roles described by the National Collaborating Centre for Determinants of Health (NCCDH) (3) that many public health units are currently using as a guide for advancing work in health equity. These include to: 1) Assess and Report; 2) Modify and Orient Interventions; 3) Partner with Other Sectors; and 4) Participate in Policy Development.

Purpose of this Report

In collaboration with the aLPHa-OPHA Health Equity Workgroup, OPHA launched a project in March 2016 to better understand the work being done by public health units to advance health equity in Ontario. This report provides an overview of these findings, and serves to describe the opportunities and challenges, range of professionals involved, and the types of supports needed to further advance work in this area. In addition, it is anticipated that this report will provide select examples of the *Roles for Public Health in Advancing Health Equity* (3) as they relate to the newly released *Standards for Public Health Programs and Services* (2). The examples selected were not identified through a comprehensive review process or screened for best practice, but rather are meant to serve as inspiration that others may benefit from in tailoring programs and services to their local populations.

BACKGROUND

Public Support for Public Health Equity Interventions

Establishing public awareness of health inequities in Ontario can serve to support a climate of political motivation for governments to advance policy solutions (4). In 2010, a group of researchers surveyed 2,006 Ontario adults seeking information about public awareness of income-related health inequities (4). They found that between 53%-64% of respondents recognized the link between socioeconomic status and health status (4). In a more recent article developed from the same 2010 telephone survey data, researchers demonstrated optimism that Ontarians generally support interventions that address health equity, with support being influenced by the framing of inequity problems, the type of intervention, and political affiliation of the respondent (5).

Political Support for Health Equity Interventions

Since 2010, there has been an increase in political support for reducing health inequities in Ontario, demonstrated in a variety of ways as outlined below.

Political Support for Poverty Reduction

With recommendations made to the Ontario government for a Basic Income Guarantee in Ontario (6), the Ministry of Community and Social Services has committed to a plan for a Basic Income Pilot by the spring of 2017. This important initiative has received much attention from advocates of public health, as this poverty reduction strategy has the potential to impact the social determinants of health inequities (7). The *Ontario Poverty Reduction Strategy* has also been a notable initiative where $50 million over a six year period has provided funding to support community-driven initiatives that affect those living in poverty (8).

Political Support for Anti-Racism

In February 2016 the Ontario government launched an important measure in combating systemic racism. The *Anti-Racism Directorate* looks to prevent systemic racism in policy, legislation, programs, and services (9). The current Minister of Tourism, Culture and Sport oversees the *Anti-Racism Directorate* and reinforces the government's pledge to fight discrimination and uphold concepts of equity in Ontario (10). While the *Anti-Racism Directorate* identifies 3 main populations of focus in its initial stages (anti-Black racism, Islamophobia, anti-Indigenous racism), there are additional measures by the Ontario government to support health equity for Indigenous populations such as the *Ontario First Nations Health Action Plan* (11). Working meaningfully with Indigenous Communities and Organizations is further emphasized in the modernized Ontario *Standards for Public Health Programs and Services* (2);

which promises guidance to boards of health on how to work with Indigenous communities through a dedicated Guidance Document that is currently under development (2).

Political Support for a Collaborative Approach

In its release of the discussion paper *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*, the Ministry of Health and Long-Term Care (12) emphasized its commitment to improving health equity and reducing health disparities. This paper has since materialized into the Patients First Act, 2016, which has concepts of health equity embedded throughout the outlined health care transformation. The Act further poises public health agencies for cross-sector collaboration, with one of the 15 work streams being Public Health, and the inclusion of heath equity and health promotion strategies as LHIN mandates (13). In 2013, the release of the Public Health Sector's Strategic Plan *Make No Little Plans* (14) further emphasized collaboration beyond the health sector by highlighting how public health is uniquely poised to bridge health care with "all other sectors that influence health" (14, p. 9)

Cross-sector collaboration continues to be an important theme in tackling issues of health inequity. The Health Protection and Promotion Act, 1990 provides the Minister of Health with the authority to issue guidelines describing the work of Ontario's public health system. Under these guidelines, the *Standards for Public Health Programs and Services* (2) call upon boards of health to participate in community and multi-sectoral collaboration to decrease health inequities (2). The theme of cross-sector collaboration will be revisited in the ***Discussion*** section of this report, as the first in a series of listed examples of how public health units are enacting the *Public Health Roles for Improving Health Equity* (3).

PROJECT METHODOLOGY

To develop a summary of activities undertaken by public health units throughout Ontario that address health inequities, the following methods were used as part of this project:

- Online Survey Questionnaire:
    - A short survey (10 questions) was launched among all public health units across Ontario. Questions asked about current enablers and barriers for public health's work in reducing health inequities, as well as demographic information about those involved. The survey had 150 responses. Responses were collected between March 17th 2016 and April 13th 2016. In instances where open answers were collected, fields were tabulated using *FluidSurvey* software and were manually coded and categorized. Survey questions and a summary of results are provided in ***Appendix A*.**
- Interviews:
    - Key informant interviews were held with public health managers and staff to obtain more in-depth information on the activities of their respective health units. These interviews served to contextualize survey responses and explore themes that emerged through the survey data. Four Public Health Units were reflected throughout these interviews, they included: Peterborough Public Health, Halton Region Health Department, Niagara Region Public Health, and Algoma Public Health. Interview questions are provided in ***Appendix B***.
    - Unstructured feedback and advisement sessions were held with stakeholders representing Niagara Region Public Health and Toronto Public Health to explore the direction and themes that emerged throughout the various stages of this report.
    - Informal feedback throughout various stages of this report was facilitated through the alPHa-OPHA Health Equity Workgroup and gathered electronically. Feedback was received from stakeholders representing four public health units: Peterborough Public Health, Oxford County Public Health & Emergency Services, the Region of Waterloo Public Health & Emergency Services, and Halton Region Public Health.
- Web based search of individual public health units in Ontario:
    - A web search was conducted to obtain data on public health's work on reducing health inequities and social determinants of health. Home pages of all 36 Public Health Units were searched and examined for listings or links relating to health equity, the social determinants of health, poverty reduction, anti-racism, health advocacy, cross-sector collaboration, and other themes identified as relevant. For each public health unit's home page, a search requirement for key words

"equity", "inequity", and "social determinants" was performed to further draw out documents, links, or posts that discussed related themes.

RESULTS

Summary of Health Equity Activities of Ontario's 36 Public Health Units

While the type of activities being undertaken by health units vary widely across the province, the work falls under ten main areas. These areas are described below along with examples of activities and some of the health units involved. This list of activities is not meant to be comprehensive, but rather to highlight examples of recent activities in a range of Ontario health units.

1. ***Health Equity Task Force/Teams:***
    - Several health units have developed special task forces or teams to reduce health inequities in their area. These ranged to include: multidisciplinary equity action teams, task forces that work with community partners on poverty elimination, health for all committees, leadership teams that work with partners for immigrants and refugee settlement, and the creation of Equity, Diversity and Human Rights Divisions.

    - Example of health units involved: Chatham Kent, Grey Bruce, Peterborough, Sudbury, Toronto, Wellington-Dufferin-Guelph, and Waterloo.

2. ***Poverty & Food Security Initiatives*:**
    - To tackle the root causes of health inequities, such as poverty and food insecurity, some health units participate in comprehensive community poverty reduction initiatives and work collaboratively with a wide variety of community partners to address social determinants of health, such as income, food security, and housing security, at both the local and provincial level (i.e. Peterborough Poverty Reduction Network). Others participate in professional societies (e.g. Ontario Society of Nutrition Professionals in Public Health) to advocate for poverty reduction.

    - Others are focussed on increasing public awareness regarding issues of poverty and food insecurity in their region through research reports and health status reports posted on their websites.

    - All health units monitor the cost of eating nutritiously for individuals and families in their areas by conducting an annual survey (i.e. Nutritious Food Basket Survey).

    - Example of health units involved: Grey Bruce, Haldimand-Norfolk, Huron County, Leeds-Grenville, Peterborough, Wellington-Dufferin-Guelph, and York Region.

3. ***Newcomers and Refugees (Priority Populations) Settlement Initiatives*:**

- To assist newcomers and refugees in their settlement in Canada, several health units are involved in training their staff on the health equity framework to help them understand how public health initiatives may impact newcomers and how to remove any barriers to accessing health services.

- Example of health units involved: Waterloo, and York Region.

4. ***Strategic Planning*:**
    - Almost all health units have indicated a commitment to health equity by adopting a health equity framework (SDOH) to guide policy and delivery of programs and services. Furthermore, they have highlighted health equity as one of the core values and goals of their current Strategic Plans.

5. ***Tools and Resources*:**
    - In an effort to increase knowledge, awareness and understanding of health equity and social determinants of health, several health units have developed toolkits, practical guides, course curriculum, etc. which are posted on their websites and available for service providers and the general public.

    - Example of health units involved: Chatham-Kent, Elgin-St. Thomas, Middlesex-London, Peterborough, Sudbury, Waterloo, Wellington-Dufferin-Guelph, and Windsor-Essex County.

6. ***Research Reports*:**
    - Several health units engage in research and surveillance on food insecurity, poverty and unemployment to guide programs and policies to tackle health inequities in their respective regions.

    - Example of health units involved: Brant County, Durham, Haldimand-Norfolk, Halton, Leeds-Grenville, North Bay Parry Sound, Northwestern, Sudbury, and Waterloo.

7. ***Website/Social Media Outreach*:**
    - 28 out of 36 public health units had explicit references to health equity or the social determinants of health. Several health units have also incorporated a short video called *Let's Start a Conversation about Health* which describes how social and economic conditions influence a person's health outcomes.

8. ***Community Engagement/Partnerships & Advocacy Efforts*:**
    - Several health units encourage community participation and engagement (e.g. youth) and form partnerships with other sectors to reduce health inequities. They also engage in several advocacy efforts.

    - Example of health units involved: Algoma, Eastern Ontario, Halliburton-Kawartha-Pine Ridge, Middlesex-London, Peterborough, Simcoe Muskoka Sudbury Toronto, and Waterloo.

9. ***Promoting Diversity and Inclusiveness*:**

- Some health units have initiated approaching health equity from a community perspective by promoting diversity and inclusiveness, which ultimately helps to advance health equity in the province.

- For example, Middlesex-London has core values of anti-oppression and cultural humility in their strategic plan.

- Example of health units involved: Middlesex-London, Sudbury, Toronto, Waterloo, and York Region.

10. ***Workforce Training and Skills Development*:**
    - Several health units provide ongoing support to their staff by enhancing their knowledge on SDOH and health equity through courses and encourage them to apply a health equity framework for program planning and evaluation.

    - Example of health units involved: Northwestern, Toronto, and York Region.

11. ***Other efforts*:**
    - All health units are involved in programs such as Healthy Babies Healthy Children and oral health programs that target those that are marginalized and most at risk; other initiatives include child and youth networks, York Region Food Network (YRFN), Basic Income Guarantee initiatives (BIG) etc.

    - Example of health units involved: Middlesex-London, Peterborough, Toronto, and York Region.

Enablers and Challenges

In addition to the ten main areas discussed above, survey respondents were asked to identify perceived enablers and challenges to advancing work in health equity (***Table 1).***

Enablers	Challenges
Organizations' strategic plan	Lack of accountability indicators
Provincial resources	Lack of resources
Federal and other organizational resources	Lack of understanding by municipal/regional governments
SDOH Public Health Nurses and/or dedicated health equity staff at health unit	Lack of clarity in the OPHS and the Public Health Unit's role
alPHa-OPHA Health Equity Work group	Lack of opportunities for capacity building
SDOH Public Health Nurse Network	Health equity not seen as a priority

Table 1: Survey identified enablers and challenges faced by public health units in advancing work in health equity.

Health Equity Workforce

The 2016 survey showed a wide range of public health professionals involved in health equity work, and variation in how this work is defined and distributed. Consequently, it is difficult to quantify the number of staff who have health equity as their primary responsibility.

The various types of arrangements in place include:

- health equity divisions;
- cross agency teams;
- leadership champions;
- training of colleagues;
- promoting the use of a health equity lens for all staff and agency programs; and
- working with community partners and/or clients to advise work related to health equity

In addition to staff working to advance health equity as a dedicated job task, many public health units work internally to ensure that the rest of the public health unit workforce is trained around the social determinants of health and health equity. As an example, the Halton Region Public Health Department provides an excellent resource (link provided in ***Appendix C***) summarizing their findings from staff training on the social determinants of health and health equity (15). Interestingly, they found that after training, their employees were most likely to use health equity websites as a preferred resource for ongoing support.

Key Factors Identified to Further Advance Health Equity Work

Preliminary survey results in 2016 demonstrated that there is a wide variation of activities underway by health units in the province. In addition, health units also provided information regarding common enablers and challenges faced when conducting their health equity work. Many health units identified the following as key factors that could further advance their health equity work and ultimately reduce health inequities in the province.

1. Stronger OPHS guidelines on health equity and social determinants of health in public health practice.

2. Clarity in the OPHS, defined health unit roles, accountability indicators, and a clear understanding by municipal governments.

3. Dedicated resources (staff), leadership in local public health units and opportunities for capacity building.

4. Funding to support capacity building for SDOH Public Health Nurses and overall staff, and thereby, establishing health equity as a priority by leadership in the health units.

Key findings from the initial stages of this report that highlighted the above key factors were shared in April 2006 with the Ministry of Health and Long-Term Care in an attempt to influence the modernization of the public health standards.

Since the findings of this survey, the Ontario government has released the modernized *Standards for Public Health Programs and Services* (2) for consultation as of February 17th 2017. It has been encouraging to see the inclusion of health equity as a concept embedded throughout the new Standards.

An area for future consideration would be to investigate how the new Standards impact the needs identified above and shift what public health units consider to be key enablers and barriers to achieving their work in advancing health equity. In the following sections of this report, examples of how enablers have been put into action by public health units will be reviewed in the context of the newly released modernized Standards for public health.

DISCUSSION

Examples of Advancing Health Equity in Public Health

The previous section of this report served to outline a variety of health equity activities taking place throughout the 36 public health units in Ontario. The following section of this report will serve to expand on key findings and offer selected examples where public health units have undertaken activities under specific themes. The examples selected were not screened for best practice, but rather are meant to act as examples where public health units can learn from and be inspired by each other. **Links to all examples and resources used in the following section are provided in *Appendix C*.**

The National Collaborating Centre for Determinants of Health's (NCCDH) *Public Health Roles for Advancing Health Equity* (3) framework will be used as a thematic guide for discussing examples as they relate to the *Standards for Public Health Programs and Services* (2). ***Figures 1a and 1b*** serve to depict how the examples are navigated throughout the pages that follow.

Partner with Other Sectors Partner with other government and community organizations to identify ways to improve health outcomes for populations that experience marginalization.	**Assess & Report** Assess and report on a) the existence and impact of health inequities, and b) effective strategies to reduce these inequities.
Participate in Policy Development Lead, support and participate with other organizations in policy analysis and development, and in advocacy for improvement in health determinants and inequities.	**Modify & Orient Interventions** Modify and orient interventions and services to reduce inequities, with an understanding of the unique needs of populations that experience marginalization.

Figure 1a: Adapted from the NCCDH Roles for Public Health framework (3)

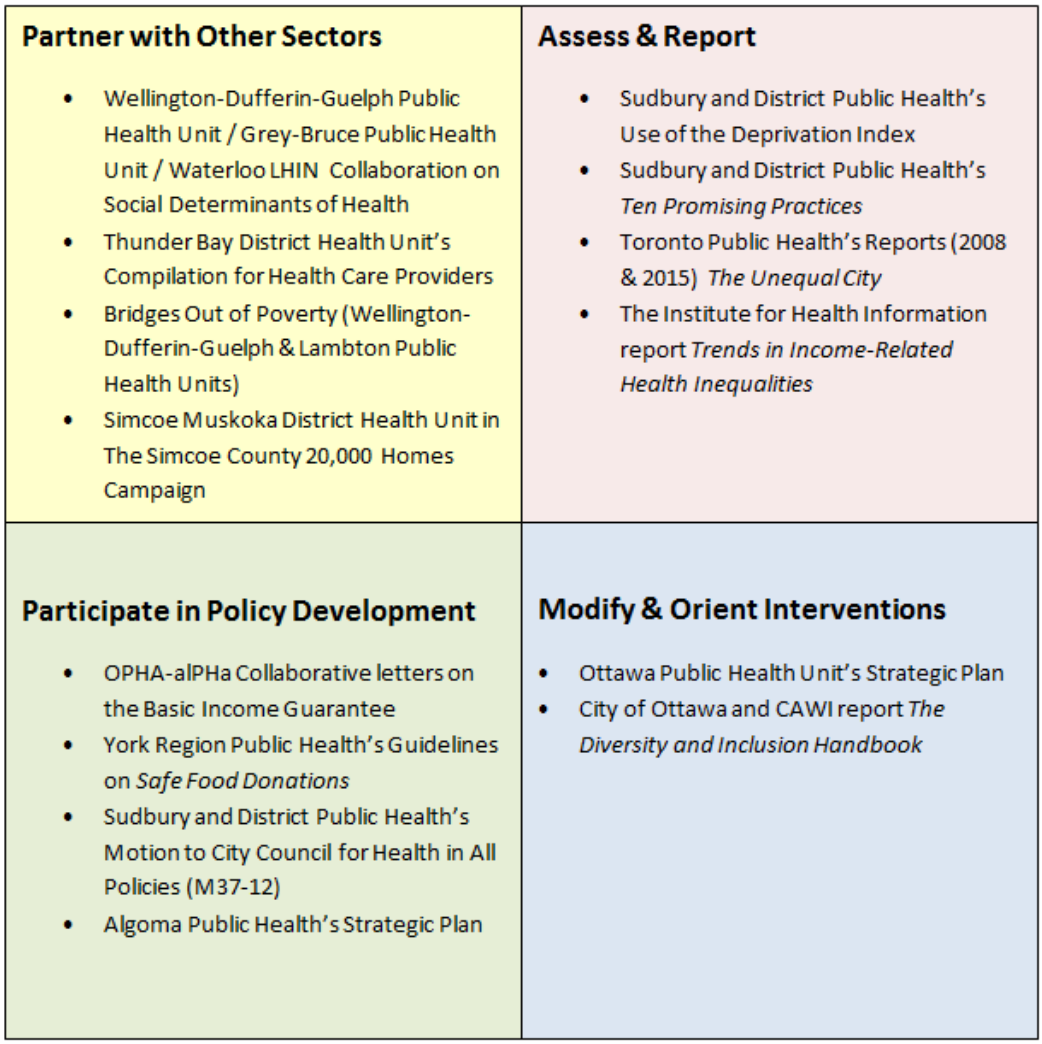


Figure 1b: Featured examples organized according to themes adapted from the NCCDH framework (3)

ROLE: PARTNER WITH OTHER SECTORS

Public health units and their boards of health have a provincial mandate to identify, assess, manage, and prevent health inequities. According to the *Standards for Public Health Programs and Services* (2) one of the four program requirements under the *Health Equity* program standards reads as follows:

> *The board of health shall engage in community and multi-sectoral collaboration with LHIN(s) and other relevant stakeholders in decreasing health inequities. Engagement with Indigenous organizations and communities shall include, but not be limited to, fostering the creation of meaningful relationships with them, starting with engagement through to collaborative partnership.* (2, p.16)

One of the pathways outlined for achieving this mandate is to collaborate with the health sector and community partners in the public and private sectors to achieve health outcomes for the population (3). With the upcoming implementation of the Patient's First Act, 2016, collaboration continues to be an important theme. Under this Act, Public Health Units will be collaborating with LHINs, who will also have strategies for health equity as a mandate.

Collaboration with Local Health Integration Networks

In 2011, the Wellington-Dufferin-Guelph public health unit, the Region of Waterloo public health unit, and the Grey-Bruce public health worked in collaboration with the Waterloo Wellington Local Health Integration Network (LHIN) to release an extensive report titled *Addressing Social Determinants of Health in the Waterloo Wellington Local Health Integration Network Area* (16). Their report was developed by assembling a steering committee comprised of representatives from each of the three public health units and the Waterloo Wellington LHIN. This report serves as a great example of how collaboration with Local Health Integration Networks can inspire locally driven programs.

Collaboration with the Health Sector

The Thunder Bay District Health Unit features on its website an excellent collection of resources that showcase how health care providers can use important information in the primary care setting to screen for social determinants of health (17). Among the resources listed is a link to *TheWell* which features tools "for providers by providers" in addressing poverty in a clinical setting (18). In addition to this resource, the Thunder Bay District Health Unit also lists a link to a healthcare provider form (19) that can be used to diagnose social determinants that may impact a patient's health equity.

Collaboration with Other Sectors

Bridges out of Poverty is an example of a framework that can help to bring community partners together in a common mission to reduce income disparities. Under this framework, training helps to educate about the lived experience of poverty. Currently, the Wellington-Dufferin-Guelph Public Health Unit, and the Lambton Public Health Unit facilitate various aspects of the Bridges out of Poverty Framework (20; 21). By recognizing four causes of poverty (individual behaviour, community conditions, exploitation, political and economic structures) the Bridges Model creates awareness and support for cross-sector community strategies (22).

The Simcoe Muskoka District Health Unit offers an excellent example of multi-sector collaboration, where they participated on a steering committee along with several other municipal and community partners in The Simcoe County 20,000 Homes Campaign Registry Week lead by the Simcoe County Alliance to End Homelessness (SCATEH) in April 2016. Their participation is part of a broader movement across the country to end homelessness under the Canadian Alliance to End Homelessness (CAEH) (23). The campaign is an example of how public

health units are actively getting involved in tackling issues that affect health equity within their communities.

Another example of a public health unit working collaboratively with other sectors is well demonstrated by Peterborough Public Health through their active participation in the Peterborough Poverty Reduction Network (PPRN) (24). In this initiative, Peterborough Public Health participates on the Planning Committee as well as in a number Work Groups that address food security, income security, housing security, as well as other basic needs. The goal of the Network is to work collaboratively and take local action by advocating for system and policy changes that address the root cause of poverty (24)

ROLE: ASSESS AND REPORT

The gaps that exist to create health inequities will inevitably vary from one region to another given the specific socio-demographic characteristics of the population. Reporting on the health inequities that exist is an important component of identifying the needs of a specific population. Assessing and reporting can serve two purposes; 1) "to assess and report on the existence and impact of health inequities", and 2) to assess and report on "effective strategies to reduce these inequities" (3). In the 2017 *Standards for Public Health Programs and Services*, boards of health are called upon such that;

> *The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.* (2, p.16)

Reporting can also help to uncover the manner in which programs and services offered by the public health unit may serve to widen or narrow the current gaps in health equity that exist. The Institut national de santé publique du Québec (INSPQ) has developed a Deprivation Index which has been used by the Canadian Population Health Initiative to report on disparities in health status and uptake of health services across the gradient of socio-economic status throughout Canada (25). Using the deprivation index associated with a specific region can be an effective way of communicating the status of health inequities to garner support for solutions.

The Sudbury and District Public Health Unit has found success in leveraging the Deprivation Index as part of a *10 Promising Practices* strategy to influence the social inequities in health (26). They have highlighted this aspect of reporting among other helpful tips, in their document outlining the second promising practice of *Purposeful Reporting* (27). Another approach they have highlighted is the importance of stratifying data by socio-economic status.

Reporting Can Create Awareness

When reporting is effective in capturing the status of health inequities, the results can further help to engage other sectors in collaborating for improvement strategies. In 2008 when Toronto Public Health first published *The Unequal City: Income and Health Inequalities in Toronto*, it was clearly articulated that health status was linked to income differences such that those of lower income had worse health for 21 out of 34 of the health status indicators that they analyzed (28). In 2015, Toronto Public Health conducted a follow-up report that articulated health inequities in 16 of the indicators has persisted and four had worsened (one had improved) (29). The 2015 report called for the need for intersectoral collaboration and received attention from several media outlets (30).

The Canadian Institute for Health Information has also produced an extensive report that analyzes *Trends in Income-Related Health Inequalities* (31). This report may serve as an example of the kind of data that can be valuable for reporting in health inequities.

ROLE: MODIFY AND ORIENT INTERVENTIONS

When public health interventions are universal, there is risk that not everyone will have the ability to access the programs equitably. Removing systemic barriers by modifying interventions to ensure equitable access is encouraged under the *Standards for Public Health Programs and Services* (2). Specifically, as a program requirement, the standards reference the following:

> *The board of health shall modify and orient public health interventions to decrease health inequities by: a) Engaging priority populations in considering their unique needs, histories, cultures, and capacities; and b) Aiming to improve the health of the entire population while leveling up the health of priority populations.* (2, p.16)

The Ottawa Public Health Unit incorporates health equity into its strategic plan. Under their plan they specifically make reference to modification of their services. Specifically they state a commitment to modifying their "services to include those who have fewer opportunities to be healthy" (32). The Ottawa Public Health Unit complements their strategic plan with an excellent report by the City of Ottawa and the City for All Women Initiative (CAWI) on Equity and Inclusion titled *The Diversity and Inclusion Lens Handbook* (2015). Below, ***Figure 2*** has been showcased from the report (33, p.10) as an excellent example depicting the difference between providing accommodations for participation in a program, versus modifying the program to remove the barriers for a more inclusive approach.

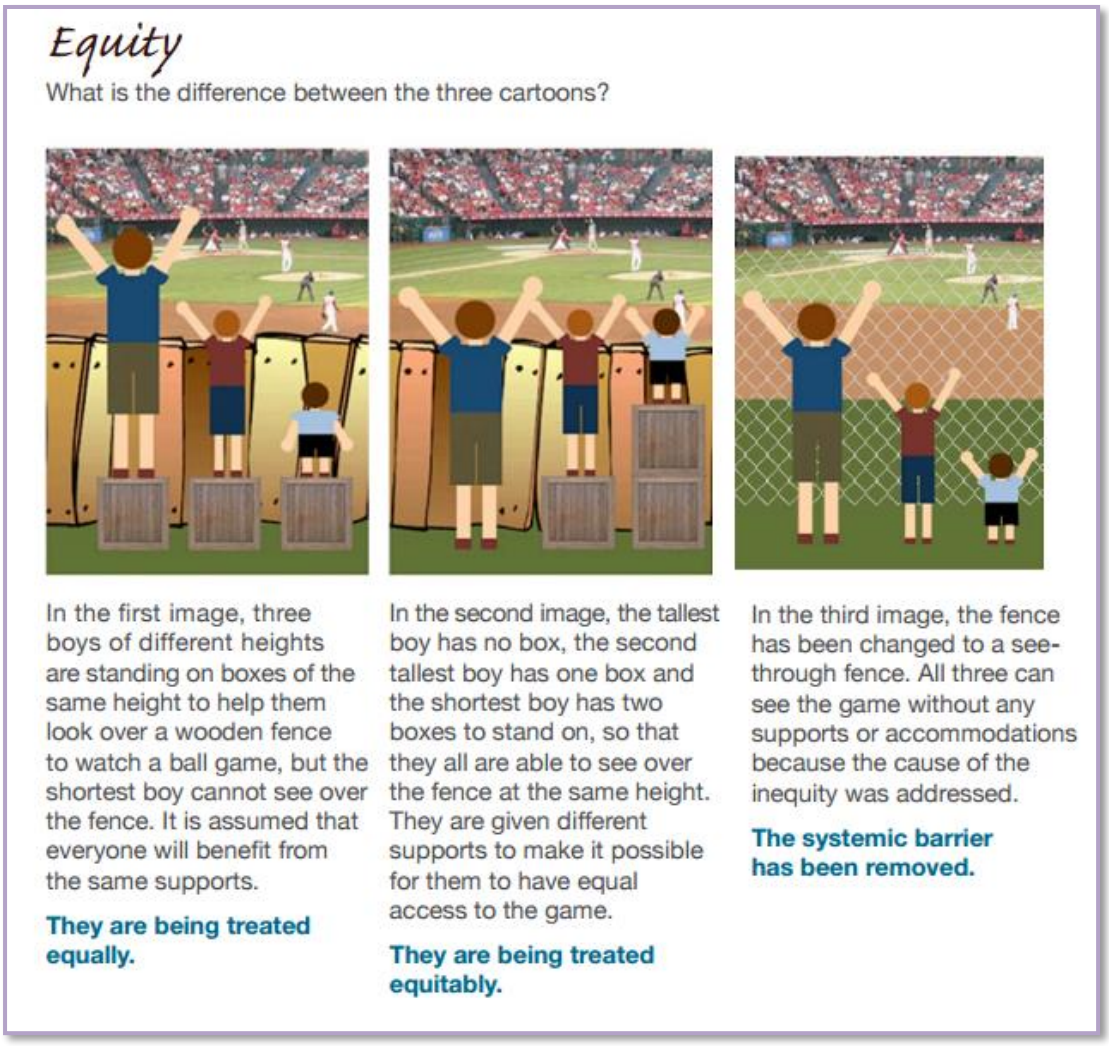


Figure 2: City of Ottawa, & City for All Women Initiative (CAWI). Equity & Inclusion Lens Handbook, 2nd Edition. Ottawa. 2015. p.10

In *The Diversity and Inclusion Lens Handbook* (33), strategies to increase inclusiveness are listed as follows: 1) Check assumptions, 2) Ask about inclusion, and 3) Apply to your work. A fourth step encourages programmers to take action and advocate for those who risk exclusion. The guide recommends asking 3 specific questions that will help to ask about inclusion (33). These include:

- *Who is not being included in the work you do?*
- *What could contribute to this exclusion?*
- *What can you do differently to ensure inclusion?*

Applying a lens of inclusion can be helpful in identifying barriers that warrant modifications. The NCCDH (3) describes how "an understanding of the unique needs of populations that experience marginalization" (3, p.2) is an important initial step in modifying and orienting public health interventions. This notion can be applied to the multitude of ways that public health units work to address barriers to services. For example, program modifications can include

outreach programs or mobile health clinics, where public health units are addressing a barrier to access by modifying their services.

Building staff support for program modifications can help to ensure that efforts are ongoing. Peterborough Public Health has developed a specific Policy and Procedure on *Ensuring Access to Programs and Services* (34) that helps to ensure program staff have an actionable plan for identifying barriers to public health programs and services. With this policy, Peterborough Public Health can identify and respond effectively to barriers, and document modifications using a chart (34). This useful tracking checklist is then completed annually to gather information on barriers addressed and lessons learned. In addition to tracking modifications, an excellent feature of their checklist is the incorporation of reflective questions that ask about lessons learned and the inclusion of priority populations in the decision to modify or orient a program.

ROLE: PARTICIPATE IN POLICY DEVELOPMENT

While the term advocacy is not explicitly used in the new *Standards for Public Health Programs and Services* (2), there is an explicit requirement for boards of health to engage in policy making under the following requirement;

> *The board of health shall lead, support, and participate with other stakeholders in policy development, health equity analysis, and promoting decreases in health inequities.* (2, p.16)

This requirement mirrors the NCCDH roles (3) that use a broader term in recommending "policy analysis and development" and also calls for public health professionals to engage in "advocacy for improvement in health determinants and inequities" (3, p.2).

Policy Making in Federal and Provincial Government

Policy development can take on several forms. At the federal or provincial level, public health units may participate in advocacy efforts to influence decision makers who are reviewing legislation. In lobbying to government, Moore (35) recommends several tips to increase the effectiveness of advocacy efforts. Among them, a central importance is placed on the level of understanding and awareness exhibited towards the process of policy development (35). For effective advocacy to take place, Moore (35) stresses how a deeper understanding encourages more strategic and effective analysis of policy and communications.

Several representatives from public health units across Ontario recently took part in advocacy activities under the alPHa-OPHA Health Equity Workgroup in submitting a letter to Special

Advisor to the Minister of Finance, Hugh Segal, providing input for the proposed Basic Income Pilot (7). These advocacy activities were furthered through a technical submission on Ontario's Basic Income Pilot which was drafted in collaboration with Public Health Ontario and the alPHa-OPHA Health Equity Workgroup (36).

Local Policy Making

Policy making at the local level can be an effective vehicle for influencing the social determinants of health inequities. In York Region, Public Health staff have responded to the need to address second-hand smoke in multi-unit housing by encouraging housing providers and landlords to develop smoke-free policies (37). Their emphasis on providing support through the *York Region Public Health Tobacco-Free Living* program potentiates increased uptake by landlords who may be hesitant in navigating the complexities of policy making. York Region Public Health offers consultations to help develop smoke-free policies in addition to quit smoking supports for tenants (38). This type of involvement in local policy making can be especially relevant for health equity when considering the impact of reducing exposure to second hand smoke in social housing units. In a report by The Regional Municipality of York (39), it is cited how Housing York would typically deny transfer requests from tenants complaining of second-hand smoke, given that without a policy there is little assurance that the destination unit would be smoke-free (39). York Region Public Health offers an excellent example of how they worked with Housing York to propose a smoke-free policy (39).

In Sudbury, an example of local advocacy is featured whereby the Sudbury & District Health Unit worked with local municipal governments to integrate a health equity lens into local decision making for a health in all policies perspective (40). The Sudbury & District Health Unit put forward a motion (Motion #37-12) to their local municipality to urge the use of the *Equity-Focused Health Impact Assessment* as a tool in their decision making processes (40).

Several other public health units have also incorporated the use of a health equity lens into their internal policies. Algoma Public Health presents a great example of how health equity can take centre stage in the health unit's logic model and strategic plan (41).

LIMITATIONS

With regards to the survey responses, it must be considered that responder bias may have affected the findings of this report. This report is based on data from results of a voluntary survey in March/April, 2016 that polled all 36 Health Units in Ontario. Of the survey responses, the location of the public health unit was specified to one of 5 geographical categories. Of these, southwestern public health units had the highest response rate. The percentage of respondents per health unit region is depicted in ***Figure 3***. The self-reported job titles that completed the surveys ranged to include: dental staff, directors/managers, epidemiologists,

health promoter/health equity specialist, Medical Officer of Health, non-public health employee, public health nurse, public health dietitian, public health inspector, social determinants of health public health nurses. The survey data was self-reported, presenting some limitation from self-reporting bias.

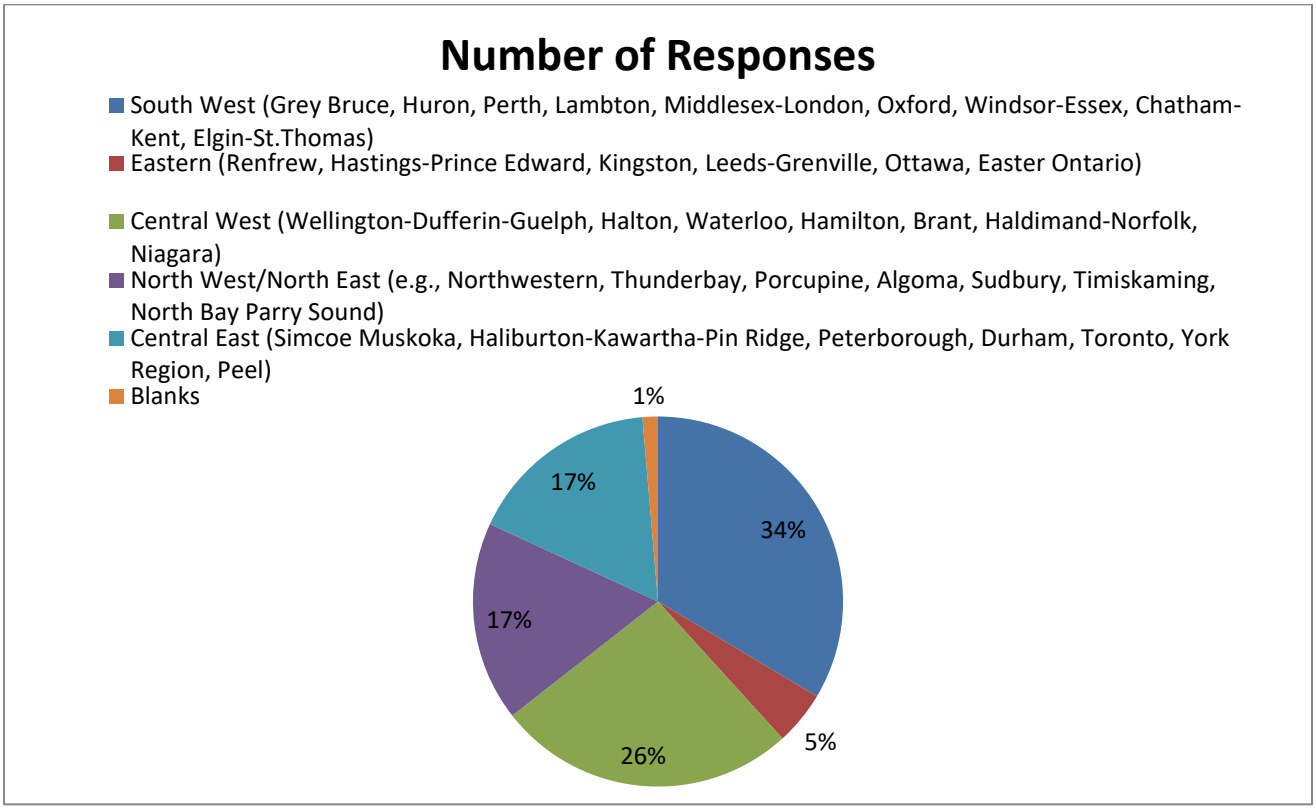


Figure 3: Survey responses per regional grouping of health units

Integrated components of this report considered research that was collected from public health unit internet sites and key informant interviews.

A significant limitation of the web-based research method is the lack of ability to delve into any internal procedures or initiatives that may not be published to the internet. Other than in instances where key informants provided specific resources, it was not possible to access public health unit intranet sites where additional internal resources might have been relevant to the scope of this report. Furthermore, this search method also risks the inadvertent inclusion of data stemming from corporate offices rather than public health branches in instances where public health units are part of regional health departments or municipal administrations.

CONCLUSIONS AND NEXT STEPS

Health equity is a common theme and is visibly a priority among a majority of the public health units that were researched. Specifically 28 out of 36 public health units had explicit references to health equity on their public-facing websites. Of these, many incorporated health equity into

their strategic planning and provided resources for the general public to learn more about the social determinants of health. In several instances, public health units showcased the roles they played in advancing health equity by listing their work and resources for other public health professionals to benefit from. Of these examples, a select compilation was highlighted within this report.

Given the launch of a new set of requirements for health equity as a Foundational Standard in the *Standards for Public Health Programs and Services* (2); this report reinforces the notion that many public health units currently have a variety of initiatives underway. While these appear to be in line with the new ministry requirements, further information about accountability has yet to be confirmed as the Ministry of Health and Long-Term Care continues to work on its anticipated accountability framework. By capturing themes of current enablers and challenges faced by public health units, this report may further serve to inform how ongoing support and ministry prioritization of health equity can reinforce efforts underway in advancing health equity in public health.

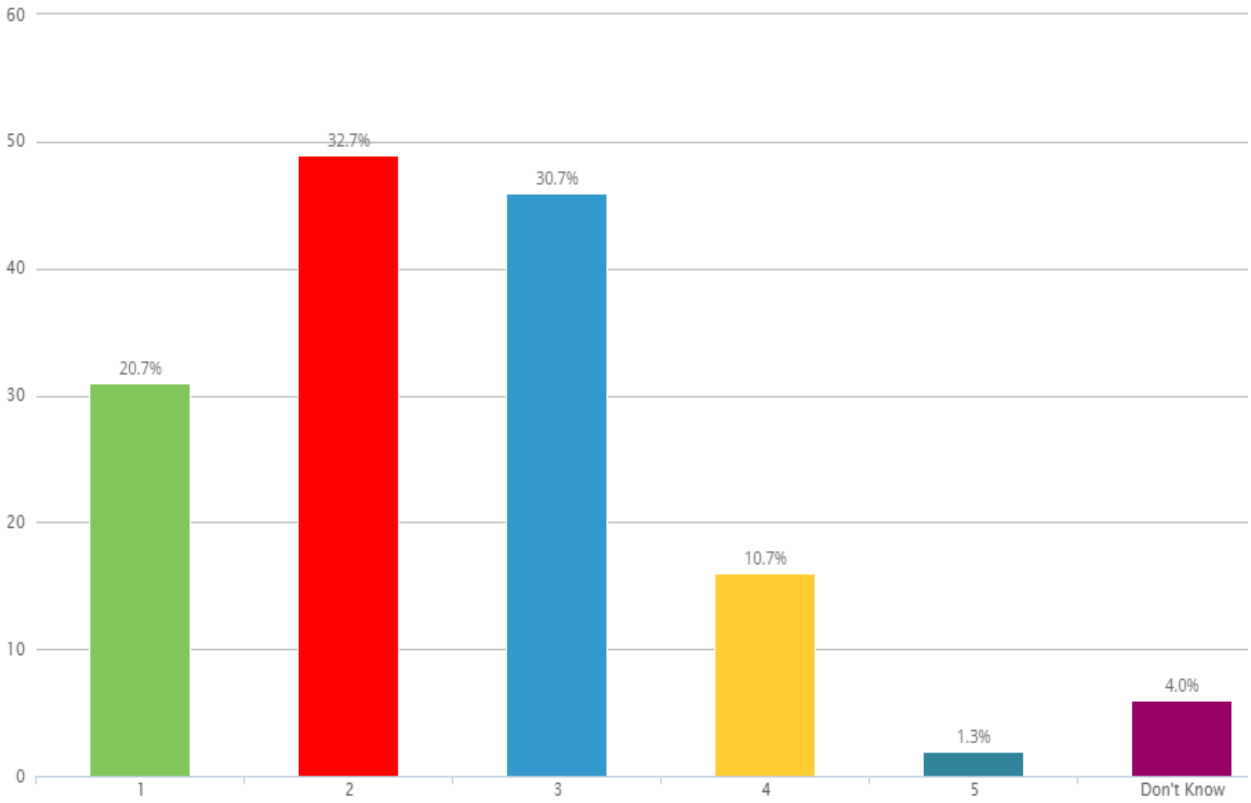
APPENDIX A:

SURVEY QUESTIONS AND SUMMARY OF RESPONSES

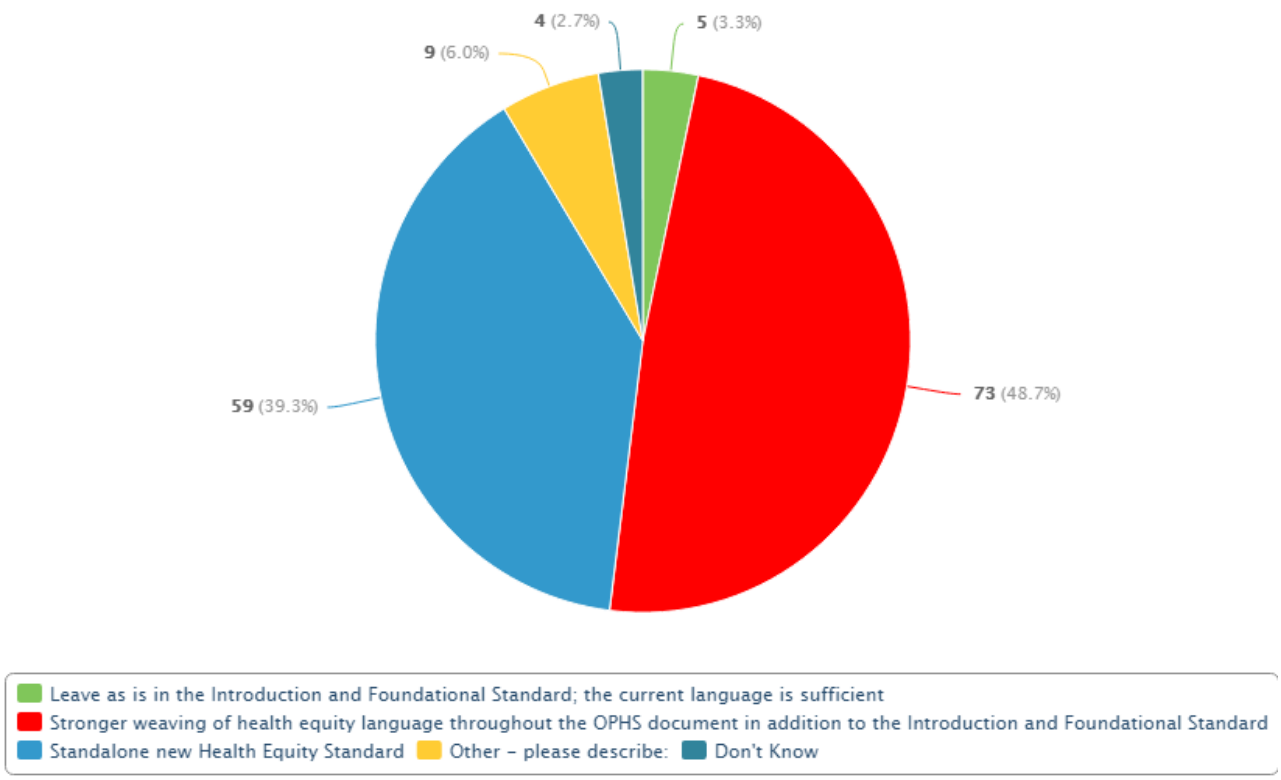
Survey Findings

The total number of responses collected for the survey questionnaire was 150.

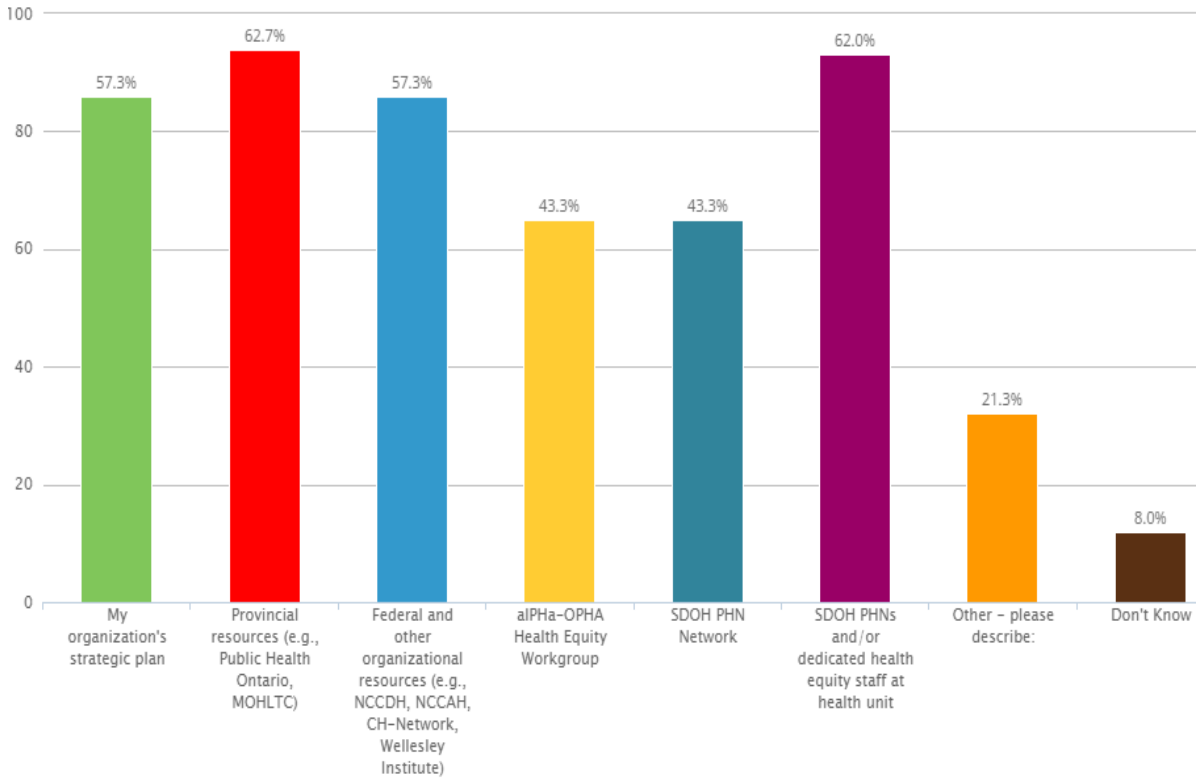
Question 1 – Guidance provided by current Ontario Public Health Standards (OPHS)



Question 2 – Need for stronger language for health equity in the OPHS



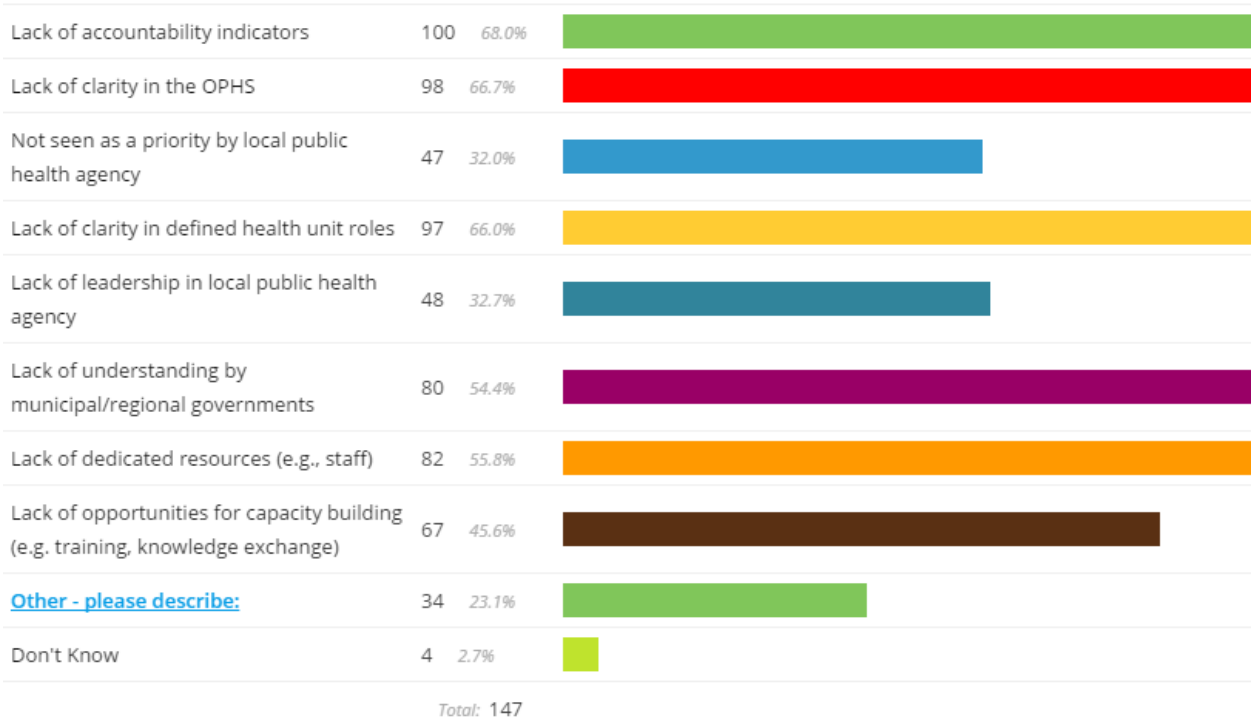
Question 3 – Enablers to conducting health equity work in public health



Around 21% of respondents expressed other enablers for their health equity work:

- Need for additional dedicated staff within PHUs as equity work is not embedded into practice
- A coordinated approach with other community partners i.e., boards of education, mental health agencies, addiction agencies, Family Health Teams
- More management support in SDOH initiatives in advocacy and collaboration
- Additional funding to support resources development, training for SDOH PHNs, lunch and learns to external partners i.e. physicians etc.
- OSNPPH - Ontario Society of Nutrition Professionals in Public Health

Question 4 – Barriers to conducting health equity work in public health



Around 23% of participants expressed other barriers in conducting their health equity:

- Lack of funding to support capacity building for SDOH PHNs and overall staff
- Health equity not seen as a priority by management and leaders when program planning due to diminished funding

Question 5 – Additional activities to reduce health inequities

Respondents expressed their views on additional activities that can be added to the role of public health agencies to reduce health inequities:

- More emphasis (clear language) from the Ministry on the role and responsibility of local public health agencies to address and reduce health inequities.
- Inter-sectoral action on addressing the social determinants of health could be an explicit requirement under the OPHS, as could the setting of health equity targets with other partners, including health sector partners.
- Stronger support from management and dedicated resources and capacity.
- Need for a standard job description for the SDOH PHNs that is used by all health units to help with consistency and clarity of their role.
- Take a leadership role in confronting and influencing the social, political, and economic factors that determine population health to sustainably protect the health of the public against old and new threats.

- Take a leadership role in reducing inequities by working to narrow health gaps across groups in ways that promote social justice and human rights.
- Educating the public and political figures on how health is influenced by SDOH.

Question 6 – Evidence-informed actions to be added in revision of OPHS

Participants were asked to mention key evidence-informed actions that should be incorporated into the OPHS that were not known in 2008. Some of the actions highlighted by respondents are:

- Clearer definitions and roles pertaining to advocacy and health equity work.
- Rural Health Framework - how to use, when to use, how to consider
- A common way of defining priority populations
- Partnership auditing - so that partnerships are strategic and collaborations are not duplicated
- A provincial peer-reviewed knowledge exchange tool (e.g. a journal) that focuses on showcasing Ontario public health best practices.
- NCCDH 4 roles for public action need to be included; also a requirement to apply a healthy equity lens to policies, programs and services
- Use of health equity impact assessment mechanism in program planning to assist in modification and reorientation of program to improve health equity related outcomes
- The OPHS should look more upstream. Ex. when looking at Chronic Disease prevention, there is language around "adoption of behaviours", placing much of the responsibility of individuals. Public health should shift its focus further upstream to the SDOH and work to create better living conditions and environments through policy.

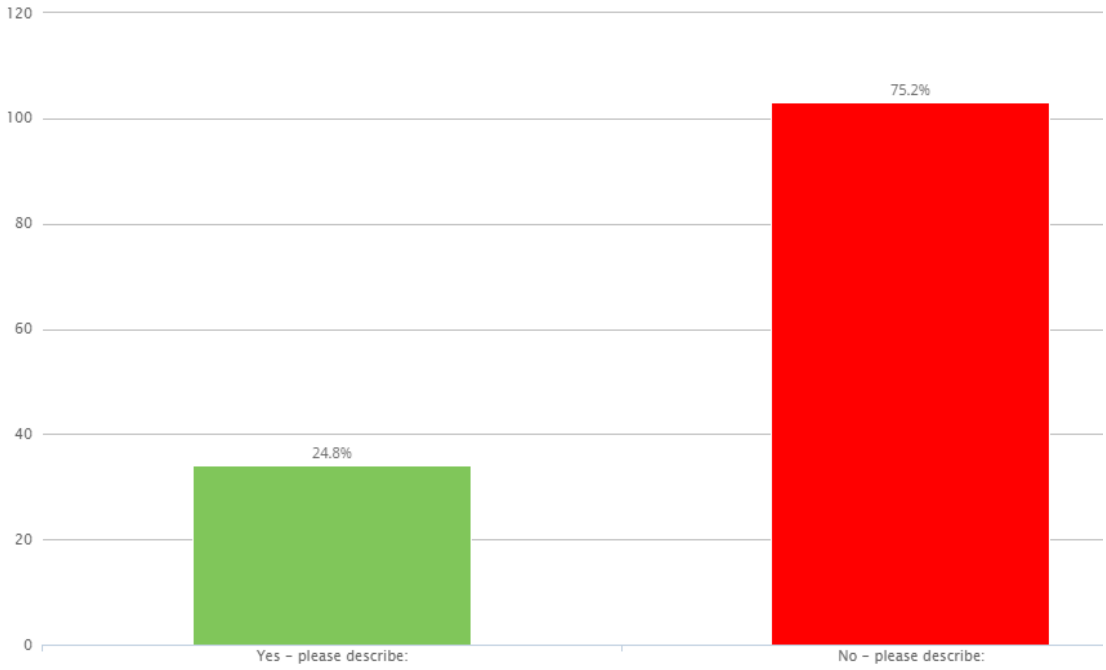
Question 7 – Provincial supports to strengthen local health equity efforts

Participants were asked to highlight some of the supports that could be provided at a provincial level that could strengthen their local efforts to reduce health inequities. They highlighted that the following provincial supports would beneficial to conducting their health equity work:

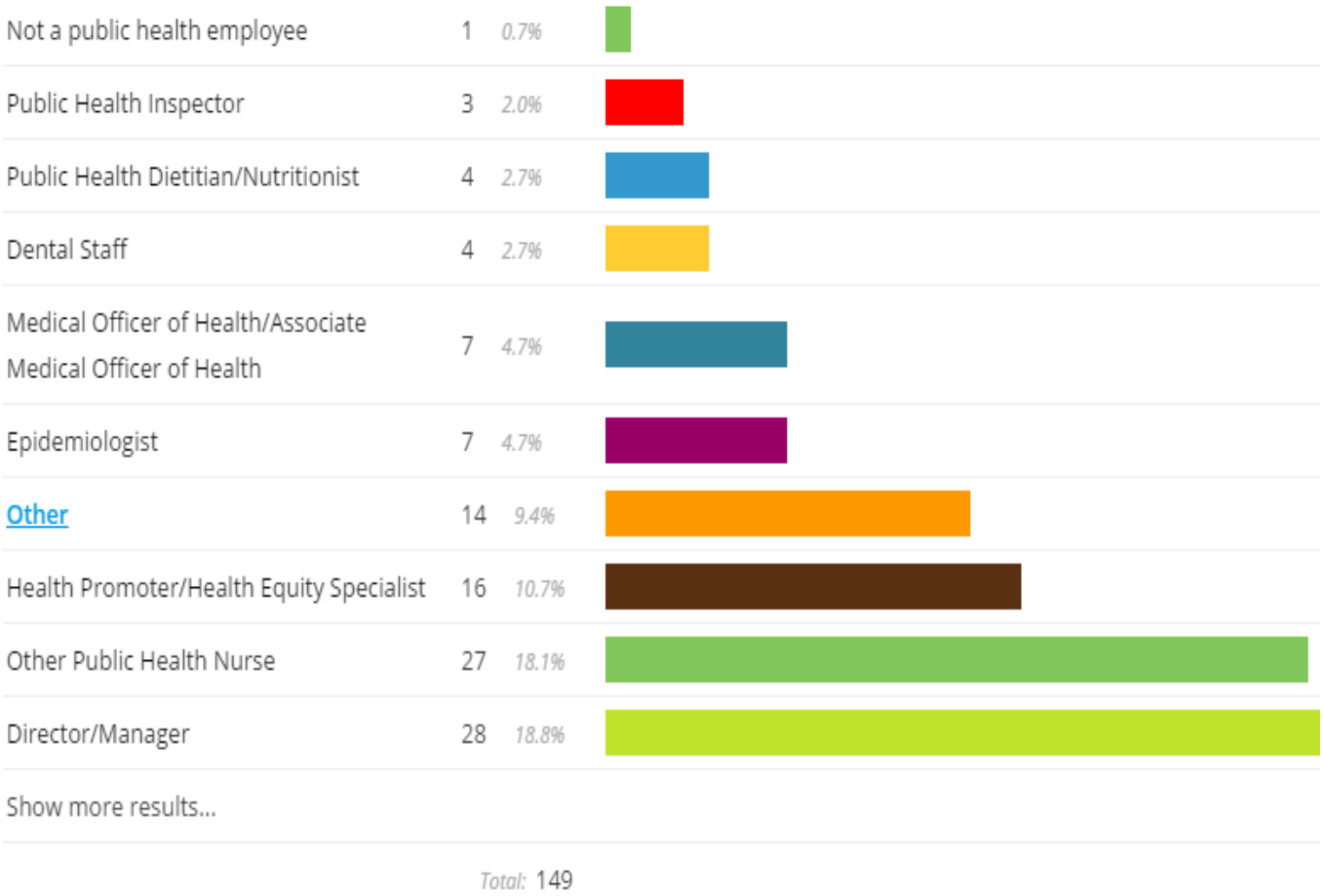
- Have alPHa/OPHA apply for funding to do a communication campaign provincially, using Sudbury's 'You can create change' resources. Provide digital storytelling workshops for health units to support these messages that could be done locally to support the provincial campaign.
- Increased access to data, e.g. provincial RRFSS data, investing in infrastructure for new data and exploring opportunities for integrating data systems, e.g. linking health records through different systems.

- Accountability indicators for health equity must be mandated for all health units and funding must accompany the implementation of these indicators. Funding is required to prioritize equity and implement the changes and mitigations necessary to improve health equity.
- Clear leadership - someone specifically assigned, someone available and supportive in their role - to help strengthen and support the Ontario SDOH PHNs
- Some more clear directives for PHUs mandated so that health Unit Medical Officers of Health will offer more support to SDOH PHNs. There is a lot more that PHNs could be doing in this role if there was more clear support from the Ministry (support from the top down).
- Some health units are very progressive and have the full support/backing of their MOH and Senior Administration, however many health units undervalue their SDOH PHNs and do not support said PHNs to their full potential in their roles.
- Regular workshops and educational teleconferences (to learn, share, network etc.)

Question 8 – Does your local public health agency have dedicated staff time to address health inequities among First Nations/Inuit/Metis/Indigenous populations in your geographic area?



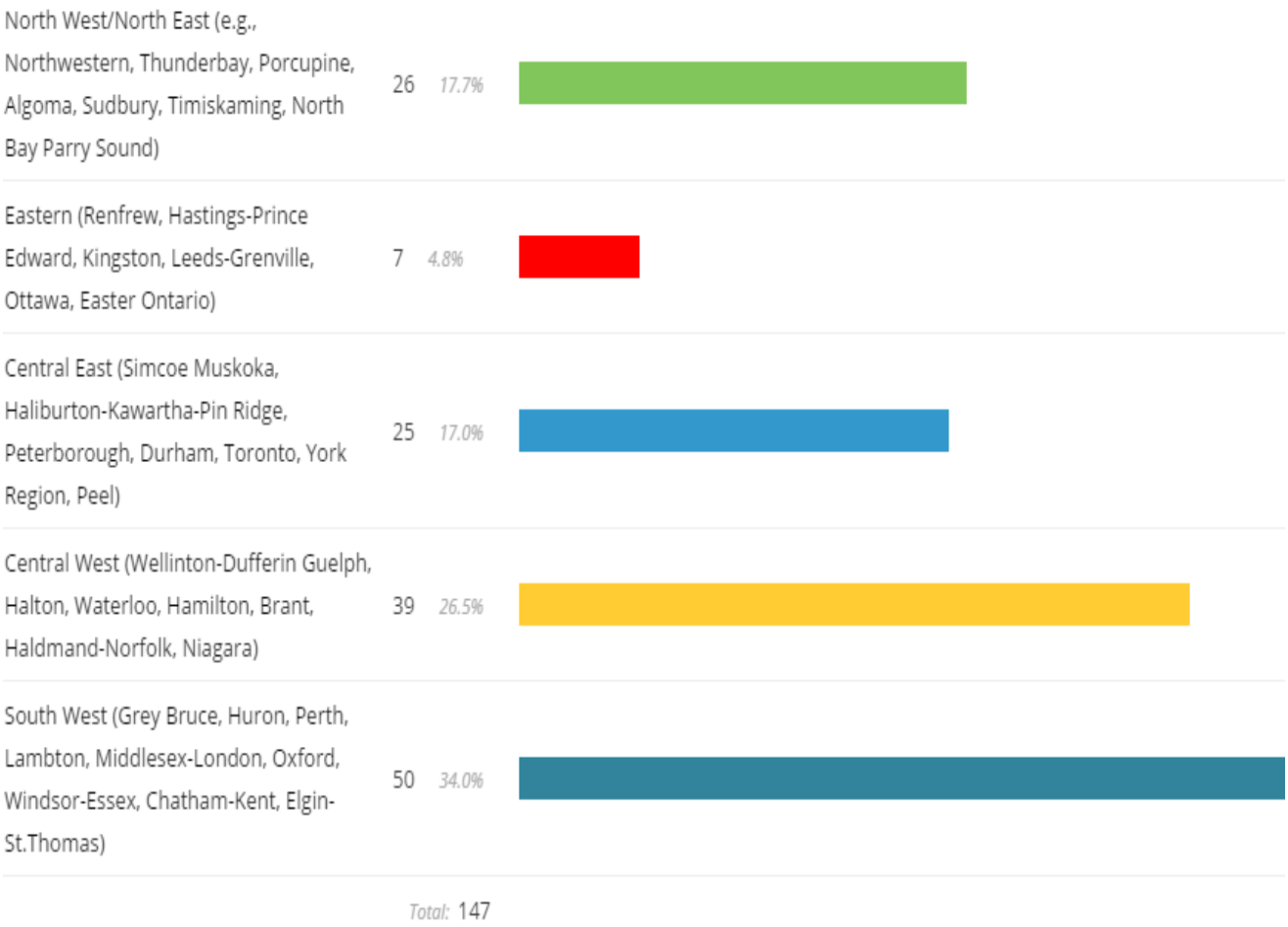
Question 9 – Current Public Health Position



Other participants include:

- Parent Resource visitor
- Immigrant Advocate
- SDOH Nurse and Mental Wellness and Resiliency Nurse
- Currently MPH Practicum student, regular role is as a PHI
- Public Health Planner
- Program Evaluator
- Planning and Evaluation specialist
- Combined SDOH nurse serving 2 priority populations and health equity coordinator
- Community Developer
- Public Health Planner

Question 10 – Location or Region of Public Health Unit



Survey Questionnaire

Provincial Survey on Public Health & Health Equity

1. The current Ontario Public Health Standards (OPHS) provide sufficient expectations to guide my work on health equity and the social determinants of health.
(1 = very little, 5 = completely)

- 1
- 2
- 3
- 4
- 5
- Don't Know

2. How could public health work on health equity and the social determinants of health be better supported by the OPHS?

- Leave as is in the Introduction and Foundational Standard; the current language is sufficient
- Stronger weaving of health equity language throughout the OPHS document in addition to the Introduction and Foundational Standard
- Standalone new Health Equity Standard
-

Other - please describe:

- Don't Know

3. What, if any, are current enablers to conducting health equity work in public health (check all that apply):

- My organization's strategic plan
- Provincial resources (e.g., Public Health Ontario, MOHLTC)
- Federal and other organizational resources (e.g., NCCDH, NCCAH, CH-Network, Wellesley Institute)
- alPHa-OPHA Health Equity Workgroup
- SDOH PHN Network
- SDOH PHNs and/or dedicated health equity staff at health unit
-

Other - please describe:

- Don't Know

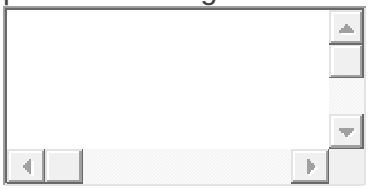
4. What, if any, are barriers to conducting health equity work in public health (check all that apply):

- ☐ Lack of accountability indicators
- ☐ Lack of clarity in the OPHS
- ☐ Not seen as a priority by local public health agency
- ☐ Lack of clarity in defined health unit roles
- ☐ Lack of leadership in local public health agency
- ☐ Lack of understanding by municipal/regional governments
- ☐ Lack of dedicated resources (e.g., staff)
- ☐ Lack of opportunities for capacity building (e.g. training, knowledge exchange)
- ☐

Other - please describe:

- ☐ Don't Know

5. From your experience, what additional activities should be added to the role of local public health agencies in order to decrease health inequities?



6. What key evidence-informed actions should be incorporated into the OPHS that were not known in 2008 (i.e., when the OPHS were created)?

7. What supports could be provided at a provincial level that could strengthen your local efforts to reduce health inequities?

8. Does your local public health agency have dedicated staff time to address health inequities among First Nations/Inuit/Metis/Indigenous populations in your geographic area?

Yes - please describe:

No - please describe:

9. Please indicate your current public health position:

- Medical Officer of Health/Associate Medical Officer of Health
- Director/Manager
- SDOH Public Health Nurse
- Other Public Health Nurse
- Epidemiologist
- Public Health Dietitian/Nutritionist
- Public Health Inspector
- Health Promoter/Health Equity Specialist
- Dental Staff
-

Other

- Not a public health employee

10. Where are you located:

- North West/North East (e.g., Northwestern, Thunder bay, Porcupine, Algoma, Sudbury, Timiskaming, North Bay Parry Sound)
- Eastern (Renfrew, Hastings-Prince Edward, Kingston, Leeds-Grenville, Ottawa, Easter Ontario)
- Central East (Simcoe Muskoka, Haliburton-Kawartha-Pin Ridge, Peterborough, Durham, Toronto, York Region, Peel)
- Central West (Wellington-Dufferin Guelph, Halton, Waterloo, Hamilton, Brant, Haldimand-Norfolk, Niagara)
- South West (Grey Bruce, Huron, Perth, Lambton, Middlesex-London, Oxford, Windsor-Essex, Chatham-Kent, Elgin-St. Thomas)

APPENDIX B:

INTERVIEW QUESTIONS

1. *What is the nature of your work as it relates to health equity?*

2. *Please describe examples of how your work advances health equity.*

3. *Would you tell me more about any partnerships or collaborations you have done, are planning or have underway?*

4. *What supports would you find helpful to advance your work in this area? Supports include but are not limited to: training, knowledge exchange, conferences, evaluation tools, frameworks, etc.*

5. *How have you or your organization worked intentionally towards building internal organizational capacity for action on health equity matters, if at all? Please describe.*

6. *Has this work used a human rights or anti-oppressions framework?*

7. *OPHA is working on a health equity action plan. What activities, if any, do you think OPHA could undertake to help advance health equity in Ontario?*

8. *Do you have materials you can share with me that will help me better understand your work?*

APPENDIX C:

LINKS TO RESOURCES AND EXAMPLES FEATURED

National Collaborating Centre for Determinants of Health's *Public Health Roles for Improving Health Equity* (2013):
http://nccdh.ca/resources/entry/lets-talk-public-health-roles

Robert Wood Johnson Foundation (RWJF) report *A New Way to Talk About the Social Determinants of Health* (2010):
http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023

Champlain Community Health Centre Executive Director's Network's *Resources, Principles and Practice of Health Equity* available from The Champlain Community Health Centre Network website:
www.coalitionottawa.ca

Halton Region Public Health Department's findings from staff training on the social determinants of health and health equity (2013):
http://www.halton.ca/common/pages/UserFile.aspx?fileId=150770

EXAMPLES OF PARTNERING WITH OTHER SECTORS

Wellington-Dufferin-Guelph public health unit, Region of Waterloo public health unit, Grey-Bruce public health unit and Waterloo Wellington Local Health Integration Network (LHIN) report titled *Addressing Social Determinants of Health in the Waterloo Wellington Local Health Integration Network Area* (2011):
http://chd.region.waterloo.on.ca/en/researchResourcesPublications/resources/SDOH_FullReport.pdf

Thunder Bay District Health Unit's website featuring a collection of resources that showcase how heath providers can screen for the social determinants of health in primary care settings:
http://www.tbdhu.com/professionals/health-care-providers

Thunder Bay District Health Unit's s link to *TheWell* a resource "for providers by providers" in addressing poverty in clinical settings:
https://thewellhealth.ca/poverty

Thunder Bay District Health Unit's s link to *TorontoHealthEquity* a resource that provides a form for screening for social determinants of health in clinical settings:
http://torontohealthequity.ca/wp-content/uploads/2014/10/TC-LHIN-Hospitals-Demographic-Data-Form-Oct-2014.pdf

Wellington-Dufferin-Guelph Public Health Unit link report mentioning involvement with Bridges out of Poverty:

https://www.wdgpublichealth.ca/sites/default/files/file-attachments/report/ht_report_2013-addressing-social-determinants-of-health-in-guelph_access.pdf

Lambton Public Health Unit link to Brides out of Poverty Events:
https://lambtonhealth.on.ca/events/eventid/69/

Bridges out of Poverty Information:
http://circlesgw.ca/bridges-out-of-poverty/

Simcoe Muskoka District Health Unit example of multi-sector collaboration in *The Simcoe County 20,000 Homes Campaign Registry Week Report (2016)*:
http://www.simcoe.ca/ChildrenandCommunityServices/Documents/Data%20Consortium/Simcoe%20County%20Community%20Engagement/20,000%20Homes%20Campaign/SC%2020,000%20Homes%20Campaign%20Registry%20Week_Final%20Report.pdf

EXAMPLES OF ASSESSING AND REPORTING

Sudbury and District Public Health's use of The Institut national de santé publique du Québec Deprivation Index:
http://communitydata.ca/CDC-DCC/files/roundTable/Presentations2013/CDCR2013_SDHU.pdf

Sudbury and District Public Health's Ten Promising Practices: Purposeful Reporting (2012):
https://www.sdhu.com/wp-content/uploads/2016/04/02-Purposeful-Reporting.pdf

The Institut national de santé publique du Québec's Deprivation Index Report (2011) :
https://www.inspq.qc.ca/pdf/publications/1258_QcIndexDeprivation1991-2006.pdf

Toronto Public Health's Report *The Unequal City: Income and Health Inequalities in Toronto* (2008):
http://www.toronto.ca/legdocs/mmis/2008/hl/bgrd/backgroundfile-16293.pdf

Toronto Public Health's Report *The Unequal City 2015: Income and Health Inequalities in Toronto* (2015):
http://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-79096.pdf

The Institute for Health Information report on *Trends in Income-Related Health Inequalities* (2016):
https://secure.cihi.ca/free_products/trends_in_income_related_inequalities_in_canada_2015_en.pdf

EXAMPLES OF MODIFYING AND ORIENTING INTERVENTIONS

Ottawa Public Health Unit's strategic Plan (2015-2018):
http://ottawa.ca/en/residents/public-health/about-ottawa-public-health

City of Ottawa and City for All Women Initiative (CAWI) report on Equity and Inclusion *The Diversity and Inclusion Lens Handbook* (2015):

http://documents.ottawa.ca/sites/documents.ottawa.ca/files/documents/EI_Lens_Handbook_2015_FINAL_EN_WEB_2.pdf

EXAMPLES OF PARTICIPATING IN POLICY DEVELOPMENT

Sean Moore's report *IMPROVING THE NON-PROFIT, VOLUNTARY AND CHARITABLE SECTOR'S EFFECTIVENESS IN INFLUENCING DECISIONS OF GOVERNMENT* (n.d.):
http://www.advocacyschool.org/PDF/MuttartPaperAdvocacy.pdf

Link to alPHa-OPHA Health Equity Workgroup letter submitted to Special Advisor to the Minister of Finance Hugh Segal about the Basic Income Guarantee (2016):
http://opha.on.ca/getmedia/49300612-2411-491c-a62f-da541d12f565/2016_MeasuringCommunityHealthOutcomes_BI-Pilot_Final.pdf.aspx?ext=.pdf

Link to alPHa-OPHA-PHO Collaborative technical submission on Ontario's Basic Income Pilot (2017):
http://opha.on.ca/getmedia/0eca550e-374a-42e3-8d2a-d28014772f1b/alPHa-OPHA-PHO-BI-consultation-technical-response-final-Jan-17-2017.pdf.aspx?ext=.pdf

Housing York Inc.'s report *SMOKE-FREE POLICY FOR HOUSING YORK INC* (2014):
https://www.york.ca/wps/wcm/connect/yorkpublic/2c0d97b8-cf08-4dca-80b9-62d5ae2f93cf/jun+12+smoke.pdf?MOD=AJPERES

York Region's website and resources on smoke-free spaces (2017):
http://www.york.ca/wps/portal/yorkhome/health/yr/substanceuse/smokefreespaces/smokefreespaces/!ut/p/a0/04_Sj9CPykssy0xPLMnMz0vMAfGjzOI9Hd09PTy8Dbz8TSycDRwN_B29jMwtDFwtDfULsh0VAZAcf3w!/#.WNvoCW8rLGg

http://www.york.ca/wps/wcm/connect/yorkpublic/c27ce6ef-5aa3-48ca-946f-20f81ca2f5a2/SmokeFreeHousingCard.pdf?MOD=AJPERES

York Region's Committee of the Whole report on the social determinants of health; this report contains several examples of York Region's initiatives in advancing health equity as they relate to each of the four NCCDH roles (2017):
https://www.york.ca/wps/wcm/connect/yorkpublic/1eaa3ac3-3f7e-40ac-8bb9-302ec83eb742/feb+2+social+ex.pdf?MOD=AJPERES

Sudbury & District Health Unit's Motion (#37-12) for local policy makers to use a health equity lens in decision making processes:
https://www.sdhu.com/about/board-health/motions-approved-sudbury-district-board-health/equity-focused-health-impact-assessment-tool-support-local-decision-making-within-sudbury-district-municipalities-motion-37-12

Algoma Public Health example of using health equity in their internal policies by incorporating health equity into their logic model and strategic plan:
http://www.algomapublichealth.com/about-us/strategic-plan/

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