National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

BUILDING A CULTURE OF EQUITY IN CANADIAN PUBLIC HEALTH: ENVIRONMENTAL SCAN 2018

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

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Advisory group members

- Louis Sorin, Consultant (For much of the period during which this scan was undertaken, Louis was CEO of End Homelessness Winnipeg)
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1. EXECUTIVE SUMMARY

This report is the third environmental scan undertaken by the National Collaborating Centre for Determinants of Health (NCCDH) since 2010. It is focused on responding to concerns about the significant decline in commitment to public health programs and services that has occurred over the past 3–5 years in the Canadian health sector. This scan explores the implications for the public health sector in undertaking effective action to address the social determinants of health and improve health equity.
In order to assess the aforementioned trajectory, we pursued answers to the following questions:

1. How is the erosion of resources and independence for public health structures and leadership within the Canadian health system affecting action to advance health equity?
2. What impact does this organizational context have on the way public health and health system leaders perceive and support action on the issue of health equity?
3. Within this organizational environment, where can the strategies and opportunities to support health equity as a key value and way of working be found?

Primary data collection included a roundtable discussion, individual interviews and a focus group, engaging a total of 46 public health and health system leaders. Participants included front-line health equity champions and public health and health system leaders from across Canada, as well as international experts. We also did a search for relevant health equity and public health literature published since the previous scan in 2014.

Erosion of public health resources and independence

What we heard from public health and health sector leaders was that public health work in Canada, generally — and on health equity, specifically — has been affected profoundly by four main trends contributing to the erosion of public health resources and independence: integration, consolidation, budget cuts and standardization.

The key informants confirmed that there is a need for improved evaluation of structural and program changes in the health sector that impact public health services so that we can better understand impacts of these changes on health equity. There is also a serious lack of peer-reviewed literature from the implementation sciences to assist with understanding and assessing the impact of integration, consolidation, budget cuts and standardization.

Public health and health sector leadership

We asked about how the erosion of public health resources and independence is impacting leadership for action to improve health equity. Key informants responded to this question by focusing on three different areas:

- The impact of how public health programs and services are managed
- The types of programs and services that are prioritized to improve equity of health outcomes
- The leadership qualities most likely to result in actions to improve health equity

Key informants tended to focus on individual leadership and how public health action can drive change at multiple levels. However, the connection between the role of individual leadership in supporting organizational leadership at all levels (and vice versa) by public health (and the health system more broadly) was not clearly articulated. This same gap can be found in the literature, where what exists on public health leadership to improve health equity tends to focus on the attributes of individual leaders, rather than the organizations and systems in which they work.

It seems that individual leadership is resulting in upstream action to improve health equity in those places where specific senior leaders see an organizational leadership role for public health and the wider health system. This results in a wider scope of action that includes increasing equitable access to health services, as well as focusing on tearing down structural barriers to health equity.

Emerging organizational strategies and opportunities

Key informants talked about how equity of outcomes at a population and sub-population level tends to be the mandate of public health programs and services. However, they reported that there is reluctance to define this work as mandatory, to identify standards for this work or to resource it appropriately.

Opportunities and challenges for implementing health equity as a key value within this context were identified in three different areas: within public health organizations, across the wider health system and with partners outside the health system. The key informants told us that the values that inform change processes across all of these areas are critical to the outcome. Building a culture of equity within the public health sector and the wider health system is essential if we want to achieve equity in health outcomes for all Canadians.

Resources for action

To that end, we revisited the four public health roles to address health equity as per the NCCDH environmental scan from 2010.[1] While doing this, we further explored the question of which resources are essential for undertaking these roles and could be harnessed for organizational and system development. The resulting framework uses what we have termed ***resources for action*** *to bridge public health action* (the four roles) and *organizational and community change processes* focused on supporting health equity. The resources for action provide the information and tools that public health practitioners need to fulfill the four roles and build a culture of equity:

- **Leadership:** Formal leadership and systems leadership (transformational)
- **Evidence:** Research and evaluation to guide decision-making
- **Communication:** To frame, educate and inform internally and externally
- **Training:** Skill development and partnership development

Five **action areas** for building organizational and leadership capacity to improve health equity in the context of the current health system are distilled from the findings. These recommendations are as follows:

1. Incorporate health equity as a foundational value for the health system.
2. Support a values-reflection process for leaders.
3. Prepare public health leaders to advocate for health equity work across the health system.
4. Support the use of an equity lens in evidence-based decision-making.
5. Support grounded community engagement as a foundation for health equity work.

Building a culture of equity

The potential strategies described under each action area above have been selected to align with the knowledge translation role of the NCCDH. However, each action area and resource for action is equally applicable across public health and the wider health system at all levels (local, provincial/territorial, national). Ultimately, our priority is to contribute to a culture of equity within public health, the wider health system and the community. To drive the transformational change necessary to achieve our health equity objectives for Canadians, we need to strengthen our understanding of the change processes associated with building a culture of equity.

2. INTRODUCTION

The National Collaborating Centre for Determinants of Health (NCCDH) is one of six national collaborating centres (NCCs) for public health in Canada. Established in July 2006 and funded through the Public Health Agency of Canada (PHAC), the NCCDH supports public health practitioners, decision-makers and research partners in their efforts to address the social determinants of health and advance health equity. These goals are achieved through the advancement, translation and sharing of evidence related to health equity and the promotion of networks and knowledge exchange at all levels in the public health community.

This is the third environmental scan undertaken by the NCCDH since 2010. The first two are:

- *Integrating social determinants of health and health equity into Canadian public health practice: Environmental scan 2010*[1]; and
- *Boosting momentum: Applying knowledge to advance health equity.*[2]

The purpose of the NCCDH environmental scan process is to explore the context for public health work undertaken to address the social determinants of health and improve equity in population health outcomes in Canada. What is learned through the scan is used to support and strengthen NCCDH planning and evaluation processes and is intended to serve as a resource for public health decision-makers, practitioners and researchers in Canada as they work to address health inequities.

Each scan cycle focuses on a key aspect or priority issue related to the social determinants of health and health inequities in the work of the public health community. The first scan[1] responded to the challenge that public health practitioners reported in trying to integrate the social determinants of health and health equity work into their practice. The findings of this first scan helped the NCCDH shift focus from supporting action on specific determinants of health towards a more comprehensive approach to building public health capacity to address health inequities. It also resulted in the identification and validation of four key roles for public health organizations and practitioners to reduce health inequities.[3]

The second scan[2] was undertaken during a time of significant government cutbacks, where both the NCCs and public health service providers were challenged to do more with less. The focus of this second scan was on the growing but variable interest and leadership from public health related to addressing health inequities and how to harness existing momentum. The key recommendations from the 2014 report[2] identified approaches to increase and leverage public health capacity, including support for leadership commitments, engagement of partners, development of individual skills and competencies, and facilitation of difficult conversations to lead critical reflection on complex questions and challenges.

Environmental scan 2017–2018

The 2017–2018 scan is focused on responding to concerns about the significant decline in commitment to public health programs and services that has occurred over the past 3–5 years in the Canadian health sector. As governments and health authorities restructure in their struggle to cut spending and increase efficiencies in the health sector overall,[4,5] public health service providers have felt the impact of eroding resources and independence. Some articles published in Canadian and international journals describe the public health sector as being significantly weakened, and even "under siege."[6] There are significant concerns that this shift will jeopardize population health and the sustainability of the health system.[7-9] The decline in organizational and leadership capacity to address public health priorities is also expected to have a negative impact on meaningful action on health inequities by public health and the broader health sector.

The organizational environment for public health in Canada has been one of significant change as governments struggle to bring healthcare costs under control while also improving both quality of care and population health outcomes. The "Triple Aim" of "better health, better care and better value" has been a guiding framework in the acute care sector for some time. In their review of regionalization in Canada, Bergevin et al[4] cite several sources arguing that the process of healthcare regionalization in Canada over the past 20 years has been undertaken to achieve the Triple Aim. However, Bergevin et al conclude that the results relating to the population health objective of "better health" have been partial, variable and with insufficient evidence to attribute any perceived improvement to regionalization specifically.

This scan is focused on exploring this context and the implications for the public health sector in undertaking effective action to address the social determinants of health and improve health equity.[a] It is guided by research questions that were developed[b] and refined to intentionally focus on organizational capacity, governance and leadership for public health action to address health inequities. These questions are as follows:

1. How is the erosion of resources and independence for public health structures and leadership within the Canadian health system affecting action to advance health equity?
2. What impact does this organizational context have on the way public health and health system leaders perceive and support action on the issue of health equity?
3. Within this organizational environment, where can the strategies and opportunities to support health equity as a key value and way of working be found?

Limitations

Although it would have been interesting to explore the evolution and impact of regionalization on public health and population health outcomes broadly across Canada, it was beyond the scope of the project. The lack of Canadian research in this area, and the limited time and resources available to undertake this scan, contributed to this decision. As a result, the opportunities and challenges identified in this scan are focused on actions to address health inequities within the current public health context. Recommendations have not been made with respect to organizational restructuring or areas for increased funding. It is expected that the findings of this scan will help to inform decisions being made in these areas.

[a] See the glossary in **Appendix 1** for our definition of *health equity* and other key terms used throughout this scan.
[b] See the preliminary research questions in **Appendix 2**.

3. APPROACH AND METHODOLOGY

As was the case for the 2010 and 2014 scans undertaken by the NCCDH, capturing the experience of public health practitioners is central to understanding the challenges and opportunities for undertaking work within the public health sector to address the social determinants of health and improve health equity. Early in the process, speaking to formal (positional) leaders within the public health sector and the broader health system was identified as a critical task; however, this definition of leadership is insufficient to understand leadership for health equity work. Health equity work is both a *service delivery* process associated with ensuring equitable access to care and a *social change* process focused on upstream action such as the development and implementation of healthy public policy. Leadership in this context requires that leaders be understood as embedded in a complex, adaptive system and not necessarily in formal leadership positions. This type of leadership can emerge at every level within the system.[10]

As a result, resources were dedicated to conversations with key informants at a variety of levels, positions and settings (including public health researchers) via interviews, a roundtable conversation and a focus group. This was supported by a literature review to capture essential reports and research published in English and French since the previous environmental scan.

Advisory group, staff and contractors

The project was guided by an Advisory Group and undertaken using NCCDH staff and two external contractors.

The Advisory Group[c] was made up of health equity champions, including a mix of public health decision-makers, academics and allies from across Canada. It was established to guide the implementation of the environmental scan and analysis of findings, including the development and refinement of the research questions, selection of the contractor, identification of key informants, recommendation of relevant literature and review of the draft report.

NCCDH staff members coordinated the request for proposals process to find and select a contractor to undertake the data collection and analysis and draft the report. This included the identification and selection of key informants. NCCDH staff members also carried out the English literature review and sub-contracted the French literature review.

There were two external contractors engaged in writing the report. The first contractor, Ken Hoffman, helped revise the research questions and undertook the primary data collection through a roundtable conversation, interviews and a focus group. Themes were developed based on analysis of the data and a draft report was prepared. The second contractor, Lesley Dyck, a former NCCDH employee, incorporated the results of the literature review, reframed the findings and created a revised report. This version was sent to an external reviewer for validation and the feedback was incorporated into the final version.

[c] See **Appendix 3** for a list of Advisory Group members.

Primary data collection

Data was collected from public health leaders engaged in practice at a variety of levels, positions and settings, including public health researchers. NCCDH staff members and the Advisory Group identified a selection of leaders who met the following criteria:

- Representative of all geographic regions of Canada, balancing urban, rural and remote perspectives as well as language and culture (Anglophone, Francophone)
- Holding formal leadership roles in the public health sector or the broader health sector, or holding academic/researcher roles. These representatives intentionally included those with a public health background and those with a non-public health background, those who have system-wide authority and those who have more limited influence, and those who identify as health equity champions and those who do not.

The selection of participants was not intended to be a comprehensive survey of practices or conditions across Canada but a sampling of leadership perspectives. The NCCDH issued invitations to the key informants for the roundtable discussion, interviews and focus group. All were facilitated primarily by the first consultant. The NCCDH was very successful in reaching the targeted leadership: 95% of the individuals contacted either participated or arranged for a substitute.

Three different methods were used to collect primary data between June and August 2017, engaging a total of 46 participants:

1. ROUNDTABLE DISCUSSION[d]
    - Participants: 15 participants (9 NCCDH staff members, 6 national/international practitioners who would describe themselves as "health equity champions")
    - Purpose: This discussion took advantage of the Canadian Public Health Association conference (Halifax, June 2017) to convene a roundtable conversation with national and international health equity champions. The purpose was to host a strategic, high-level conversation about the current situation of health equity in Canadian public health and the strategic role that the NCCDH could play in advancing this agenda in the current context.

2. KEY INFORMANT INTERVIEWS[e]
    - Participants: 21 participants (13 public health leaders, 4 health system leaders, 4 researchers)
    - Purpose: The goal for these interviews was to get a sense of how people in leadership positions in public health organizations and health system organizations (health authorities/ministries) viewed and acted on the issue of health equity. Researchers whose work focuses on public health system and health equity leadership were interviewed to get a sense of the current state of research in this area.

[d] See **Appendix 4** for a detailed description of the data collection process.
[e] See **Appendix 5** for a detailed description of the data collection process.

3. FOCUS GROUP[f]

- Participants: 7 participants from the NCCDH Health Equity Collaborative Network (5 from Ontario, 1 each from Alberta and Manitoba)
- Purpose: The purpose of this conversation was to seek the perspective of public health practitioners who are actively engaged in front-line health equity work.

All participants were assured that they would not be individually identified in the findings unless they granted permission for the use of specific quotes.

Literature review

A literature review was undertaken in both French and English.[9] The NCCDH conducted a general search of published and grey literature in English to determine what had been published since the literature review done for the environmental scan in 2014.[2] Search terms included a combination of public health with the following terms (and related variations):

- inequity
- inequality
- disparity
- equity
- equality
- determinant

Only 20 documents were identified as relevant in English, and all were previously known to NCCDH staff members. Five of these articles are also available in French. The search was repeated in French with only 7 documents identified as relevant, 2 of which are also available in English.

Analysis and validation

The contractor responsible for primary data collection developed themes based on the results of the roundtable discussion, key informant interviews and focus group. These were reviewed and discussed with NCCDH staff members as part of a review of the preliminary report. Key informants were not invited to validate the themes.

The second contractor incorporated the results of the literature review and reframed the findings and themes. The report was provided to the Advisory Group for feedback and revised again. This version was sent to a senior public health leader for external validation. The feedback from the validation process was incorporated into the final version.

[f] See **Appendix 6** for a detailed description of the data collection process.
[9] See **Appendix 7** for a detailed summary of the search strategy and a complete list of the documents identified as relevant.

4. FINDINGS

The findings section draws on the responses from the roundtable discussion, interviews with public health and health system leaders and focus group; it also references the review of health equity and health system literature published between 2013 and 2017. We would like to emphasize that the primary data should not be interpreted as a definitive survey of what is happening in jurisdictions across the country.

The findings are discussed in three sections, each corresponding to one of the three research questions identified on page 14. Within each section, themes are identified and discussed with reference to opportunities and challenges for public health action to improve health equity.

4.1 Erosion of public health resources and independence

The first research question explored how the organizational context of public health work in Canada is affecting action on the social determinants of health and efforts to reduce health inequities. We wanted to discern the following:

Q1. How is the erosion of resources and independence for public health structures and leadership within the Canadian health system affecting action to advance health equity?

What we heard from public health and health sector leaders was that public health work in Canada — both generally and on health equity, specifically — has been affected profoundly by four main trends contributing to the erosion of public health resources and independence: integration, consolidation, budget cuts and standardization.

Integration

The key informants told us they have observed public health structures across the country that are being integrated more and more with the rest of the health system. In most jurisdictions, there has been an organizational integration, with public health functions being integrated into health authorities that are responsible for the gamut of health services, usually extending from home and community care (and sometimes primary care) to acute and long-term care. These health authorities have a single governance structure that is responsible for all services provided, managed by a chief executive officer and a senior management team. Formal public health leadership is commonly provided by a public health physician who may be a part of the senior management team.

A notable exception to this structure is Ontario, where public health units are governed by boards of health and include a mix of elected and appointed members. The CEO in Ontario health units is the medical officer of health, and the senior leadership team consists of public health practitioners in management roles. Even in Ontario, however, there is a move toward increased alignment and integration between public health and the rest of the health system through the Local Health Integration Networks (LHINs). A 2017 paper[11] proposes that the boundaries of existing public health units be realigned to match the LHIN geographic boundaries.

Although there are a number of ways to structure and define public health functions, programs and services, they are generally organized around six core public health functions:[12]

1. Health protection
2. Health surveillance
3. Disease and injury prevention
4. Population health assessment
5. Health promotion
6. Emergency preparedness and response[h]

These roles are undertaken at all levels — regionally (largely by Health authorities), provincially/territorially (by Ministries of Health) and federally (by PHAC). The roles are supported by legislation at each level in ways that are unique to public health decision-making in comparison to the other parts of the health system. For example, the position of medical officer of health (MOH) (sometimes referred to as medical health officer, or MHO) and, to some extent, public health physicians, is required by legislation to identify and speak out regarding risks or threats to the health of the population. The authority of this position is protected under the law to ensure that the MOH/MHO can provide independent advice.

The decentralized structure of the health system in Canada, however, means that public health roles and legislation are not consistent across jurisdictions.[4,5] The key informants confirmed this assessment, reporting that the various interpretations and integrations of public health roles across Canada have resulted in the fragmentation of public health service delivery. On the one hand, the public health roles of surveillance and protection (particularly related to communicable disease control and environmental health) have tended to retain their independence from other health-sector programs. They continue to be directed by public health practitioners, primarily physicians and epidemiologists. In comparison, public health programs associated with disease and injury prevention and health promotion (including early years programs) have tended to be integrated with community-based programs such as primary care, mental health, home care and chronic disease management.

The result has been a fracturing of traditional public health services (e.g., communicable disease programs being separated from chronic disease programs) and increased sharing (integration) of the management structure for health promotion and primary care services (e.g., early years programs). According to the key informants, the impact on public health services — and action to address the social determinants of health and improve health equity, specifically — has been variable. In a couple of jurisdictions (British Columbia and Alberta) there has been some absorption of public health staff (primarily public health nurses) into the workforce of the health authority as they have moved to a generalist nursing model. Some key informants raised concerns that the use and maintenance of core competencies in public health[13] and public health nursing[14] are not being adequately developed and supported in this structure.

[h] For a more detailed description of each role, see **Appendix 7**.

> Although the integration of public health means that it is theoretically in a position to influence the health system, the fact is … it is a very small department, accounting for only about 3–4% of the budget of the [organization].
>
> KEY INFORMANT, PUBLIC HEALTH

Consolidation

As noted earlier, health system structures in Canada look different across jurisdictions. However, there has been a national trend towards greater consolidation of health service organizations,[2,4,5] seen in how the number of organizations responsible for the delivery of health services has shrunk steadily over the past 20 years. Several provinces and one territory (Alberta, Saskatchewan, Prince Edward Island, Nova Scotia and Northwest Territories) have each consolidated what were once multiple, smaller structures into province-/territory-wide health authorities.

The impact of consolidation has varied depending on the aspect of public health service involved. Core public health functions such as epidemiology and surveillance have often been centralized, which, according to some interviewees, has been an advantage since smaller or more remote health authorities previously had limited capacity, resulting in difficulty in filling positions. On the other hand, centralization has created challenges when it comes to providing programs and services tailored and responsive to local contexts. Some of the key informants noted that, in some health authorities, the response to centralization has been the creation of service delivery zones or regions to support a decentralized approach. This raises questions about the implications of creating an artificial separation between public health practitioners who deliver programs to clients at the zone level and those who focus on policy and population interventions and decision-making at the provincial/territorial level. The result is an inconsistent and fragmented approach to using policy levers at local and regional levels that is especially problematic for effective system change approaches to the social determinants of health.

As noted above, integration and consolidation have had a significant impact, both positive and negative, on the context for public health service delivery over the past 20 years. However, public health and health sector leaders noted that it is the combination of these structural changes — along with budget cuts and increased standardization of programs and services — that may have had the most significant impact on public health action to improve health equity.

Budget cuts

The key informants noted that two jurisdictions (Quebec and New Brunswick) have recently experienced significant cuts to public health services, and that significant cuts are being considered in at least one other (Manitoba). This prompts reflection regarding what priorities are guiding the cuts both within public health and in the wider health sector. Unfortunately, there is limited peer-reviewed literature to assist with understanding and assessing the implications of this observation.

Standardization

Along with budget cuts, several key informants mentioned a corresponding trend towards standardization of public health services, possibly as a way to manage with fewer resources. Their concern is that, when programs and services are often required to look the same and be delivered in the same way across a jurisdiction, there is less room for innovation and tailoring to meet the needs of local communities. This situation directly challenges the public health principle of targeting within universalism (also known as *proportionate universality*) where interventions are adapted to ensure marginalized groups are not disproportionately or negatively impacted by universal programs.

In summary, the key informants confirmed that the current emphasis on efficiency in the organizational environment is likely having a detrimental influence on the effectiveness of core public health roles and actions, and health equity work in particular. In order to better understand the impact of such a system on health equity, there is a need for improved evaluation within the health sector related to structural and program changes that impact public health services. As noted earlier, there is also limited peer-reviewed literature from the implementation sciences to assist with understanding and assessing the impact of integration, consolidation, budget cuts and standardization.

4.2 Public health and health sector leadership

The second research question focused on how the erosion of public health resources and independence is impacting leadership for action to improve health equity:

Q2. What impact does this organizational context have on the way public health and health system leaders perceive and support action on the issue of health equity?

Key informants responded to this question by focusing on three different areas, described in greater detail in the paragraphs that follow:

- The impact of how public health programs and services are managed
- The types of programs and services that are prioritized to improve equity of health outcomes
- The leadership qualities most likely to result in actions to improve health equity

Management of public health programs and services

Interviewees were asked to describe the roles of senior public health leaders in the context in which they worked. They reported that in health authorities, MHOs/MOHs are generally in charge of epidemiology, disease surveillance and communicable disease control. MHOs/MOHs also sit as members of the senior management teams of their health authorities. Outside of surveillance and communicable disease control roles, the level of authority and management responsibility varies; some MHOs/MOHs have departmental management authority while others serve as specialists or consultants; some health authorities used dyad management models where public health physicians serve as specialists and/or consultants alongside administrative managers.

Key informants provided positive and negative examples of these different management structures, elaborating on the structures' impact on the development and delivery of interventions to address health inequities. There was general concern, however, that without formal public health leadership guiding all of the public health roles within the organization, there is a risk that non-clinical interventions to improve population health, including those that focus on health equity, are not prioritized. The result of such action, it was expressed, may be the chance of such strategies being implicitly dropped from the mandate of the organization.

> Our public health nurses used to be working a lot more with communities. Now, with the cuts, there is a lot more focus on core program areas like immunization and much less flexibility to actually work with communities on broader issues.
>
> KEY INFORMANT, PUBLIC HEALTH

Prioritized programs and services to improve equity of health outcomes

We asked key informants to describe examples of how their organization had acted to address the issue of health equity; the goal was to get a sense of how they interpret appropriate health sector action in this area. All participants reported that their work is informed by a population health approach and that health equity is an important consideration. However, the way in which they target health inequities and work to improve health equity varies considerably.

Key informants spoke of equity action in two ways: an individual focus on equity of access to services and supports, and a more systemic focus on the equity of health outcomes for populations. Data collected from the interviews showed that all participants were able to identify examples of actions that their organizations had taken to improve equitable access to services, including the integration of equity into population health status reporting indicators that are used to guide service planning and evaluation.

Examples of population health status reporting being used as a strategy to take action to address health inequities included:

- surveillance and mapping to identify groups adversely affected (e.g., disaggregating data by gender, ethnicity, Indigeneity, racialization);
- incorporation of health equity themes into population health status reporting (e.g., identifying structural and systemic causes of differences in health status between groups);
- better communication and sharing of data (e.g., interactive maps to identify marginalized populations); and
- collaboration with other stakeholders concerned with equity issues on data collection, sharing and analysis (e.g., the Pan-Canadian Health Inequity Reporting Initiative).

EXAMPLES OF INTERVENTIONS INTENDED TO SUPPORT INDIVIDUAL ACCESS TO SERVICES:
Many of the interviewees mentioned initiatives or strategies their organizations have developed to ensure that individual clients are connected to the supports and services they need, including:

- assessment and referral to appropriate services (often led by public health nurses in expanded roles);
- assistance when accessing social benefits (e.g., family supports, tax benefits, etc.);
- initiatives to, according to participants, "eliminate silos from service delivery," ensure that "any door is the right door" to accessing services (often between programs such as public health, primary care, mental health and social services) and "[make] sure people don't fall through the cracks in the system";
- capacity-building initiatives for individuals from marginalized groups (e.g., how to access food banks, shopping for healthy food on a low budget); and
- population health status reporting (e.g., disaggregating data by gender, ethnicity, Indigeneity, racialization).

Some informants identified having used population health status reporting to measure and draw attention to systemic causes of health inequities. Fewer than half (7 of 18) of the public health and health system leaders interviewed for this scan were able to identify any other actions their organization had undertaken to address structural barriers to health equity. For example, only a few respondents were able to point to instances where their organization is working to support actions such as strengthening local food systems, improving access to affordable child care and housing, and promoting anti-poverty initiatives such as living wage campaigns.

EXAMPLES OF INTERVENTIONS INTENDED TO DRIVE STRUCTURAL CHANGE:
A few interviewees offered examples of when their organizations have taken systemic approaches to address health equity, including:

- use of a health equity lens in the process of critical reflection and rethinking the design of programs (e.g., redesigning tobacco control programs for Indigenous communities);
- increasing the scope of public health nursing practice to allow more latitude in how programs are delivered, how much support clients receive and what kind of support is available (following the principle of proportionate universality in the approach to program delivery);
- systemic approaches and structures that strengthen effective, cross-sector collaboration (e.g., health, social services, education, government, not-for-profit) to support groups of clients (e.g., youth) or to address specific issues (e.g., early child development);
- a strengthened, multidisciplinary team approach (especially between public health, mental health and primary care); and
- active participation and leadership in structural and system change initiatives such as poverty reduction and food security.

Lack of evidence was reported as a significant barrier in relation to the ability of public health practitioners to prioritize health equity action. Some interviewees stated that the evidence base for interventions simply was not available to them or that it was not substantial enough for them to act. This was especially in comparison to the evidence for action on communicable disease.

> Public health is generally much better at the 'diagnosis' of health inequities than at identifying the 'cure' for how to address them.
>
> KEY INFORMANT, PUBLIC HEALTH

> In communicable disease, the diagnosis is the challenging part and the cure is relatively straightforward. Health equity is just the opposite: It is relatively easy to identify where inequities are occurring, but what to do to address them is a complicated question.
>
> KEY INFORMANT, PUBLIC HEALTH

The consistency of equity being integrated into population health status reporting and the focus on equity of access to programs and services both give cause for optimism. At the same time, there is a lack of engagement on structural equity issues reported by most of the respondents. This prioritization of individual access to services over interventions that address root causes, both in practice and in research, reinforces concern about whether there is a clear public health mandate to improve health equity at the population level, as well as whether there is sufficient action to do so.

Individual and organizational leadership qualities

Some of the key informants viewed social determinants and health equity as being absolutely central to the work of public health. Some of them report bringing a high level of motivation, skill and commitment to creating the partnerships and securing the resources to take action at a systemic level. Others viewed health equity as not being "core" or mandated work and report being much less certain about the role that public health could play to address social determinants. These practitioners focused primarily at the individual level to reduce barriers to accessing services.

The key informants who reported acting at a systems level demonstrated common individual leadership qualities:

- A personal commitment to the issue (sometimes describing themselves as coming from a "social justice background")
- A clear sense of health equity as a "legitimate" public health issue
- Skills for effectively communicating equity issues to others in terms that are meaningful to these other parties and garner their support

These informants also reported being able to negotiate successfully for resources within their organizations.

TOOLS FOR DEVELOPING PUBLIC HEALTH LEADERSHIP

In her dissertation on public health leadership to advance health equity, Betker[10(p160)] identifies seven categories of tools, strategies and mechanisms from the literature to support or develop public health leadership:

- Supportive processes, structures and models
- Access to relevant and usable evidence
- Institutionalized, equity-informed policy and program development, implementation and evaluation
- Public health workforce and practice development
- Active and facilitated discourse about values, ethics and political activity
- Equity-informed quality improvement, evaluation and accreditation
- Relevant conceptual and theoretical frameworks

Understanding leadership from an organizational perspective did not emerge as strongly from the data. There was recognition that public health action can collectively drive change at multiple levels:

> Public health can address health equity at three levels: strategic, tactical and operational. At the strategic level it can advocate for policy change. At the tactical level it can help to mobilize its partners. And at the operational level public health can adjust its own services to decrease barriers to clients.
>
> KEY INFORMANT, PUBLIC HEALTH

However, the connection between the role of individual leadership in supporting organizational leadership at all levels (and vice versa) by public health (and the health system more broadly) was not clearly articulated. This same gap can be found in the literature, where the research that exists on public health leadership to improve health equity tends to focus on the attributes of individual leaders, rather than the organizations and systems in which they work. But as Betker notes:

> Public health leadership to advance health equity occurs at multiple systems levels simultaneously. In other words, public health leadership occurs at the local community level, the organizational level and at a societal level concurrently.[10(p173)]

It seems that individual leadership is resulting in upstream action to improve health equity in those places where senior leaders see an organizational leadership role for public health and the wider health system. This results in a wider scope of action that includes increasing equitable access to health services while also focusing on tearing down structural barriers to health equity.

4.3 Emerging organizational strategies and opportunities

Key informants for this scan were asked to help identify approaches that are showing promise for improving health equity in the current context of eroding public health resources and leadership. We wanted to know the following:

Q3. Within this organizational environment, where can the strategies and opportunities to support health equity as a key value and way of working be found?

Improved population health is a generally accepted objective of the health system at all levels — federally, provincially and territorially. As noted earlier, most jurisdictions have adopted improved population health as part of the Triple Aim and an expected outcome of regionalization.[4] However, as Bergevin et al note, the healthcare system has a limited impact on health outcomes at the population level[4] and, as a result, the equity focus tends to be on equity of access to care. This was reinforced by the key informants who noted that equity is sometimes mentioned in mission statements and strategic plans but is most often interpreted as equity of access to services.

Equity of outcomes at a population and sub-population level tends to be the mandate of public health programs and services. However, there is reluctance to define this work as mandatory, to identify standards for this work or to resource it appropriately. Key informants reported that only Ontario has included health equity in its provincial public health standards.[15] Other provinces have either not mandated health equity as a prescribed outcome or have included it in guidelines but not standards (see *Promote, protect, prevent: Our health begins here: BC's guiding framework for public health*[16] for an example). This approach results in limited accountability measures or indicators for action on health equity.

> What are the expectations of public health to address health equity? The expectations are where the money is attached. We are accountable for health protection, communicable disease prevention, but not for health equity. We are not expected to be advocates for health equity or healthy public policy.
>
> KEY INFORMANT, PUBLIC HEALTH

Capacity was identified by the key informants as a significant challenge to health equity work. Capacity was referenced in two ways:

- **A lack of resources to do the work in question:** Most interviewees interpreted health equity as an "added extra" responsibility on top of regular public health programs; it was seen to be in competition for other public health (and health authority) resources, and usually seen to be a lower priority that could be delayed indeterminately.
- **A lack of specific skilled human resources and a lack of support to develop further:** This was most often mentioned as a difficulty in attracting and keeping public health physicians or epidemiologists, especially in rural or remote settings.

The researchers interviewed for this scan observed that the approach to supporting health equity work in public health has tended to focus on the development of specific, individual skill sets and competencies. They make the point, however, that capacity-building also needs to be anchored in organizational values and a supportive culture. In public health, an orientation to service delivery alone can result in good program delivery, but not necessarily a critical analysis of whether the programs are actually addressing health equity issues. The informants emphasized that this comes from engaging the community and working together in a process of reflection and review.

It should be noted, however, that there are reasons to be optimistic. Interviewees mentioned that recent policy direction around "diversity and inclusion" in at least two jurisdictions (Ontario and Manitoba) has been helpful in providing support for health equity work. At the same time, the work of the Truth and Reconciliation Commission[17] and its Calls to Action are stimulating attention and action to address Indigenous-specific inequities.

Opportunities and challenges for implementation

Within this context, the key informants identified a number of opportunities and challenges for implementing health equity as a key value in three different contexts:

- Within public health organizations
- Across the wider health system
- With partners outside the health system

I. IMPLEMENTING HEALTH EQUITY IN PUBLIC HEALTH ORGANIZATIONS

A number of public health organizations have already prioritized health equity at the organizational level. Doing this work involves applying a health equity lens to program assessment, as well as reflecting on the causes of health inequalities and how programs and public health roles across the board could more effectively address health equity issues at an individual and systemic level. The key informants noted that in such organizations, health equity is not viewed as a program or an additional activity but rather as a "way of working." These organizations demonstrate a clear sense of organizational direction and commitment, and there tends to be some staff providing support at an organizational level to assist program staff in review and assessment processes.

> We initially reorganized health promotion to make health equity the major framing for their work. Now we expect all public health departments to use this framing for their work.
>
> KEY INFORMANT, PUBLIC HEALTH

However, the key informants also noted that the dominant approach within public health organizations is to limit equity work to specific program areas, usually those related to health promotion. These programs are sometimes reviewed to examine how they could incorporate a health equity approach, resulting in program modifications and sometimes a revision of job descriptions. Where staff with a special role to work on health equity issues exist, such positions are generally placed within the aforementioned program areas.

One area where public health organizations appear to be integrating equity across the board is in population health status reporting. The key informants noted that reporting has been identified as key to equity work since it provides a foundation for evidence-based decisions and strategies. Ultimately, it seems that the direction taken by public health organizations is largely dependent on how the issue of health equity/inequity is understood and operationalized by senior leadership.

A number of opportunities for supporting public health leadership on equity issues emerged from the interviews with public health and health sector leaders:

- **Create opportunities to learn from each other:** Explore which approaches are being used across the public health system and the benefits/challenges of each.
- **Take advantage of the consolidation of resources** into larger health authorities to strengthen regional equity data and develop provincial approaches to issues such as poverty, housing and racism.
- **Look for opportunities to build health equity into new governance structures** as they are developed.
- **Find ways to include people with lived experience** in local/regional advisory boards or councils as they are being developed. These individuals can provide advice on local issues and ensure health equity is built into the role of these structures.

Respondents also identified a series of inherent challenges in health equity work that public health leaders should be mindful of when implementing such strategies:

- **Program standardization and improved efficiency is the mantra of health system reform:** According to the interviewees, this process has resulted in fewer opportunities to tailor and adapt programs to address special needs and conditions at the community or individual level. In some cases, funding is tied to performance (service delivery) targets. This approach has also made it politically difficult to get support for both a targeted approach and prioritized delivery of public health programming to marginalized populations.
- **Lack of understanding and commitment to core values that support system/structural change for equitable health outcomes:** Because social determinants lie outside the direct control of the health system, there continues to be debate about the role(s) that public health play(s). In the wider health system, this contributes to a sense that influencing social determinants should not be a service delivery priority. Interviewees told us that the limited amount of power and resources that public health has within health systems makes it challenging to advocate for health equity and system change as a public health mandate. This situation also influences the availability of time and resources to public health practitioners to do work on health equity issues, as the work is seen as "extra" and beyond core public health programs.

- **Community engagement is increasingly disconnected from core public health work:** The interviewees told us that the increasing centralization of public health work has resulted in public health practitioners finding themselves more and more removed from the communities they serve. This is true at both the governance and staff levels and can result in less of an incentive to be accountable and responsive to local communities for issues such as health equity. This is further reinforced by an increase in "specialist" roles, which has the impact of decreasing roles where public health practitioners engage in and develop relationships with the community.
- **Lack of equity-sensitive data:** Interviewees noted that there is a need for better indicators to report on and measure progress on health equity. Such indicators could help depoliticize this work and help support conversation about equity from a non-partisan perspective. It could also help provide evidence on the impact of cutbacks in public health, a shift that has gone largely unnoticed by the general public and makes public health politically vulnerable to further cuts.

II. IMPLEMENTING HEALTH EQUITY ACROSS THE HEALTH SYSTEM

As noted earlier, one of the objectives of regionalization within the Canadian health system has been the improvement of population health. By definition, this goal actively seeks the elimination of health inequities between groups. While responsibility for population health falls largely within the public health mandate, primary care and home and community care providers have recognized the importance of improving the accessibility of services for marginalized populations. Interviewees shared examples of how the increased integration of public health with other parts of the health sector has resulted in improved action on equity issues. These examples include initiatives to decrease barriers to accessing health services for many marginalized groups and getting acute care providers to collect sociodemographic data to identify social determinant issues at intake (e.g., the We Ask Because We Care initiative in the Toronto LHIN). The key informants suggested that seeing the impact of social determinants on the clinical outcomes of their clients increases the level of interest in health equity among clinicians.

The notion of drawing attention to the intersection between social determinants and clinical outcomes raises the idea that public health could be a catalyst for helping the broader health system to adopt approaches that recognize and address health equity issues. While many interviewees viewed regionalization and the integration of public health as an opportunity for public health to have greater influence, others were much more skeptical. The opposing view is that amalgamation is a dilution of public health services. Many respondents emphasized that public health represents a very small element of the amalgamated health authorities and therefore carries little weight and influence. Some said that health authority management is not familiar with a population health approach. In addition, instead of being able to make independent decisions about how to prioritize issues and allocate resources, public health now needs to negotiate these decisions with the rest of the health authority, especially for non-mandatory services such as action on structural issues that impact health equity.

> We created a health equity audit tool to look at how to stratify data, then how to engage with the literature, as well as engaging with the patients on their barriers in accessing the system …. We embedded this work in quality improvement processes. We have also found champions in other parts of the system who were already thinking about health equity, worked with them and supported them.
>
> KEY INFORMANT, PUBLIC HEALTH

Although the key informants were divided in their opinions on the matter, there were a number of opportunities identified to help the public health sector build action on health equity across the health sector as a whole:

- **Ensure a senior public health** leader is sitting at the senior leadership table in the health authority. Whether this is an MHO/MOH or an executive with public health responsibilities and competencies, make sure they are supported to participate in key discussions and decisions, and to provide advice on leadership on equity issues and actions.
- **Engage with the quality improvement team** to ensure issues of equity are integrated into quality improvement processes. Several interviewees identified quality improvement as an area where the broader health system is receptive to discussions of health equity, once it is demonstrated how social determinants have an impact on outcomes of health interventions.
- **Support actions to improve access to care**: Although working on individual care issues feels like it is a long way from addressing structural inequity, the interviewees told us that in some health organizations the only way practitioners feel they can address health equity is by dealing with the situation one person at a time. Helping clinicians to recognize systemic barriers and develop strategies using resources inside and outside the health system can be a good starting point for conversations about structural issues.

At the same time, there was a general feeling among interviewees that public health needs to be clearer in its own work to address health equity. Moreover, many said the sector needed to consider how well equity is integrated across core public health roles before trying to bring this approach to other parts of the health system.

> We can't expect other parts of the system to address health equity if we don't do our part.
>
> KEY INFORMANT, PUBLIC HEALTH

III. WORKING WITH OTHER PARTNERS TO ADDRESS HEALTH EQUITY

Although the interviewees shared the perception that it is essential for other sectors to be engaged on social determinant work to improve health equity, there was a range of perceptions relating to the role of public health as a leader/catalyst for this work. Some felt this is an extremely important role for public health.

> The revolution in health equity will not come from public health acting alone but in mobilizing partners to take action.
>
> KEY INFORMANT, PUBLIC HEALTH

> [We need to ask] … how can we add value to what other sectors are doing?
>
> KEY INFORMANT, PUBLIC HEALTH

Others did not see health equity as a core public health responsibility and felt that engaging external partners to address health equity should not be identified as a mandatory program area.

Those interviewees who identified public health leadership in this area as a core responsibility shared several examples of where public health is playing a variety of roles while engaging with other sectors/partners on health equity:

- The Canadian Council on Social Determinants of Health brings together governmental and non-governmental organizations to focus on a national response to health equity priority areas. These include healthy child development and Indigenous cultural competency and well-being.
- In Quebec, there are a series of networks with which public health works through pre-established structures (healthcare, municipalities, NGO/community, schools, preschool/daycare and occupational health)
- Priority equity issues at the local level, such as poverty reduction and food security, provide the organizing structure for public health collaboration in some jurisdictions. Some examples include anti-poverty work at Peterborough Public Health (Ontario) and the partnership work on urban planning and health between Peel Public Health (Ontario) and its municipal council.
- Innovative work is happening in northern/rural areas around encouraging collaboration between government departments and communities to break down silos and develop more coordinated approaches to deliver services and respond to issues. One example would be bringing together the social envelope of health, education, housing, social development, economic development and justice in the Northwest Territories, or also the collaboration between band councils, public health, primary care and mental health services in northern Manitoba.

These examples can help us to identify key elements and areas of opportunity for public health to work across sectors in the community to address health equity, including the following:

- **Partner with non-governmental organizations to undertake advocacy initiatives**: Public health practitioners working within a government-funded system can be politically vulnerable when speaking critically of government policy. Interviewees noted that some governments provide greater freedom to speak out on social change issues than others. By partnering with other organizations, public health can provide information and support, but does not need to be the public face of the advocacy message.
- **Build communication tools to help partners deliver key messages** about the social determinants of health and health equity. How health equity is understood and communicated is key to building a broader base of support for this work. The research informants talked about research that is under way to look at communication and framing tools, such as metaphors to help convey the meaning of health equity more effectively.

Although these opportunities are based on examples of intersectoral work by public health in the community, there are clear challenges for public health to overcome:

- **Underdeveloped skills and limited resources for effective community partnership**: Skills in working collectively, coalition-building, developing partnerships, negotiation and collective impact were identified by interviewees as being very important for supporting action on health equity. Many noted, however, that public health leaders and practitioners are often not adequately trained or supported. Investing time to establish relations with partners for collective work is not seen as a priority in the context of funder demands for "core, operational public health work." The current trend of moving many public health practitioners towards more "specialist" roles has also moved them away from developing broad relationships in the community. As one interviewee noted, "Public health staff are often seen as 'distant experts' rather than 'community partners.'"
- **Moving from diagnosis to action**: One interviewee commented that public health tends to be better at the diagnosis of health equity issues than the prescription of what to do. In part, this is the result of a lack of clarity of the public health role to intervene in complex social determinants issues. Some have attributed this to a lack of intervention research, while others have suggested that the long time horizon for change makes is difficult to measure the results and know if progress is being made.
- **Public health's shift away from municipal structures toward health system structures**: This has been a hallmark of regionalization across Canada and has led to a reduced influence at the municipal level, often in relation to departments such as Planning.

> The SDH discourse is very abstract. It puts public health in an 'expert layer' that nobody really understands. We need to change our language to what resonates with people.
>
> KEY INFORMANT, PUBLIC HEALTH

5. IMPLICATIONS AND OPPORTUNITIES FOR ACTION

The focus of this environmental scan is to describe the impact of changes in organizational and leadership capacity of the Canadian public health system on meaningful action on health inequities. It also aims to look at strategies the public health sector can take to work within this environment.

Public health roles to address health equity

In the 2010 environmental scan,[1] the NCCDH received confirmation from public health practitioners that the four public health roles for advancing health equity identified in the scan are essential for guiding public health action (see **Appendix 8**). The clear "unit of adoption" targeted in the 2010 scan was the public health organization itself. Since that time, the NCCDH developed a stand-alone publication on the four roles[3] and a common agenda[18] to help guide practitioners. In response, a number of public health organizations have used these roles to organize their planning and service delivery.

What we heard from the key informants in this 2017 scan is that while the four roles are still valid, they are being undermined by current health system restructuring at all levels in Canada. Public health organizations may be the unit of adoption for these roles, but they are being severely impacted by the larger organizational structure changes within the health system. Put differently, equity is not being maintained (assuming it was already in place) as a key value in the work of achieving improved population health, improved quality of care and improved value for investment in the health system (as per the Triple Aim).

Building public health leadership and communication skills

In the 2014 environmental scan,[2] we heard about the importance of strengthening public health leadership and communication capacity in support of the four roles, done to boost the momentum of the work that was under way. A particular recommendation from that scan was to facilitate difficult conversations by using "existing forums and emerging networks to lead critical reflection on a number of commonly expressed, often complex, questions and challenges."[2(pvi)] As a result, the NCCDH undertook initiatives focused on supporting leadership and communication skills in a number of areas, including advocacy, upstream allocation of resources, intersectionality, environmental equity and tackling foundational issues such as racism.

What we heard from the key informants in this scan is that the conversation — which is essentially a conversation about values — needs to extend beyond the public health community and engage the wider health sector to support a culture of equity. This was also a key message in the *Common agenda for public health action on health equity*,[18] under the build a foundation for action theme. In fact, based on the findings of this scan, we should be concerned that the foundation for action on health equity is in jeopardy. According to the key informants, all three of the elements within the foundation for action[18(p17)] are under threat within the context of the Canadian health sector:

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

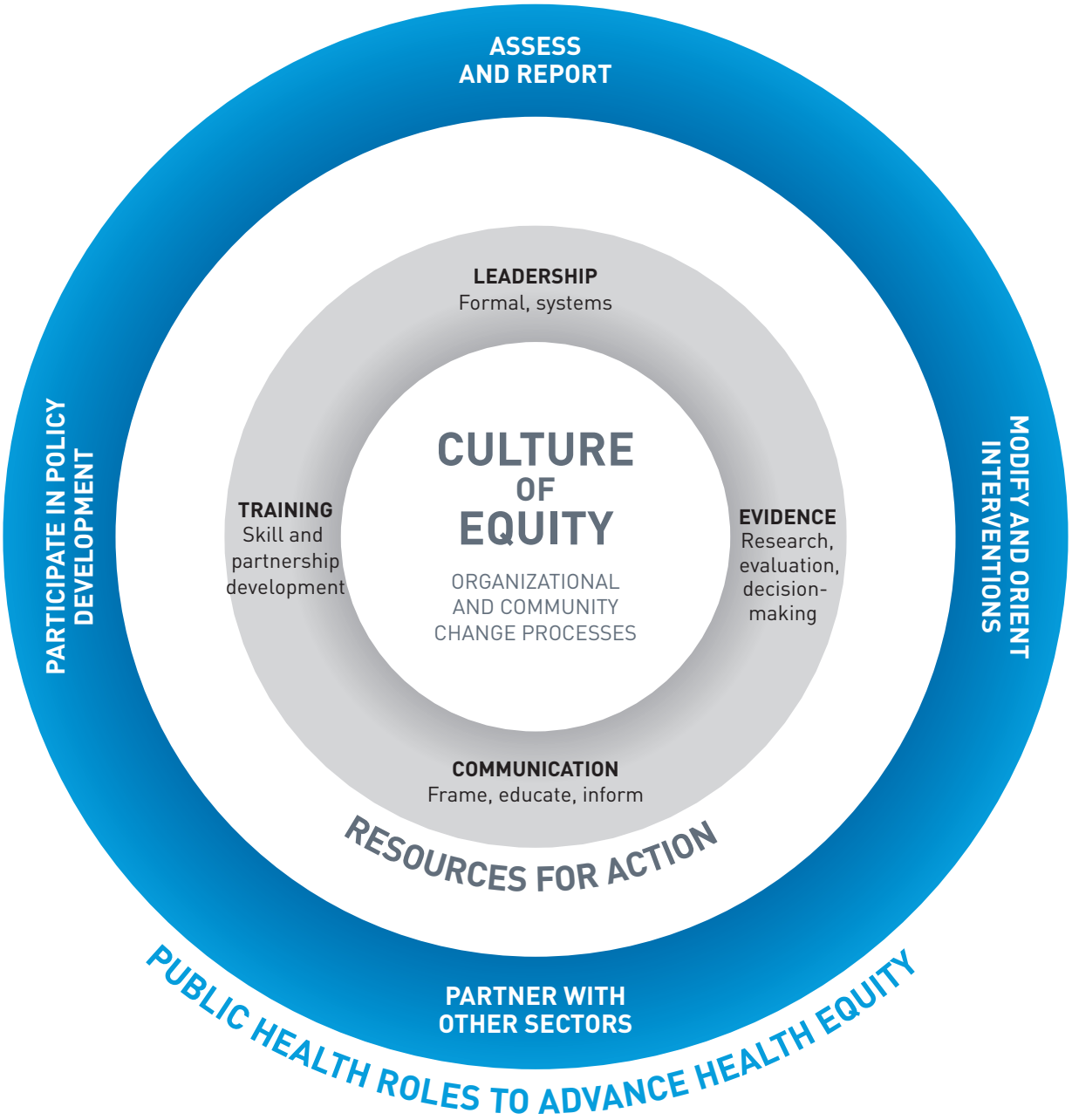
Building a culture of equity

Although the four public health roles for advancing health equity fall within the purview of the public health sector, organizational capacity to support these roles requires that a culture of equity be found at every level of decision-making in the system, including federal, provincial/territorial, health authority and health unit levels. The key informants told us that public health has an important role to play:

> Public health needs to adopt a culture change model when working with the regional health authority. Public health should see themselves as (1) a public health service provider and (2) a support department that provides a population health perspective to the rest of the system and helps to co-opt others into adopting this perspective.
>
> KEY INFORMANT, PUBLIC HEALTH

The following framework builds on work done in the first environmental scan to not only identify the four public health roles to advance health equity but to describe how public health can achieve and strengthen these roles.[1] The essential components are grouped within four clusters of resources for action: leadership, communication, evidence and training. The organizational and system development element from the original scan has been put in the centre, based on what we heard in this scan about the importance of building a culture of equity for the entire organization. This development places the importance of effective organizational and community change processes at the centre of any action to improve health equity.

DIAGRAM 1: FRAMEWORK FOR BUILDING A CULTURE OF EQUITY



The values perspective that informs this work is particularly important and influences how public health and other healthcare services are provided to the community. If the focus is on overall quality of services (as is currently dominant in the broader health sector, as per the Triple Aim), it is important to recognize that quality improvement does not automatically reduce inequities. In fact, if quality improvement efforts are focused on the general population they can instead increase inequities due to increased uptake by those who already have good capacity to improve their health behaviours.[19] If the focus is on working in partnership and solidarity with the community, however, the quality of the care can improve and health equity will more likely be a priority.

To illustrate this point, we can look at a needs assessment that takes a deficit-based approach to identify the populations that might be at higher risk for certain health problems. In such a scenario, the needs assessment will likely result in recommendations to provide more healthcare services. However, a health equity approach would prompt public health to ask why certain population groups are at higher risk, or what role public health can play to address this issue. The recommendations in this case are more likely to include ways to change the underlying reasons and not focus entirely on illness care.

One interviewee cited the example of high rates of smoking in many Indigenous communities. While we know that these high rates reflect reality, many public health organizations have approached this as an issue of targeting programming rather than working with the communities to ask the question of why smoking rates are higher and whether different approaches might be required. Some of the tools that the research informants noted have been identified in the literature to support a health equity approach in public health. This list of strategies includes prioritization tools, points-of-leverage analysis, concept mapping, planning models (for program development), partnership agreements (social contracts), health impact assessments, health status reporting, resource allocation mechanisms and "best value performance reviews."

Resources for action

A number of challenges and opportunities for implementing health equity approaches were identified in the findings section, corresponding to work within both the public health system and the wider health system, as well as with external partners. Regardless of where these opportunities and challenges are identified, they correspond to the four resources for action required to undertake the four public health roles to address health inequities. In addition, they support the change processes that build a culture of equity.

RESOURCES FOR ACTION	CHALLENGES	OPPORTUNITIES
Leadership (formal, systems)	» Program standardization and improved efficiency is the mantra of health system reform, to the detriment of health equity outcomes. » There is a lack of understanding and commitment to core values that support system/structural change for equitable health outcomes. » On equity issues, public health is slow in moving from diagnosis to action. » The shift of public health away from municipal structures toward health system structures makes action on the social determinants more difficult.	» Look for opportunities to build health equity into new governance structures. » Support actions to improve access to care across the health sector. » Ensure a senior public health leader is sitting at the senior leadership table in the health authority and the wider health system structure.
Evidence (research, evaluation, decision-making)	» There is a lack of equity-sensitive data, including evidence for effective interventions.	» Take advantage of the consolidation of resources in the health system to strengthen regional equity data.
Communication (frame, educate, inform)	» There is a lack of clarity in public health programs and services about how the work addresses health equity.	» Find ways to include people with lived experience. » Build communication tools to help partners deliver key messages about the social determinants of health and health equity.
Training (skill and partnership development)	» Community engagement is increasingly disconnected from core public health work. » Underdeveloped skills and limited resources for effective community partnership are common across the health sector.	» Create opportunities to learn from each other. » Engage with the quality improvement team to integrate equity as a quality measure. » Partner with non-governmental organizations to undertake advocacy initiatives.

Change processes

The values that inform organizational and community change processes are critical to the outcome. This has been borne out by the results of austerity approaches to managing healthcare funding in many jurisdictions in Canada. As noted earlier, several regions have already gone through budget exercises in which public health has endured substantial cuts, and others are contemplating similar reductions. Public health is particularly at risk in such an environment because much of the work is invisible to the citizens and politicians; health equity work is at further risk because it is not defined as a mandatory outcome of service.

Henry Mintzberg, a management consultant with extensive experience in health system reform, has proposed a model for transformation that is based on grounded engagement in the community.[20] Termed "communityship," this model's main elements are as follows:

- Effective organizations are communities of engaged human beings, not collections of passive human resources
- Anyone can come up with a great idea for change
- Communication is open so that ideas get shared easily
- Strategies, whether as overall visions or market positions, emerge gradually from grounded learning; they are not immaculately conceived

Communityship is based on grounded learning — in this case, from the community. According to Mintzberg, this work should be informed by members of the communities experiencing health inequities, with relationships with community members and partners providing a base. This grounded learning and these relationships happen with the help of all public health practitioners. Innovation and new ideas can happen anywhere, but the organization needs to be open and to nurture this culture.

Many of the interviewees stated that it is very hard to make the argument for additional resources for health equity work in the face of general budgetary pressures, especially with new pressures from other parts of the health authority for resources. However, there is light in this darkness. The key informants also told us about public health organizations that have approached health equity as a "way of working" and have been able to use a health equity lens to guide decisions regarding which programs to offer, the roles played by staff and how to address health equity. This shift has led to changes in program design and in the roles of staff without extra costs. Such an approach requires a high level of understanding about how to use reflective processes, how to engage community members and how to support broader cultural change in an organization.

Action areas and potential next steps

To support change processes that build a culture of equity within public heath, the broader health sector and the community, health equity champions within public health and the wider health system (including the NCCDH and the other NCCs) can take advantage of the opportunities that have been identified throughout this environmental scan process. These have been distilled into five action areas with opportunities defined as potential next steps for health equity champions within public health.

1. Incorporate health equity as a foundational value for the health system

> Strong public health action on health equity needs to be founded on both a top-down as well as a bottom-up approach. From the top, health equity should be built into the mindset of the governing boards, including making sure you have a diverse and inclusive governing structure. At the front line you should explicitly include workforce practices that increase equity and diversity, such as hiring practices, performance evaluations and workforce development.
>
> KEY INFORMANT, PUBLIC HEALTH

Ideally, health equity should be an objective in legislation and standards that guide decision-making and practice in the health sector, including public health. Ontario has made a significant stride by creating a health equity standard. In the absence of a legislated or regulatory mandate, public health leaders can be greatly assisted when health authorities and other governance structures include health equity as one of their foundational values. This statement may be aspirational, yet it confers a sense of organizational commitment.

Opportunity: Several health authorities have already incorporated health equity into their values, missions and strategic plans. There is an opportunity to assist senior public health leaders by compiling these statements as references and making them available. Case studies of how senior leaders were able to gain the support of their health authorities for incorporating these values would also be useful for others working toward this objective.

2. Support a values-reflection process for leaders

> We can't underestimate the impact of where we've come from in our lives on the way we approach an issue like health equity. We did a privilege questionnaire with senior leadership to understand the values and perspectives that we bring to the table, and how they influence our work. We also brought patient and community stories to the table to understand how their lives are affected.
>
> KEY INFORMANT, PUBLIC HEALTH

One theme that emerged strongly from the interviews is that health equity work is not only based on a set of skills but on a "just society" worldview and analysis. While this is a commonly shared perspective within public health, it is not a foundational value of all senior public health leaders.

As a way of addressing the issue of value sets among leaders and practitioners, a few of the interviewees noted that they had taken their organizations through cultural safety processes. Although most organizations are familiar with the idea of cultural sensitivity (the recognition of the importance of respecting difference) and cultural competence (focusing on the skills, knowledge and attitudes of practitioners), cultural safety goes a step further. It involves self-reflection and an understanding that the cultural values and norms of the client may be different due to unique sociopolitical histories.[21] The self-reflection process often leads to increased empathy and a greater recognition of how one's own values as a senior health leader can influence the way one understands — and acts on — issues such as health equity.

Opportunity: It would be helpful to document the process, resources and tools that organizations have used to support value reflection and cultural safety processes at senior management levels. The results could then be disseminated to public health and health system leaders.

Another aspect of values leadership relates to the issue of tacit knowledge and how to develop it across organizations. This concern is particularly relevant when applying a health equity perspective, as much of this knowledge is tacit rather than explicit. It is not just a question of transmitting a base of knowledge or developing a set of skills but rather how to apply them in given situations. This type of tacit knowledge is transmitted much more effectively through opportunities for ongoing conversations and in environments where emerging leaders can be supported over time.

Opportunity: The NCCDH Health Equity Collaborative Network provides opportunities for public health practitioners and equity champions to share knowledge and experiences and support each other in health equity work. This platform could be used as a model to support senior public health leaders since they face a distinct set of challenges in advancing the health equity agenda in their organizations. This group could also benefit from sharing their experiences with each other while mentoring new leaders.

3. Prepare public health leaders to advocate for health equity work across the health system

The integration of public health into large health system organizations has been challenging. At the same time, the process has provided an opportunity for senior public health leaders to build a culture of equity in the wider health system. Part of this work is being able to advocate to clinical colleagues about why health equity work is important and why the health authority should allocate resources to this work. Some interviewees reported that they felt unprepared for this task. It is important that they are able to make the case not only on behalf of public health but also from the perspective of why this should be important for the health authority, and doing so in terms that resonate with other senior managers. Some of the points that were brought up by interviewees included the relevance of the health equity approach to clinical work, the need to be able to identify interventions that could address health equity and the cost-effectiveness arguments that support health equity work.

Opportunity: There is leading-edge work going on in community health centres related to an equity approach to community care. The NCCDH should consider learning from health equity champions in these settings by, for example, collaborating on case studies. Engaging community health centres along with public health to tell these stories could help inform other opportunities to integrate health equity, public health and community health programs.

Part of building a culture of equity is embedding an equity imperative in established system change processes. The key informants identified quality improvement, accreditation and strategic planning processes as key opportunities.

Quality improvement is well entrenched in the culture of healthcare professionals and organizations in Canada; in the interviews it was frequently identified as an opportunity for bringing a health equity lens to the broader health system. Experience to date has shown that a data-driven approach to health equity through quality improvement can be a strong tool for calling attention to health equity issues. It can also help build trust and confidence in the system when it comes to action to improve equity of access and outcomes.

Accreditation was also mentioned as an opportunity to embed a health equity lens into organizational practice and culture. Performance measures in areas such as needs assessments and engaging with the community would be particularly relevant to the application of equity criteria. In fact, the United States has developed an accreditation board specific to public health and has integrated equity criteria throughout its measures (Public Health Accreditation Board).

As has already been discussed, the Triple Aim is a commonly used framework for organizational and system change in the health system in Canada and the United States, particularly in relation to regionalization and strategic planning.[4] The Triple Aim is a conceptual framework developed by the Institute for Health Improvement in the United States that calls for simultaneously placing a strategic focus on three dimensions:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost of healthcare

Opportunity: There are opportunities at national and provincial/territorial levels to explore how health equity could be more explicitly addressed using common conceptual frameworks such as the Triple Aim to complement an equity-specific framework. The Triple Aim framework could also be applied to other organizations that are responsible for healthcare quality (e.g., Health Quality Ontario) and healthcare accreditation (e.g., Accreditation Canada).

4. Support use of an equity lens in evidence-based decision-making

A variety of approaches can help health sector and public health leaders and practitioners to act based on the evidence they have at hand and learning as they go, rather than waiting for seemingly perfect evidence.

In the absence of evidence on effective action, knowledge of the pathways between the social determinants of health and health inequities and of alternative theories of change underpinning different approaches can also help entities to think through what might work, where action should be targeted and who should be involved.[22]

This would require health sector and public health leaders to develop decision-making strategies that allow them to form hypotheses, test new approaches and gather evidence as they go. These approaches would support ongoing learning and innovation in public health practice based on best-available data.

Opportunity: It is important that the public health sector emphasize its role as a learning organization, using evidence-based community engagement and developmental evaluation approaches focused on health equity priorities.

Health equity data and equity indicators, specifically, were most-often mentioned as a necessary support for integrating equity into evidence-based decision-making. Robust indicators can help to define the desired processes and outcomes of health equity work and provide a base for measuring progress over time. They can also form the basis of a process for reporting to funders and ultimately create the case for doing work to improve health equity at individual and systems levels.

The development of equity indicators has been a focus of national- and provincial-level stakeholders for a number of years. Provinces like British Columbia and Ontario have been working to define and enhance access to equity indicators, while national data organizations such as PHAC, the Canadian

Institute for Health Information (CIHI) and Statistics Canada have been collaborating to provide baseline, equity-oriented statistics; equity trends over time; and a platform to provide access to real-time equity data across Canada. (For examples, see CIHI's health inequalities page and PHAC's health inequalities data tool.) In addition, the Institute of Population and Public Health (IPPH) of the Canadian Institutes of Health Research (CIHR) has been discussing the potential value and feasibility of establishing an urban data observatory with public health stakeholders and researchers, which would have the capacity to include equity indicators.

Population health status reporting and equity indicators were identified as a priority in the 2010 scan,[1] and the NCCDH has developed a number of projects to support and advance this work (e.g., Learning together, equity-integrated population health status reporting: Action framework), with a peer-reviewed paper in press. One of the central challenges identified in this work is ensuring the information is relevant and useful for all of the intersectoral partners at the local level who are necessary to generate effective action to improve health equity.

Opportunity: The public health sector has an opportunity to engage intersectoral partners in population health status reporting in order to increase the use of evidence in local decision-making, as well as raise the profile of public health priorities and outcomes both inside and outside the health sector. Public health practitioners would benefit from training and tools to engage community members in community health assessment and improvement processes.

5. Support grounded community engagement as a foundation for health equity work

The leaders interviewed for this environmental scan observed that many of the trends affecting public health work in Canada — amalgamation into large health service organizations with unitary governance structures, pressure to standardize services, redefinition of public health jobs to specialist roles in community and reduced time for engagement with community partners — are moving public health relationships further from the communities that they serve. These trends are shifting the culture of public health organizations from community partners to service delivery organizations. Such an environment makes it challenging to do health equity work.

> Health systems are focused on medicalized approaches. They are driven by treatment and cure, so it is difficult to bring forward the health equity perspective. Public health needs to focus on community development and community engagement to find out about community priorities and use them to influence a culture shift in the health system. Our strategy should be to engage people with lived experience to help us to understand the issues better.
>
> KEY INFORMANT, PUBLIC HEALTH

The insight above illustrates the importance of relational leadership, sometimes called "complexity leadership."[23] This type of leadership fosters conditions to bridge the administrative leadership that is common within organizational structures and the adaptive leadership that is common in spaces promoting innovation and change. In the NCCDH's appreciative inquiry of leadership to advance health equity,[24] relational leadership was described as a strategy that bridges organizational activity with community action. This type of leadership enables leaders to "work the 'in betweens' to bridge or develop useful and real connections between the formal organization and system and the people, communities, partners and other sectors."[10]

In the absence of a supportive organizational culture, however, even the most competent leadership will not lead to action. Supporting organizational change that builds a culture of equity within the health sector is essential.

Opportunity: Public health could be supported to use a grounded learning model like communityship to inform and enrich its own work, as well as to benefit and ground the work of the broader health sector. This will require intersectoral partnerships between the health sector, other service providers and community organizations to support the work of addressing social determinants to improve health equity. Internally, the health sector will need to consider how equity contributes to the goals of "better health, better care and better value" and potentially reframe how services are delivered (e.g., housing strategies as part of community care initiatives, health-promoting hospital initiatives).

6. CLOSING COMMENTS

This environmental scan focused on the impact of changes in organizational and leadership capacity of the Canadian public health system on meaningful action on health inequities. The key informants confirmed what leaders in public health having been saying publicly for some time;[7,8] that is, the decline in organizational and leadership capacity to achieve public health priorities is negatively impacting the ability of public health and the broader health sector to address inequities in health outcomes.

This scan also explored opportunities for the public health sector to build organizational and leadership capacity for undertaking action on health inequities. The key informants told us that the values that inform change processes are critical to the outcome, and that building a culture of equity is essential if we want to achieve equity in health outcomes for all Canadians.

To that end, we revisited the four public health roles to address health equity, as per the NCCDH environmental scan from 2010.[1] In doing this, we further explored the question of which resources are essential for undertaking these roles and could be harnessed for organizational and system development. The resulting Framework for Building a Culture of Equity (see **Diagram 1** on page 29) explicitly highlights the link between public health action (the four roles) and organizational and community change processes focused on supporting health equity. The resources for action act as the bridge between the roles and change processes by providing the information and tools that public health practitioners need to fulfill the four roles and build a culture of equity. The resources for action are as follows:

- **Leadership:** Formal leadership and systems leadership (transformational)
- **Evidence:** Research and evaluation to guide decision-making
- **Communication:** To frame, educate and inform internally and externally
- **Training:** Skill development and partnership development

Potential next steps emerged based on what the key informants told us, distilled into five clear areas of opportunity to build organizational and leadership capacity to improve health equity. These recommendations include the following:

1. Incorporate health equity as a foundational value for the health system
2. Support a values-reflection process for leaders
3. Prepare public health leaders to advocate for health equity work across the health system
4. Support the use of an equity lens in evidence-based decision-making
5. Support grounded community engagement as a foundation for health equity work

The potential strategies described under each area have been selected to align with the knowledge translation role of the NCCDH. However, the resources for action (leadership, evidence, communication and training) woven throughout are the same resources that are necessary to support the public health roles to address health equity at all levels (local, provincial/territorial, national). Ultimately, actions to improve health equity are about building a culture of equity within public health, the wider health system and the community. Strengthening our understanding of the change processes associated with building a culture of equity would make an important contribution to achieving our health equity objectives in Canada.

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APPENDIX 1
GLOSSARY

The following definitions can be found in the NCCDH Online Glossary.[25]

HEALTH INEQUALITY

Health inequality refers to measurable differences in health between individuals, groups or communities. It is sometimes used interchangeably with the term health disparities.

HEALTH INEQUITY/INEQUITIES

Health inequity is a sub-set of health inequality and refers to differences in health associated with social disadvantages that are modifiable and considered unfair.

HEALTH EQUITY

Health equity means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic or environmental conditions.

MARGINALIZED

Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.

TARGETING WITHIN UNIVERSALISM

Targeting within universalism is an approach to providing programs and services that makes them available to all (universal) and reaches out to vulnerable and marginalized populations so that they get supports and services that meet their needs (targeted).

Additional terms and definitions are listed below, along with a primary source (where available) for further reference:

HEALTH SECTOR

The workforce delivering programs and services within the health system. (No source)

HEALTH SYSTEM[26]

Health system: (i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill health through a variety of activities whose primary intent is to improve health.

POPULATION HEALTH[27]

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.

PUBLIC HEALTH[28]

Public health is defined as the organized efforts of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians.

PUBLIC HEALTH SECTOR

The workforce primarily responsible for implementing public health programs and services within the broader health sector. (No source)

PUBLIC HEALTH SYSTEM[29]

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

- public health agencies at state and local levels;
- healthcare providers;
- public safety agencies;
- human service and charity organizations;
- education and youth development organizations;
- recreation and arts-related organizations;
- economic and philanthropic organizations; and
- environmental agencies and organizations.

STRUCTURAL INEQUITY[30]

Structural inequities refer to the systemic disadvantage of one social group compared to other groups with whom they coexist. The term encompasses policy, law, governance and culture and refers to race, ethnicity, gender or gender identity, class, sexual orientation and other domains.

APPENDIX 2
PRELIMINARY RESEARCH QUESTIONS

FROM THE REQUEST FOR PROPOSALS, MARCH 2017:

1. What is the current state of public health action in Canada to improve SDH and HE?
    b. What are the current actions/interventions (practice and organization based) being undertaken by public health?
    c. What actions/interventions appear to be effective or showing promise?
    d. What are the key challenges, needs and gaps?

2. Where are the opportunities for public health action to improve SDH and HE?
    c. Where are the key opportunities in relation to the 3 priority areas of the Common Agenda[18] (build a foundation for action; establish and use a strong knowledge base; collaborate with non-health sector partners)?
    d. Who is well positioned to provide leadership among the various stakeholders to take advantage of the opportunities?

3. Where can the NCCDH work most effectively to mobilize knowledge in relation to our three objectives (build knowledge, skill and leadership; strengthen networks; encourage research)?
    d. What is the current niche for the NCCDH? Who are the primary and secondary audiences (formal public health system, public health influencers and stakeholders) within this niche?
    e. Where are the opportunities to refine our niche and audiences? What factors would help the NCCDH stand out from our partners and competitors?
    f. What KM tools would be most effective to reach and support our target audiences, including virtual platforms, convening role/technology and partnership improvement?

APPENDIX 3
ADVISORY GROUP MEMBERS

ENVIRONMENTAL SCAN ADVISORY GROUP

1. Louis Sorin, Consultant (for much of the period during which this scan was undertaken, Louis was CEO of End Homelessness Winnipeg)
2. Sana Shahram, Post-Doctoral Research Fellow, Sessional Instructor, Michael Smith Foundation for Health Research and Centre for Addictions Research of British Columbia; Social Epidemiologist, Interior Health Authority, UBC Okanagan
3. Padi Meighoo, PhD Student, Arthur Labatt Family School of Nursing, University of Western Ontario
4. Louise Potvin, Chaire de recherche du Canada, Approches communautaires et inégalités de santé
5. Claire Betker, Director of Population Health and Health Equity, Public Health Branch, Manitoba Health, Health Living and Seniors

APPENDIX 4
DATA COLLECTION: ROUNDTABLE DISCUSSION

DATA COLLECTION METHOD:

- Roundtable discussion, 2 hours
- Facilitated by Ken Hoffman (consultant)

GOAL/PURPOSE:

- To take advantage of the Canadian Public Health Association conference (Halifax, June 2017) and convene a roundtable conversation between NCCDH staff and national and international health equity champions
- To host a strategic, high-level conversation about the current situation of health equity in public health in Canada and the strategic role that the NCCDH could play in advancing this agenda in the current context

PARTICIPANTS:

NCCDH STAFF	HEALTH EQUITY "CHAMPIONS"
» Connie Clement – Scientific Director	» David Butler-Jones, First Nations Inuit Health Branch (FNIHB), Atlantic
» Faith Layden – Program Manager	» Annette Elliot Rose, First Nations Inuit Health Branch (FNIHB), Atlantic
» Jacqueline MacDonald – Admin Support	» Louise Potvin, Approches communautaires et inégalités de santé
» Danielle MacDonald – Research Officer	» Sana Shahram, University of Victoria
» Karen Fish – Knowledge Translation Specialist	» Jenny Popay, University of Manchester
» Dianne Oickle – Knowledge Translation Specialist	» Margaret Barry, National University of Galway, Ireland
» Sume Ndumbe-Eyoh – Knowledge Translation Specialist	
» Lesley Dyck – Knowledge Translation Specialist	
» Pemma Muzumdar – Communications Coordinator (NCCPH)	

METHOD/CONVERSATION GUIDE:

Participants were encouraged to read the following background documents in advance of the conversation:

- *Common agenda for public health action on health equity*[18]
- Environmental Scan 2010[1] – executive summary[31]
- Environment Scan 2014[2] – executive summary[32]

The following questions were used to guide the conversation:

- What is your assessment of health equity in public health in Canada? Where is it well established? Where are the opportunities for it to take root? Who and what are the main drivers?
- What are the main challenges to advancing the health equity agenda in public health today? What preconditions need to be in place to build on assets and opportunities?
- Where are the strategic opportunities for the NCCDH? Where has it been more and less successful? How can it leverage its connections and resources?

APPENDIX 5
DATA COLLECTION: KEY INFORMANT INTERVIEWS

DATA COLLECTION METHOD:

- Key Informant Interviews with 21 formal public health, health system and research leaders; each interview was approximately 1 hour in length and conducted over the phone
- Interviews (19) were conducted by Ken Hoffman (consultant)
- Half of the researcher interviews (2) were conducted by Connie Clement (NCCDH Scientific Director)

GOAL/PURPOSE:

- To get a sense of how people in leadership positions in public health organizations and health system organizations (health authorities/ministries) viewed and acted on the issue of health equity
- To get a sense of the current state of the public health system and health equity research

PARTICIPANTS:

NAME	TITLE AND ORGANIZATION	LEADERSHIP CATEGORY
David Allison	Chief Medical Officer of Health, Department of Health and Community Services, Government of Newfoundland and Labrador (St. John's, NL)	Public health
Sandra Allison	Vice President and Chief Medical Health Officer, Northern Health (Prince George, BC)	Public health
Claire Betker	Acting Executive Director, Active Living, Population and Public Health, Manitoba Health, Seniors and Active Living (Winnipeg, MB)	Research
Luc Boileau	Président, Institut national d'excellence en santé et services sociaux (Quebec, QC)	Public health
Sabrina Broadhead	Director, Indigenous Health and Community Wellness Division, Department of Health and Social Services, Government of Northwest Territories (Yellowknife, NT)	Health system
Helga Bryant	Chief Executive Officer, Northern Health Region (Flin Flon, MB)	Health system
Freda Burkholder	Manager, Public Health Capacity and Knowledge Management Unit, Public Health Agency of Canada (Ontario Region) (Toronto, ON)	Public health
Marisa Creatore	Assistant Scientific Director, CIHR Institute of Population and Public Health (Toronto, ON)	Public health
Peter Donnelly	President and CEO, Public Health Ontario (Toronto, ON)	Public health
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Gerry Gallagher	Executive Director, Centre for Chronic Disease Prevention and Health Equity, Public Health Agency of Canada (Ottawa, ON)	Public health

NAME	TITLE AND ORGANIZATION	LEADERSHIP CATEGORY
Deb Gordon	Vice President and Chief Health Operations Officer, Alberta Health (Edmonton, AB)	Health system
Ak'ingabe Guyon	Public Health and Preventive Medicine Specialist, Montreal Public Health; Professor of Public Health, Université de Montréal (Montreal, QC)	Public health
Michelle Kilborn	Analyst/Researcher, Alberta Health Services (Calgary, AB)	Research
Carol MacKinnon	Senior Director of Population and Public Health, Nova Scotia Health (Kentville, NS)	Public health
Glen Mays	F Douglas Scutchfield Endowed Professor of Health Services and Systems Research, University of Kentucky College of Public Health (Lexington, Kentucky, United States)	Research
Marie DesMeules	Director, Social Determinants Division, Public Health Agency of Canada (Ottawa, ON)	Public health
Cory Neudorf	Chief Medical Health Officer, Saskatoon Health Region (Saskatoon, SK)	Public health
Bernie Pauly	Associate Professor, School of Nursing, Scientist, Centre for Addictions Research of BC, University of Victoria (Victoria, BC)	Research
David Sabapathy	Deputy Chief Public Health Officer, Health and Wellness PEI (Charlottetown, PE)	Public health
Sabrina Turgeon	Healthy Living Facilitator, Southern Health (Southport, MB)	Public health

METHOD/CONVERSATION GUIDE:

Interviews followed a semi-structured interview process guided by two sets of questions. The first set (A) was for key informants from the public health and health system leader categories, with slight adaptations made within for each category (noted below). The second set (B) was for key informants from the researcher leader category.

A. QUESTIONS — Public Health Specialist Leaders and Health System Leaders

PREAMBLE:

For its environmental scan, the NCCDH is primarily interested in three issues in terms of the ability of public health to support action on social determinants to address health equity:

- The role of leadership in public health and in the broader health system
- The interface between public health and the rest of the health system
- The role of organizational structures, values and practices

QUESTIONS:

Organizational role/structure/position

1. Please describe your position and main areas of responsibility. (Clarify role, mandate of the organization, if necessary.)

Experience with social determinants of health and health equity

2. Where has your organization taken action to address SDH to improve health equity? Provide a few examples. What kinds of supports or conditions made it possible for your organization to take this action?

Policy change and partnership

3. How is your organization involved in policy change to address issues of SDH and health equity?
4. How does your organization work in partnership to address SDH and health equity issues:
   a) with other partners in health sector; (b) with organizations outside the health sector?

Role of public health

5. a) What leadership role does public health play in your organization to advance issues of SDH and health equity? (Please provide examples.) Do you see opportunities for public health to play a greater role? What would this look like?
   b) What are the challenges and opportunities for public health to play a greater leadership role on SDH and health equity in the system in which you are working? (PH Specialists only)

Opportunities and challenges for SDH/health equity work

6. How could a greater emphasis on SDH and health equity help to achieve multiple health system objectives? What opportunities do you see for this?
7. Are there any disadvantages to placing a greater focus on SDH and health equity?

Organizational/structural supports for SDH/health equity work

8. Where is the responsibility to deal with SDH and health equity issues in your organization?
9. In your organization, what governance, policies or structures guide or support the discussion of SDH and health equity issues?
10. What elements of the values and culture in your organization support SDH and health equity work? How is this carried through the organization?

Looking ahead; role for NCCDH

11. What would help your organization to advance its work on SDH and health equity issues? What are the challenges?
12. What are opportunities to institutionalize the SDH and health equity approach within existing organizational practices? (e.g., Strategic directions? Priorities? Population targets? Quality improvement?)
13. a) What groups/organizations do you turn to for information/support on issues of SDH and health equity? (PH Specialists only)

    b) What groups/organizations do you turn to for information/support in designing and delivering your organization's SDH and health equity commitments? (Health System Leaders only)
14. What role could the NCCDH play, as a national public health knowledge (translation) centre, to assist your organization in its work on SDH and health equity issues?
15. Do you have any further comments you would like to make?

B. QUESTIONS — Researchers

PREAMBLE:

For its environmental scan, the NCCDH is primarily interested in three issues in terms of the ability of public health to support action on social determinants to address health equity:

- The role of leadership in public health and in the broader health system
- The interface between public health and the rest of the health system
- The role of organizational structures, values and practices

QUESTIONS:

Leadership in public health and the broader health system

- What is current research telling us about the role of public health and health system leadership in taking action on SDH to address health equity?
- What are the main qualities/skills/approaches that have been used by successful public health and health system leaders in supporting the creation of an organizational culture that addresses social determinants to address health equity?
- How can this leadership role be supported?
- What are the gaps in the current research in this area?

Interface between public health and the rest of the health system

- What is current research telling us about how public health has been able to work with other parts of the health system to address SDH and health equity?
- How have new health system configurations (where public health is organizationally more integrated with the rest of the health system) affected the way in which issues relating to SDH and health equity are addressed?
- Where has public health been able to influence other parts of the health system to address issues related to SDH and health equity? How has this happened?
- What are the gaps in the current research in this area?

The role of organizational structures, values and practices

- What is current research telling us about how organizational structures, values and practices support action to address SDH and health equity?
- How have health systems embedded SDH and health equity approaches into their ongoing practices (e.g., quality improvement)?
- What are the gaps in the current research in this area?

APPENDIX 6
DATA COLLECTION: FOCUS GROUP

DATA COLLECTION METHOD:

- A focus group of members of the NCCDH Health Equity Collaborative Network was conducted by Ken Hoffman (consultant)
- The focus group was conducted by phone and lasted 1.5 hours

GOAL/PURPOSE:

- To seek the perspective of public health practitioners who are actively engaged in health equity work

PARTICIPANTS:

NAME	TITLE AND ORGANIZATION	LEADERSHIP CATEGORY
Erin Cowan	Health Equity Public Health Nurse, Timiskaming Health Unit (New Liskeard, ON)	Public health – health equity specialist
Margot Fournier	Public Health Nurse, Priority Populations; SDH Nurse, Haldimand-Norfolk Health Unit (Simcoe, ON)	Public health – health equity specialist
Jennifer Johnson	SDH Public Health Nurse, Windsor-Essex Health Unit (Windsor, ON)	Public health – health equity specialist
Patricia Martz	Alberta Health and Education (Edmonton, AB)	Public health – health equity specialist
Hannah Moffatt	Population Health Equity Initiatives Leader, Winnipeg Regional Health Authority (Winnipeg, MB)	Public health – health equity specialist
Christine Post	Health Promoter, Peterborough County-City Health Unit (Peterborough, ON)	Public health – health equity specialist
Marcela Tapia	Program Development Officer, Health Equity Team, Ottawa Public Health (Ottawa, ON)	Public health – health equity specialist

METHOD/CONVERSATION GUIDE:

The focus group followed a semi-structured process guided by the following questions:

Organizational Role/Structure/Position

1. What role do you play in your organization to advance issues of SDH and health equity?
2. How many of you are working in health authorities versus separate health units?

Leadership Role of Public Health

3. What are some of the challenges and opportunities associated with public health playing the following leadership roles:
    a. Providing data to identify groups affected by health inequities
    b. Encouraging adoption of a health equity approach across public health
    c. Encouraging other parts of the health system to adopt a health equity approach
    d. Working with organizations outside the health system on health equity issues
    e. Advocating for action to address health inequities
    f. Getting public support to address health inequities
    g. Other major challenges, if any?

Looking ahead:

4. What are opportunities to institutionalize the SDH and health equity approach within existing organizational practices? (E.g., strategic directions, priorities, population targets, quality
5. improvement.)
6. What would help your organization to advance its work on SDH and health equity issues? (E.g., explore information/resources, training, examples, convening/making connections.)
7. What role could the NCCDH play, as a national public health knowledge (translation) centre, to assist your organization in its work on SDH and health equity issues? (Explore what is helpful at present, what additional roles the NCCDH could play in convening, type and format of information/resources from the NCCDH and others.)
8. Whose work is currently influencing your practice in the area of SDH and health equity?
9. Do you have any further comments you would like to make?

APPENDIX 7
LITERATURE SEARCH RESULTS AND METHODOLOGY

STEP	LITERATURE SEARCH — ENGLISH	LITERATURE SEARCH — FRENCH
Publication Dates	Documents published between 2013 and September 2017	Documents published between 2013 and September 2017
Databases searched	Cochrane Library, EBSCO CINAHL, PubMed, PubMed Central, Google Scholar and Google	*Searched:* » PubMed » Google (but not Google Scholar) » EBSCO CINAHL *Not searched:* » Cochrane Library — a search was not conducted as reviews are only available in English. » PubMed Central — a search was not conducted as it is not possible to limit the search by language.
Search terms	The initial search terms used in each database were ("public health"[Title]) AND (inequity[Title] OR equity[Title] OR equality[Title] OR inequality[Title] OR disparity[Title] OR determinant[Title]). Variations of these terms were also allowed (e.g., equity and equities).	PubMed and EBSCO CINAHL were searched using the English search terms, selecting for French abstracts/articles. PubMed was also searched using French search terms: ("Santé publique"[Title]) AND (iniquité[Title] OR équité[Title] OR égalité[Title] OR inégalité[Title] or disparité[Title] OR determinant[Title]) A Google search was conducted using various combinations of French search terms: "santé publique," determinants, direction, structure, équité, système, disparité, organisation
Other search methods	A call was also put out to the NCCDH-facilitated Health Equity Clicks online community for literature related to "leadership in public health to advance health equity at the organizational/systems/structural level." The online community comprises 340 public health practitioners from across Canada whose work focuses on health equity and the social determinants of health.	No French documents were provided by the NCCDH online community.
Selection process	*Primary selection:* Only resources written in English were reviewed. The titles of search results were filtered first, followed by a review of the document abstract or background information to determine relevance. Only the first 4 pages of the Google search results were included. *Secondary selection:* To further refine the relevance, the criteria of leadership, organization, system or structure were added as selection terms. Variations of these terms were also allowed (e.g., leader and leadership; structure and structural). *Tertiary selection:* A full text assessment was undertaken to identify articles/documents relevant to leadership in advancing health equity in public health at the organizational/systems/structural levels.	*Primary and secondary selection:* Only resources written in French were reviewed. The titles of the search results were filtered first, followed by a review of the document abstract or background to determine relevance. Only the first 4 pages of the Google search results were included. Since only a small number of documents were found, criteria of leadership, organization, system or structure were included as selection terms. *Tertiary selection:* A full text assessment was undertaken to identify articles/documents relevant to leadership in advancing health equity in public health at the organizational/systems/structural levels.
Results	Primary selection = 833 (including duplicates) Secondary selection = 85 Tertiary selection = 20 See below for a complete list of the 20 documents identified as relevant	Primary and secondary selection = 43 (2 from EBSCO CINAHL, 41 from Google search) Tertiary selection = 7 See below for a complete list of the 7 documents identified as relevant.

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APPENDIX 8
CORE PUBLIC HEALTH FUNCTIONS IN CANADA[12p8-9]

1. Health protection – Actions to ensure water, air and food are safe, a regulatory framework to control infectious diseases, protection from environmental threats, and expert advice to food and drug safety regulators.
2. Health surveillance – The ongoing, systematic use of routinely collected health data for the purpose of tracking and forecasting health events or health determinants. Surveillance includes: collection and storage of relevant data; integration, analysis and interpretation of this data; production of tracking and forecasting products with the interpreted data, and publication/ dissemination of those products; and provision of expertise to those developing and/or contributing to surveillance systems, including risk surveillance.
3. Disease and injury prevention – Investigation, contact tracing, preventive measures to reduce the risk of infectious disease emergence and outbreaks, and activities to promote safe, healthy lifestyles to reduce preventable illness and injuries.
4. Population health assessment – Understanding the health of communities or specific populations, as well as the factors that underlie good health or pose potential risks, to produce better policies and services.
5. Health promotion – Preventing disease, encouraging safe behaviours and improving health through public policy, community-based interventions, active public participation, and advocacy or action on environmental and socio-economic determinants of health.
6. Emergency Preparedness and Response – Planning for both natural disasters (e.g. floods, earthquakes, fires, dangerous infectious diseases) and man-made disasters (e.g. those involving explosives, chemicals, radioactive substances or biological threats) to minimize serious illness, overall deaths and social disruption.

APPENDIX 9

GOALS AND APPROACHES FOR A COMMON AGENDA[33]

NURTURING A CULTURE OF EQUITY

Goals and approaches for a common agenda for public health action

The Common Agenda for public health action identifies eight priorities to improve health equity in Canada. These approaches are organized under three main themes – build a foundation for action, establish a strong knowledge base, and collaborate with non-health sector partners[1] – and complement the four roles for public health action on health equity.[2] They echo the three overarching recommendations of the World Health Organization Commission on the Social Determinants of Health to: improve daily living conditions; tackle the inequitable distribution of power, money, and resources; understand the problem and assess the impact of action.[3]

This resource is for public health practitioners, decision-makers and organizations.

Use this to take action to influence the social determinants of health (SDH) and improve health equity.

BUILD A FOUNDATION FOR ACTION

1. ***Strengthen public health leadership*** **commitments and related action.**

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

2. ***Increase public support and political will*** **to invest in policies to improve the SDH and health equity.**

   Political will is a driver for investments across health and non-health systems for the implementation of wide ranging public policy to improve equity.

3. ***Build the capacity of public health organizations and systems*** **to act on the SDH and improve health equity.**

   The ability for public health organizations and systems to adequately act on health inequities is related to the capacity within these structures to identify the problem and mobilize and reorient resources upstream to address them.

ESTABLISH AND USE A STRONG KNOWLEDGE BASE

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

   Implement existing knowledge and evidence with an emphasis on interventions that address the root causes of health inequities, and develop robust evalutation systems that are sensitive to equity issues.

5. ***Incorporate equity measures into regular monitoring, surveillance, and reporting.***

   Consistent high quality population data allows an assessment of trends and progress towards improving health equity. This assessment includes information on health inequities, the determinants of these inequities and action and strategies to address them.

COLLABORATE WITH NON-HEALTH SECTOR PARTNERS

6. ***Participate in long-term multisectoral action*** **to develop policies across health and non-health sectors.**

   Given the interrelated and dynamic nature of the SDH, no one sector (government or non-governmental) can make a significant impact in redressing inequities on its own. Actions that catalyse and amplify the actions of others can shift the distribution of health generating assets, wealth, power and resources.

7. ***Allocate time and resources for community engagement and political empowerment.***

   The communities most affected by inequities are those with the least access to power and resources. Meaningful and sustained engagement of communities in decisions and actions ensures that these voices and experiences are centered in the conversation on improving health equity.

8. ***Advocate for policy and structural change*** **to improve upstream determinants of health.**

   Public health is well positioned to frame issues, propose policies, and understand political barriers and enablers to change.

WHO Commission on Social Determinants of Health
overarching recommendations

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

Download the full report, Common Agenda for Public Health Action on Health Equity at **www.nccdh.ca**

PUBLIC HEALTH ROLES

ASSESS AND REPORT

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

MODIFY AND ORIENT INTERVENTIONS

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

PARTNER WITH OTHER SECTORS

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

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.

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Centre de collaboration nationale des déterminants de la santé

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