



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

A GAPS ANALYSIS TO IMPROVE HEALTH EQUITY KNOWLEDGE AND PRACTICES



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THE NCCDH'S APPROACH TO GAPS

As part of its mandate, the National Collaborating Centre for Determinants of Health (NCCDH) uncovers and responds to gaps that influence the public health sector's capacity to improve or mitigate social determinants of health (SDH). Given the complexity of addressing SDH to advance health equity, the NCCDH approaches gaps broadly. This analysis identifies gaps in research on public health systems and practices relating to health equity, weaknesses and inconsistencies in practitioner knowledge and skills, and barriers to accessing and applying knowledge.

The NCCDH identifies evidence and knowledge gaps through multiple means, including secondary research and synthesis of literature; consultation with its audiences, partners and other stakeholders; direct requests for information from users, researchers and other stakeholders; and evaluation and environmental scanning reports. The analysis presented here — of gaps and barriers to address social determinants of health and improve health equity — draws on 13 NCCDH resources and two environmental scans produced between 2011 and 2015, augmented by the 2017 environmental scan (which includes an evidence review).¹⁻¹⁶

Consistent with previous findings,¹⁷ the barriers reflect limited knowledge, attitudes and motivation; organizational culture; and resource constraints. Gaps occur at all stages in the knowledge translation process approach, as outlined by the Institut national de santé publique du Québec:¹⁸ knowledge generation, dissemination, reception, adoption and appropriation, use and evaluation.

To encourage action from this gaps analysis, NCCDH staff identified promising activities named in the source documents; to bring the analysis up-to-date, they included a selection of resources and programs developed outside of the review period (2011–2015) to address gaps. The actions identified in this report do not reflect all the possible activities noted in the resource documents, nor are they limited to those mentioned in these sources.

Some barriers to addressing health equity relate to public health systems, structures, culture and leadership. The sector struggles to pinpoint equity-focused outcomes and diminish the emphasis on lifestyle rather than structural change to advance equity. In keeping with an upstream approach, the NCCDH considers system modifications as the most essential to creating widespread change, followed by organizational and then practitioner considerations.

HOW TO USE THIS RESOURCE

This gaps analysis was designed as a resource to focus attention on the most pressing needs in advancing health equity. It is structured to identify gaps and actions by three key audiences:

- **Researchers:** Primarily academics outside of the formal public health system (or co-appointed) who have some capacity to undertake independent research
- **Policy-makers and government decision-makers:** Those with the authority to generate changes in the conditions and context within the public health system, influencing both how practitioners work and how public health departments and institutions are organized
- **Public health practitioners:** Those who practice in the formal public health sector, including formal leaders (senior management), middle management and front-line staff across programs and disciplines

This analysis identifies actions by each of the groups above, but please note that there is considerable overlap. Many readers may be interested in the actions identified for more than one audience. We invite readers within and associated with the public health sector to use this resource as a starting place to identify additional actions to address SDH and advance health equity. We look forward to hearing from you about proposed responses.

The gaps themselves are divided into four categories — **evidence and knowledge, workforce development, organizational capacity, and societal context/environment** — which apply to all three audiences and are contextualized in the descriptions that follow.

A. FOR RESEARCHERS

Conducting new research to close evidence and knowledge gaps is an obvious component of a researcher's role. However, researchers can also play an active part in addressing gaps in workforce development by helping to translate this research into practice and by clarifying public health roles and terminology. Providing the evidence required to close gaps in organizational capacity will go a long way towards creating the type of work environment where health equity can thrive. Finally, the credibility and evidence that researchers bring to issues can go far to creating a supportive societal context/environment for the broad systemic changes required for health equity.

B. FOR POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS

System modifications have been identified by the NCCDH as the most essential to creating widespread change. Policy- and decision-makers are the key players in this realm and have significant power to transform the public health environment to focus on upstream factors influencing health. Policies and processes that improve surveillance and evaluation will highlight effective and sustainable practices, strengthen programs and ultimately advance health equity. Clear roles, training and support, as identified in workforce development, will guide staff, including senior leaders, towards more effective, SDH-oriented practice. Decision- and policy-makers determine the structures that characterize public health, set priorities to be achieved and have the greatest power to advocate for increased public health capacity. Their leadership is also extremely important in influencing societal and political will to shift views towards a more equitable health environment.

C. FOR PUBLIC HEALTH PRACTITIONERS (INCLUDING DECISION-MAKERS)

Given proper support, practitioners are in an excellent position to shift the public health focus upstream. Their first-hand experience dealing with those who are socially and economically vulnerable can influence health policies and programs towards more equity. With clear leadership, well-defined roles and adequate resources, practitioners can not only improve the lives of individuals but affect population health outcomes as well. Their influence and support within multisectoral efforts is well respected and can act as a powerful force within society. Change within organizations can come from above, through great leadership, but also from strong front-line practitioners. It is often the confluence of the two that influences the greatest changes.

LIMITATIONS

A limitation of this analysis is that it includes only gaps that were described within the pages of the 16 products assessed. In addition, the methods used to identify gaps vary according to the source documents. However, all documents used one or more of the following methods: systematic and other literature reviews, key informant interviews, document reviews and informed opinion gained through dialogue or events. As noted previously, the actions have been updated to include a selection of newer resources that may support identified actions. At the same time, the actions are not all-encompassing and some with probable value — such as public health repositories — are not included. The analysis has two areas that could be improved upon in future reports: a better integration of Indigenous knowledge and knowledge systems into health practice, including responding to the findings of the [Truth and Reconciliation Commission](#),¹⁹ and a consideration for the ecological and one-health conceptualizations as potential approaches to advance health equity (see the Canadian Public Health Association's [discussion paper](#)²⁰).

Further, the actions were subjectively reviewed by NCCDH staff according to each action's priority and potential to be acted upon. Readers are encouraged to critically review this assessment and determine actions most appropriate to their particular needs and gaps.

GAP	APPLIES TO	ACTIONS TO RESPOND TO GAPS, TAILORED TO SELECTED AUDIENCES	SAMPLING OF RESOURCES AND ACTIVITIES BEGUN SINCE GAP IDENTIFIED
EVIDENCE AND KNOWLEDGE			
<p>1. Limited evidence about intersectoral action, including:</p> <ul style="list-style-type: none"> » mechanisms linking intersectoral processes to observed outcomes and impact on populations; and » comparative effectiveness (success factors), cost effectiveness and sustainability of community engagement interventions and models, especially those involving Indigenous peoples 	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Undertake intervention research about intersectoral and community engagement initiatives, including analysis to identify factors that impact populations, SDH and equity patterns. • Evaluate processes and cost/resource factors, with emphasis on qualitative and mixed-method evaluation. • Assess relationships between sectors and contributions of public health. • Undertake scoping and synthesis reviews to help translate and build upon existing literature (journals and grey literature). 	<ul style="list-style-type: none"> • MUSE²¹ (Multisectoral Urban Systems for Health and Equity in Canadian cities) “collaboratory” (funded by the Canadian Institutes of Health Research) • Study 2: Intersectoral collaboration for health inequities reduction²² (Equity Lens in Public Health, ELPH) • Collective impact and public health: An old/new approach²³ (NCCDH)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Require and adequately support intervention-focused evaluation and publication (grey literature as well as journals) by public health departments. 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Contribute to the evidence base by collaborating with the research community; engaging in participatory research; and publishing reports, evaluations and blogs. 	
<p>2. Inadequate extent and quality of evaluation of interventions, programs and policies, and a resulting shortage of verified (proven and promising) intervention models and minimal comparative analysis of interventions</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Partner with public health to bring intervention science and expertise to public health evaluations. • Partner with public health to help develop case studies, casebooks and other compilations showcasing promising and proven interventions. • Research and articulate evidence regarding tangible, evidence-informed strategies, interventions, policies and programs. 	<ul style="list-style-type: none"> • What works: Promoting health equity²⁴ (The Community Guide, USA) • Western public health casebooks²⁵ (Western University) • International review of health equity strategies²⁶ (Wellesley Institute)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Require and adequately support (with resources such as time, funds) intervention-focused evaluation, including resources for initiatives that: <ul style="list-style-type: none"> » address structural determinants of health across the whole population; and » take universal, mixed and targeted approaches to reducing health inequities. • Improve qualitative methods and their use to understand needs, community problem-solving and meaning of results to communities, among other factors. • Set expectations for public health to develop and disseminate case studies and stories. 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Facilitate the use of more intervention-focused evaluators. • Conduct rigorous evaluation of interventions, including qualitative and quantitative methods. • Access and apply verified assessment tools and resources. • See also <i>Workforce Development</i> on page 7. 	

GAP	APPLIES TO	ACTIONS TO RESPOND TO GAPS, TAILORED TO SELECTED AUDIENCES	SAMPLING OF RESOURCES AND ACTIVITIES BEGUN SINCE GAP IDENTIFIED
<p>3. Inadequate data measurement, indicators and monitoring to evaluate interventions and outcomes and measure organizational progress towards health equity objectives</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> Contribute to the development and promotion of organizational progress indicators on health equity. 	<ul style="list-style-type: none"> Population health status reporting: The learning together series²⁷ (NCCDH) Equity integrated population health status reporting²⁸ (National Collaborating Centres for Public Health) Health inequalities data tool²⁹ (Public Health Agency of Canada) Health equity impact assessment course³⁰ (Public Health Ontario, PHO) Priority health equity indicators for British Columbia³¹ (Provincial Health Services Authority of British Columbia) Health equity indicators for Ontario local public health agencies³² (PHO)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> Integrate health equity indicators and data into evidence-informed decision-making to assess outcomes of health equity work. Provide a base for measuring progress over time and report to politicians and funders. Take advantage of the consolidation of resources into larger health authorities to strengthen regional equity data collection (including rural and remote areas with limited population size), analysis and use, and develop provincial and territorial approaches to issues such as poverty, housing and racism. 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> Access and apply verified tools and models. Expand use of community and Indigenous research practices. 	
<p>4. Few health equity knowledge-to-action models that integrate and are responsive to health equity; little access to holistic, cross-sector and complexity-oriented knowledge-to-action models</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> Become familiar with existing analysis of knowledge translation models vis-a-vis equity. Increase engagement with community and Indigenous knowledge users throughout Canada. Further develop, test and promote equity-supporting knowledge-to-action and knowledge translation models, especially vis-a-vis: <ul style="list-style-type: none"> environmental and contextual determinants, as well as eco-health approaches; Indigenous peoples and knowledge systems; participatory and integrative research methods; and the experience of knowledge mobilizers, intermediaries and end users (community partners), possibly using feedback loops that assess equity factors. 	<ul style="list-style-type: none"> Critical examination of knowledge-to-action models and implications for promoting health equity³¹ (Davison, NCCDH) Equity-focused knowledge translation: A framework for 'reasonable action' on health inequities³³ (Masuda et al)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> Work with researchers to identify practical knowledge-to-action models that can be applied immediately, and support the use of these models in workplaces (with resources, training, etc.). 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> Collaborate with the research community to develop effective, equity-oriented knowledge-to-action models. 	

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WORKFORCE DEVELOPMENT			
<p>5. Inconsistent and unclear definitions, referencing and understanding of health equity and SDH terms and social justice concepts</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Become familiar with the NCCDH Glossary and, where feasible, apply common terminology. • Model the use of consistent terminology. 	<ul style="list-style-type: none"> • <i>English glossary of essential health equity terms</i>³⁴ (NCCDH) • <i>Ontario health equity foundational standard</i>³⁵ and related guidance document forthcoming in 2018 • <i>Closing the gap in a generation: Health equity through action on the social determinants of health</i>³⁶ (World Health Organization) • <i>Robert Woods Johnston Foundation</i>³⁷ and <i>Communicating the social determinants of health: Guidelines for common messaging</i>³⁸ (Canadian Council on Social Determinants of Health, CCSDH) • <i>A review of frameworks on the determinants of health</i>³⁹ (CCSDH)
<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Model the use of consistent terminology. • Embed concepts of social justice and SDH/health equity into competency documents (both core and discipline-specific) and public health requirements and standards. Include practice examples that illustrate public health action for social justice and health equity. 		
<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Model the use of consistent terminology. • Become familiar with most Canadian competencies to guide professional practice and make an effort to deepen the competencies' impact. • Use language/messages that maximize common interests with partners. 		
<p>6. Inconsistent public health leadership to address upstream and structural health inequities</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Summarize and promote effective leadership approaches, including uptake of organizational culture and practice change by leaders. 	<ul style="list-style-type: none"> • <i>Building a culture of equity in Canadian public health: An environmental scan</i>¹⁵ (NCCDH) • "Public health leadership to advance health equity: A scoping review and metasummary"⁴⁰ (Betker) • <i>Study 1: Assessing health equity priorities and strategies across health authorities over time</i>⁴¹ (ELPH)
<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Orient incoming leaders to upstream structural equity commitments (see also <i>Organizational Capacity</i> on page 9) • Provide more education, exchange and mentorship opportunities for senior public health leaders regarding equity, including cultural humility/safety. • Nurture champions by, for example, supporting exchange opportunities or providing cross-jurisdictional and project mentorship. • Recognize the equity efforts and achievements of leaders. 		

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<p>7. Practitioners lack knowledge, skills and access to tools to effectively advance health equity related to gaps 1–4; practitioners also lack:</p> <ul style="list-style-type: none"> » policy analysis and advocacy approaches; » communication skills and strategies, including those related to social media; » opportunities to acquire the attitudes/values necessary to address SDH/health equity; » skills in evidence-informed-decision-making, policy analysis and advocacy, and strategic communications, including social media; and » new domains (e.g., complex adaptive systems, methods to scale up effective actions) 	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Support knowledge translation of the results of research identified in gaps 1–4 and facilitate its uptake. • Contribute to the development of practice guidelines in gap areas identified. • Undertake synthesis and scoping reviews to identify most effective methods for public health. 	<ul style="list-style-type: none"> • <i>Health equity tools 2.0</i>⁴² (ELPH) • <i>Robert Wood Johnson Foundation</i>³⁷ and <i>Communicating the social determinants of health: Guidelines for common messaging</i>³⁸ (CCSDH) • <i>Common agenda for public health action on health equity</i>¹² (NCCDH) • <i>Let's Talk: Advocacy and health equity</i>⁴³ (NCCDH)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Provide training and other support for gaps 1–4. • Integrate equity roles into expectations and requirements. • Avoid wasted effort in searching for evidence that does not exist or has already been summarized by others; improve access to analysis and summaries of available policy options by level of government. • Develop comprehensive communications and advocacy campaigns for health equity, as per health behavior campaigns (e.g., tobacco, healthy eating and physical activity). Craft approaches and messages that emphasize benefits of health equity, regardless of audience orientation or context. 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Seek out and apply theoretical frameworks that support social justice and reconciliation. • Learn and apply NCCDH public health roles. • Identify personal gaps in health equity skills and competencies and seek out applicable training, including: <ul style="list-style-type: none"> » surveillance and analysis of inequities; » use of health equity assessment tools; » cultural humility and safety training; » advocacy strategies; » communication of health equity, including use of social media; and » community engagement. • Take advantage of formal and informal networks of public health staff, including the Health Equity Clicks: Community, the Public Health Network and others. • Contribute to the efforts of other sectors engaged in health equity work. Strategically focus efforts to engage with audiences and partners (e.g., the public, intersectoral groups, health care and the public health community). 	

GAP	APPLIES TO	ACTIONS TO RESPOND TO GAPS, TAILORED TO SELECTED AUDIENCES	SAMPLING OF RESOURCES AND ACTIVITIES BEGUN SINCE GAP IDENTIFIED
ORGANIZATIONAL CAPACITY			
8. Inadequate public health requirements and organizational vision regarding SDH and equity expectations	RESEARCHERS	<ul style="list-style-type: none"> Review organizational standards or requirements across Canada to determine where and how health equity is incorporated most effectively; analyze success factors. Consult with public health leaders and practitioners across Canada to learn how to better embed SDH/health equity concepts into practice, possibly through public health leaders' networks. 	<ul style="list-style-type: none"> Ontario health equity foundational standard³⁵ and related guidance document forthcoming in 2018 Various provinces and regional/local public health departments have developed equity strategies (e.g., Nova Scotia,⁴⁴ Saskatoon,⁴⁵ Winnipeg⁴⁶)
	POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS	<ul style="list-style-type: none"> Integrate health equity into clearly defined public health roles, standards, policies, programs and practices. Revise <i>Core Competencies for Public Health in Canada: Release 1.0</i> and discipline-specific competencies to establish equity-oriented expectations and improve practitioner competencies, including advocacy. Apply organizational culture-building methods to integrate equity. Include equity in expressed vision and value statements within organizations and in public relationships; include equity measures in accountability structures to monitor progress. 	
	PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS	<ul style="list-style-type: none"> Champion health equity from your position within your organization to harness and promote action. Integrate health equity into organizational decision-making expectations and practices. Make a business case for equity work. Measure progress over time. Report to funders and higher levels of government regarding progress and impact. 	

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<p>9. Lack of supportive structures (as well as policies, programs and priorities) that support public health organizational standards/ expectations to advance health equity</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Help identify appropriate organizational public health structures, policies, programs and priorities to advance health equity. • Articulate public health roles to advance equity within organizational standards and strategies. 	<ul style="list-style-type: none"> • <i>Health equity indicators for Ontario local public health agencies</i>³² (PHO) • Newer public health leaders' networks offer potential to leverage focus on equity (e.g., Provincial-Territorial Public Health Network; Rural, Remote and Northern Public Health Network)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Recognize equity considerations in all programs/ services, not just in health promotion. • Use opportunities such as quality improvement, accreditation and strategic planning (e.g., Triple Aim framework) to build a culture of equity in established system change processes. • Embed a medical officer of health in senior management in health authorities and ministries as a strong advocate for health equity in acute care and community health. Provide adequate resources to carry out this role. 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Support knowledge exchange with your peers across jurisdictions, disciplines and programs. • Take advantage of public health leaders' networks. 	
<p>10. High centralization and standardization of programs and services, and control of staff (possibly resulting from health care integration) restricts program scope and principles</p>	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Require adaptation of programs and services to meet varied contexts, opportunities and needs. • Explore and demonstrate how investment in equity work in the community sector has positive impacts and savings for acute care and long-term care. 	<ul style="list-style-type: none"> • <i>Building a culture of equity in Canadian public health: An environmental scan</i>¹⁵ (NCCDH)
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • As health equity staff, work to influence the whole organization, rather than working solely with high-need programs and clients. • As practitioners, stay connected with the communities you serve and bring your knowledge back to your organizations. • Facilitate health equity knowledge exchange within your organization and across jurisdictions, for example, by using practitioner expertise in context-specific decisions, by taking advantage of formal and informal networks or by identifying roles for health equity champions. 	

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<p>11. Widespread emphasis on individual lifestyle change and downstream factors that remediate harmful and inequitable distribution of social determinants, such as income support and social assistance programs, rather than changing conditions of daily life</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Conduct research into organizational capacity factors that support or hinder success in upstream initiatives, including: <ul style="list-style-type: none"> » values and ideology; » workplace inequities; » public health equity roles and their transferability between jurisdictions; and » factors that move health equity from words (philosophical commitment) to action. • Research approaches that successfully build widespread upstream commitment and related capacity beyond organic evolution of early adopter organizations. 	<ul style="list-style-type: none"> • “Commentary: Social determinants and the health gap: Creating a social movement”⁴⁷ (Marmot) • Upstream⁴⁸
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Create commitments to advocate for systems and processes that create equity for both social and health outcomes. • Recognize equity as more than requiring access to services and programs. • Rely on evidence-informed policy practices and emerging intervention evidence. • Reallocate staff and other resources to better address the needs of priority populations, shifting from individually oriented, education-based interventions to policy change and system-level community development. • Establish goals towards eliminating Indigenous health inequities; for example, train staff regarding colonialism, racism and Indigenous well-being and knowledge. • Build organizational capacity to identify and apply evidence, and also to adapt and contribute to scale up and scale out existing actions (reaching for collective impacts). 	
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Ensure that health equity factors are incorporated into all programs and services. • Develop specific targets and interventions to improve (1) the quality and extent of public health policy interventions and (2) the services and programs for Indigenous peoples and other populations experiencing inequities in health opportunities and outcomes. 	

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12. Limited expectation that public health leaders address systemic barriers to health inequities (See also <i>Workforce Development</i> on page 7)	POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS	<ul style="list-style-type: none"> Provide support to leadership through corporate policy and a clear vision regarding public health's role in addressing structural barriers to health equity. Ensure there are financial and staff resources to address health equity (e.g., skills development, data collection and analysis of health inequities). Nurture champions and recognize/support the achievements of leaders to advance health equity. 	<ul style="list-style-type: none"> Some jurisdictions have formalized expectations (e.g., Ontario Standards³⁵)
13. Limited or under-resourced partnerships across sectors and within the health systems, including few broad and sustained partnerships	POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS	<ul style="list-style-type: none"> Support the engagement of partners across the health sector to advance health equity. Define enabling roles of health sector partners more clearly. 	<ul style="list-style-type: none"> <i>Collective impact and public health: An old/new approach</i>²³ (NCCDH)
	PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS	<ul style="list-style-type: none"> Actively participate in coalitions, networks and partnerships to facilitate action across sectors. Track and catalogue public health practitioner/organizational contributions to community/local change. Integrate advocacy into intersectoral initiatives and support NGOs' roles as independent advocates. 	

SOCIETAL CONTEXT / ENVIRONMENT

14. Limited political will, commitment and support for health equity action by government, coupled with: <ul style="list-style-type: none"> » constraints of the political environment; » weak health equity policy documents; and » a lack of knowledge by public health about how to navigate political systems 	RESEARCHERS	<ul style="list-style-type: none"> Strengthen health policy research through analysis of the impact of formal health equity commitments (e.g., legislation, mission statements, standards, strategic plans) and approaches (e.g., whole of government, health in all policy). Document and analyze public health's role in furthering upstream and structural government interventions (e.g., Ontario case regarding commitment to pilot minimum income). 	<ul style="list-style-type: none"> "The weakening of public health: A threat to population health and health care system sustainability"⁴⁹ (Guyon et al) "Public health systems under attack in Canada: Evidence on public health system performance challenges arbitrary reform"⁵⁰ (Guyon, Perreault) Several provinces are exploring health in all policies (with Quebec most advanced), and exploring or piloting minimum income (Ontario⁵¹)
	POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS	<ul style="list-style-type: none"> Support national, provincial and territorial approaches that incorporate a social justice lens (e.g., anti-poverty measures). Support formal health equity commitments (e.g., legislation, missions, strategic plans) to bolster and legitimize local efforts. Prepare business case/economic arguments for health equity action. 	
	PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS	<ul style="list-style-type: none"> Share tacit knowledge to: <ul style="list-style-type: none"> » support sustained public health effort through government and commitment changes; and » create approaches and messages that emphasize benefits of health equity, regardless of audience orientation or context. 	

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<p>15. Eroding public health resources and independence, which is partially associated with health system consolidation and integration of public health into health system structures</p>	<p>RESEARCHERS</p>	<ul style="list-style-type: none"> • Advocate for increased funding for public health system research. 	<ul style="list-style-type: none"> • Selected health system impact fellows⁵² developing population health policy approaches for health care system application • Health equity specialist roles within selected health units, health authorities and ministries • Building a culture of equity in Canadian public health: An environmental scan¹⁵ (NCCDH)
	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Advocate for increased funding for public health system research. • Look for opportunities to build health equity into new governance structures (e.g., health authorities): <ul style="list-style-type: none"> » Set targets to decrease barriers to accessing health services for marginalized groups » Collect socio-demographic data at acute care intake to identify social determinant issues. • Include people with lived experience on local/regional advisory boards and councils. • Explore Indigenous governance principles within organizational change strategies and leadership. 	
<p>16. Less than optimal diversity among the public health workforce</p>	<p>POLICY-MAKERS AND GOVERNMENT DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Set targets and design/implement change strategies to include representation of racial, ethnocultural, Indigenous and gender/sex considerations in senior positions and those with lived experience. 	<ul style="list-style-type: none"> • Race-explicit strategies for workforce equity in healthcare and IT⁵³ (Race Forward) • Interim Toronto action plan to confront anti-black racism⁵⁴ (City of Toronto)
	<p>PUBLIC HEALTH PRACTITIONERS AND DECISION-MAKERS</p>	<ul style="list-style-type: none"> • Support recruitment and retention of racially, ethnoculturally, linguistically and gender-diverse staff in the public health workforce. • Develop inclusionary model to foster investment in community competency building and interest in public health as an agent and catalyst for sustainable change. 	

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