

**Actions to Reduce Health Inequalities in Canada: A description of  
strategic efforts led or supported by public health organizations**

**A Working Document prepared for the Public Health Agency of Canada  
Strategic Initiatives and Innovations Directorate**

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# **Actions to Reduce Health Inequalities in Canada: A description of strategic efforts led or supported by public health organizations**

## **1. Introduction**

This document provides a short description of eight strategic efforts led or supported by public health to reduce inequalities in health across Canada.<sup>1</sup>

The descriptions have been developed as background materials to contribute to discussions at the March 18-19 *Working Session on Action to Reduce Health Inequalities in Canada* organized by the Public Health Agency of Canada (PHAC), the National Collaborating Centre for Social Determinants of Health (NCCDH), the Canadian Population Health Initiative (CPHI-CIHR), the Canadian Public Health Association (CPHA), the Institute of Population and Public Health (IPPH-CIHR), and the Population Health Promotion Expert Group (PHPEG). The intent of the document is to stimulate discussion on approaches, opportunities, gaps and champions to advance further action to reduce health inequalities in Canada.

The work has been undertaken within the following parameters:

- ▶ An initial list of potential initiatives was developed by a planning committee and subsequently expanded in discussions with the writer.
- ▶ A mix of initiatives has been included, with examples at the national, provincial/territorial, regional and local levels and initiatives specifically designed to reduce health inequalities as well as initiatives intended to have an impact on one or more of the determinants of health.
- ▶ The initiatives were notionally situated against a framework of four broad categories: Government commitment, leadership and policy initiatives; Community engagement and capacity-building; Cross-sectoral action; and Research, knowledge development and exchange, monitoring and evaluation. These categories incorporate common features of promising strategies to reduce health inequalities contained in several benchmark reports, including the 2008 Chief Public Health Officer's Report on The State of Public Health in Canada.
- ▶ To the extent that readily available information permitted, the descriptions touch on the goals and expected outcomes of each initiative; the catalyst for action; key strategies; lead organization and partners; the nature of the collaboration involved/stewardship; and evaluation plans/results. However, the diverse nature of the initiatives, along with time constraints, has prompted some departures from the template.

The process to describe the initiatives began with a website search that was followed, where possible, with direct contact with a key informant to secure additional information. Again where possible, the draft descriptions were reviewed by the informant and revised. A further

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<sup>1</sup> The terms used in the description of each initiative relating to health disparity, inequality and inequity are those used by the organization itself. For general purposes disparities and inequalities refer to differences in health status that occur among population groups defined by specific characteristics. Equity/inequity refers to disparities and inequalities (i.e. differences) that are deemed to be unfair or unjust and thus entails a moral judgment.

reduction in the length of each description was subsequently conducted at the request of PHAC. While eleven initiatives were initially described, only eight are presented here to limit the length of the document.

## **2. Taking Action: From Streets to Boardrooms**

The descriptions of the initiatives that follow tell a compelling, albeit selective, story of diverse activities underway to reduce health inequalities. What do these initiatives suggest about what works and what contributes to success? The following observations may provide some ‘food for thought.’

*Leadership* – The origins of many of these initiatives can be traced directly to bold and aggressive leadership by politicians, business people, executive directors of community-based agencies and coalitions and the like. One of the features of their leadership has been the capacity to connect the initiatives, creatively, presciently and convincingly, to public policy priorities and in doing so, to carry the initiatives forward with a mandate that has been endorsed by and serves the broader interests of the community.

*Vision, goals* – Many of the initiatives have been built around a clear vision or goal - for example, the reduction or elimination of poverty, creation of the healthiest jurisdiction or the reduction of health inequalities/inequities. These goals are often very ambitious (what some have referred to as ‘stretch goals’) and would probably be considered to exceed the normal comfort zone of politicians, public servants and the perhaps citizens generally. Yet they have had traction – and appear to have stuck!

*Targets, performance measurement and evaluation* – Closely associated with the vision/goals has been the development of what is often an equally ambitious and sophisticated set of performance measures and targets to track progress and to report on a regular basis to partners, other stakeholders and the public. As well, evaluation frameworks are often in place to assess outputs (e.g. process) and outcomes (i.e. impacts). While the results of the initiatives in most cases are preliminary and relatively modest, the evaluation process is publicly regarded and supported as an integral part of the initiatives.

*Information, research, data* – The initiatives lend strong support to the importance of information and data – from the ‘voices’ of those who are vulnerable, through the agencies that ‘speak truth to power’ to the ‘scientific evidence’ that confirms that low income neighbourhoods are indeed associated with increased health care use – as a critical building block for change and progress in addressing health inequalities.

*Knowledge development and exchange* – These initiatives confirm what many know and many others suspect: that there is a great deal of information about examples of strategies, actions, messages, tools and resources - and personal experiences - associated with reducing health inequalities across the country. However, we do a poor job of communicating and sharing this information, and using it to guide and enrich further action. Some of these initiatives have made knowledge development and exchange a key feature of their efforts.

*Tools and resources* – A variety of tools and resources has played a key role, either as a centre-piece of efforts or to support action. This includes the broad spectrum of indicators of health inequalities and healthy equity lenses, community data profiles and mapping, and health impact assessments. The initiatives underline the importance of these instruments but also suggest the need to have the capacities in place to use them effectively, a consideration that may be underestimated by funders, partners and even the users.

*Communications* – There is a strong communications component associated with many of the initiatives, to strengthen public understanding of the impact of particular determinants on population health and/or of the needs and benefits associated with reducing health inequalities. It would appear, from these examples alone, that the level of discourse on determinants and inequalities/inequities at all levels of society is growing. As well, at least within individual communities, the discourse may be taking place in a language that is more inclusive than may appear to be the case from the outside!

*Stewardship models* – The initiatives are built on a broad range of governance arrangements, from formal and complex machinery within government and communities, to simple and informal stewardship built largely on trust relationships. Among other things, it appears that whoever the players may be, they have to be able to play different roles in different situations. Sometimes it may be appropriate for a government (or department) to lead and at others it is not; all sectors and stakeholders must be able to lead, to participate and at times, to follow, within the context of different scenarios within different communities.

### **3. Strategic Efforts to Reduce Health Inequalities**

The initiatives are presented in the context of the four categories noted in the ‘Introduction’ namely, (i) Government commitment, leadership and policy initiatives; (ii) Community engagement and capacity-building; (iii) Cross-sectoral action; and (iv) Research, knowledge development and exchange, monitoring and evaluation.

#### **Government Commitment, Leadership and Policy Initiatives**

##### **Newfoundland and Labrador Poverty Reduction Strategy**

The Newfoundland and Labrador Poverty Reduction Strategy (PRS) is a government-wide initiative whose goal is to transform Newfoundland and Labrador from a province with the most poverty to one with the least over a ten year; it received unanimous support in the House of Assembly in December 2006.

The five medium term goals of the Strategy (2006-2010) include improved access and coordination of services for those with low incomes; a stronger social safety net; improved earned incomes; increased emphasis on early childhood development; and a better educated population.

At the time of launching the Strategy, the province had the second highest rate of poverty overall (12.2 % in 2004) and of child poverty (16.7%). The government acknowledged that tackling poverty was essential to ensuring a healthy future for the province and was determined to reverse the trend. The PRS included initiatives that targeted the groups most vulnerable to poverty, including families led by single mothers, single people, people aged 55-64, people with work-limiting disabilities and Aboriginal peoples.

Stewardship of the Strategy has been assured by the strong personal endorsement of the Premier and the establishment of a Ministerial Committee to provide oversight to the implementation. Lead responsibility for the Strategy lies with the Minister for Human Resources, Labour and Employment.<sup>2</sup> The Ministerial Committee includes ten additional Ministers from across the health, social affairs, Aboriginal affairs, justice and trade and rural development portfolios. This Committee is supported by a Deputy Minister's Committee, an Interdepartmental Working Group (and a dedicated organization within the Ministry).

To implement the Strategy, the government has taken action in those areas where it has the capacity and jurisdiction to act, drawing on a broad spectrum of ongoing programs and launching new efforts. At the same time, it is committed to working with the federal government, other provincial governments, Aboriginal governments and organizations, business and labour, community-based groups and individuals to achieve the kind of policy mix required to address the complexities inherent in poverty reduction.

Collaboration has been achieved through an extensive bi-annual consultation/public engagement process as well as through ongoing contacts with community partners (e.g. working with the Housing and Homeless Network to find new ways to support people with complex needs requiring services from multiple departments and agencies and with community-based groups to reach people living in and vulnerable to poverty). The dialogues with vulnerable people are an important element of the Strategy and have been the source of many of the PRS initiatives.

Planning for a second phase of the Strategy has recently begun and a new round of consultations is underway.

Over three budget cycles, and beginning in 2006, the Government of Newfoundland and Labrador has committed over \$100 million on an ongoing annual basis for initiatives to prevent, reduce and alleviate poverty. Examples of successful PRS initiatives to date include enrichment of living support for persons with disabilities who are living with their family; increased support of the Kids Eat Smart Foundation to provide nutritious snack programs for school children; new funding for a province-wide Youth Addiction Prevention and Early Intervention Program; provision of free text books to students in grades K to 12; the automatic indexing of Income Support rates to the Consumer Price Index; expansion of the Prescription Drug Program to those working for low wages; and introduction of a Futures in Skilled Trades Program as a viable post-secondary option for high school students.

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<sup>2</sup> The Minister is also the Minister Responsible for the Status of Persons with Disabilities, the Labour Relations Agency, Francophone Affairs and for the Workplace Health, Safety and Compensation Commission.

Government documentation on the PRS acknowledges that while “many of the initiatives will take some time to show their full benefit, particularly those of a preventive nature,” “progress is being made and a positive impact is being felt” (among other things, the poverty rate is now 7.6%, the third lowest in Canada). (Progress to Date, 2009) In addition, next year’s report on the PRS, expected in the spring, will outline Government progress in detail.

### **Canadian Social Forum**

The Canadian Council on Social Development is organizing the first inaugural Canadian Social Forum in Calgary in May 2009. The Forum will be a biennial event with the next one scheduled for 2011.

Despite Canada’s relatively good economic performance over the last few years, poverty persists. At the same time, there is a perception that the old ways of thinking about poverty reduction haven’t worked and that solutions must go beyond anything that a single government, community or business can do on its own. There is also a sense that there are some very promising initiatives, partnerships and ideas emerging across the country.

The mandate of the Canadian Social Forum is to share this emerging information about poverty reduction with people from a wide variety of sectors - social development, public health, the environment, community safety, education and recreation - all of whom are working towards the same end. As well, the program is designed to be widely accessible and to give voice to the lived experience of poverty. The Forum is also designed to support a new wave of leaders who recognize that reducing poverty is essential to real prosperity – people willing to step outside their usual comfort zone to help achieve that goal.

CCSD is working with a national Advisory Committee charged with the planning and oversight of the Forum. Representation on the Committee includes people from diverse communities of social planning and the United Way, education, research, health, policing, and recreation, municipalities and the CCSD board itself. The Committee reports to The Council.

Presentations in the Forum will highlight promising practices, organizational obstacles, and the realities of social and political issues. Some sessions will explore innovations in communities across the country while others will present more global ideas and approaches to stimulate debate and discussions. The program will be highly interactive and assisted by the creative use of video screens, cameras and young broadcast journalists throughout. In addition, provision has been made to enable national organizations and networks to meet both before and following the Forum, helping them to inform and develop their own poverty reduction work by taking advantage of the energy and the opportunities for collaboration generated around the Forum itself.

Two additional and concurrent CCSD initiatives will complement the objectives of the Social Forum but will also make an important contribution to reducing health inequities in their own right. One is an exercise to map poverty-reduction efforts across Canada; the other is an

exercise to track particularly significant social developments across the country and to report on these to Canadians. Information on each of these is available at [www.ccsd.ca](http://www.ccsd.ca).

## **Community Engagement and Capacity-building**

### **Community Development Halton**

Community Development Halton (CDH) is a registered charitable organization in the Ontario Regional Municipality of Halton (population of about 470,000 people). CDH's primary purpose is to build and strengthen the community through research, community development, planning, and promoting volunteerism.

CDH focuses on the social impact of the larger social, economic, political and cultural forces on individuals, families, and the broader community. The organization is committed to social development as a desired state of community well-being and to social change as a continual process leading to achieving and sustaining social development for everyone in the community.

Social planning activities have been a feature of Halton communities since the early 1970s. However in 1984, the United Way and the Region of Halton asked the social planning groups to amalgamate to provide communities with a better regional perspective on social issues. Further, it was expected that this change would allow one organization to better focus on social policy issues, from the micro to the macro levels of community development.

CDH is an intermediary organization, working cooperatively and as an 'honest broker' with funders and direct service providers and supporting the efforts of municipal and regional government and local grass roots organizations. The organization serves as a meeting place for communities to collaborate in the identification of priorities and in working out solutions to local and regional issues. At the same time CDH seeks to improve the capacity and effectiveness of the voluntary sector in the community.

CDH has a membership base of 100 organizations that includes family and legal multi-service organizations, labour, the arts community and youth organizations. Oversight and stewardship of CDH are provided by a board of directors that provides strategic leadership of the organization; the eight directors represent the diversity of the community in geographic, cultural and professional factors.

The board has no standing committees but works through task forces that enhance its capacity. Further, all work undertaken by CDH is informed by advisory committees thus ensuring the input of diverse stakeholders and ownership of solutions. This approach facilitates the acceptance of recommendations for action and the building of change practices at the community level. While CDH is grounded in the community it is also well connected across the province and the country through organizations like the Social Planning Network of Ontario, Volunteer Canada and the Public Health Agency of Canada.

CDH exercises its mandate through several core functions that include applied social research and policy analysis; community development and capacity building; promotion and management of volunteerism; and community education and advocacy.

Examples of CDH activities include an examination of labour force challenges associated with the non-profit and voluntary sector; research on transitional housing for homeless youth; the development of communication tools to bring members of the community up-to-date on important social and economic issues; an analysis of the determinants of active ageing and development of recommendations for supportive environments for older persons; and strengthening the capacity of Halton communities to access, understand and use social data and to build community profiles and maps (e.g. through publication of the series *Community Lens* that disseminates and interprets community data from the 2006 Census as this information becomes available). The volunteer component of CDH's work is carried out through *Volunteer Halton* and designed to promote civic engagement and a civil society within and across the region.

Future CHD strategic priorities include promoting public understanding of the social determinants of health; a poverty reduction strategy; advancing diversity; community education; volunteer management; and labour force development within the social sector.

CDH reports to Halton Regional Council on a regular basis as the Council uses the organization as a barometer for community issues. While CDH reports annually to the public, its works with diverse communities, their boards, volunteers and staff on a daily basis to advance action on community-based recommendations, to 'speak truth to power' and to engage in 'evidence-based advocacy for change.'

### **Business Community Anti-Poverty Initiative, Saint John N.B.**

In 1997, a retired business executive acted on his concern for the high rate of poverty in Saint John and invited his colleagues to form the Business Community Anti-Poverty Initiative.

The early efforts of BCAPI focused on listening to the voices of people in poverty ("the true experts") and on addressing the concerns they identified as being most critical to their circumstances: childcare, education, employment, housing, youth and government disincentives. In 2000 BCAPI commissioned the international consulting firm of Deloitte to undertake a poverty study for the city. The study articulated the multi-generational nature of poverty in Saint John and highlighted the fact that the majority of people living in poverty were single parents and their children who were stuck in the poverty cycle; it became BCAPI's road map.

The BCAPI mission is one where business leaders, community organizations and government, working together with people living in poverty, are dedicated to substantially reducing poverty in Greater Saint John.

The BCAPI goals for 2007-2010 are to help children to succeed in school; to enhance programs for teens that prevent pregnancy, improve well-being and enable high school completion; help

young adults who are not in school or employed to become employable; put the right supports in place for young single parents to achieve education and income; involve others who can help to reduce poverty and achieve *True Growth* in Saint John; and foster BCAPI's growth.<sup>3</sup>

Stewardship of BCAPI is provided by an Executive Committee, co-chaired by two business leaders, and a Cabinet that is comprised of the Executive Committee, the Chairs of five Working Groups and the Chair of Vibrant Communities Saint John (VCSJ) (described below). The Working Groups include Single Parent Families; Housing; Youth Poverty; Education to Employment; and Communications. Each Working Group has 8-20 members each, drawn from across business, academia, federal and provincial government departments, the City of Saint John and non-government organizations (including children and youth, education, human resources development, social development, health, housing, economic development). The day-to-day operations of BCAPI are managed by a full-time Coordinator.

Some of the accomplishments of the Working Groups/BCAPI to date include: founding of Partners Assisting Local Schools, an ambitious business-community schools partnership that has been implemented in 7 inner-city schools; collaboration in establishing a residence and support program for homeless pregnant and parenting youth; facilitating the development of 100 new affordable housing units annually and the development of a housing strategy for Saint John; partnering in the establishment of The Resource Centre for Youth (TRC) a one-stop centre to engage teens in positive recreation, education, employment, health and community involvement experiences; partnerships to establish an alternative high school and daycare for teen parents and to support for adult literacy and GED preparation; and job-creation for people living in poverty.

In 2002, Saint John was invited to participate in Vibrant Communities, a Pan-Canadian Poverty Reduction initiative.<sup>4</sup> BCAPI agreed to be the local sponsoring organization and convened a Roundtable of local leaders to oversee the initiative. Vibrant Communities Saint John was officially launched in February 2005 and BCAPI continues to convene the Roundtable.

The VCSJ Leadership Roundtable engaged the community to develop a three year Poverty Reduction Strategy for Saint John built on the principles of comprehensive thinking and action, community asset building, multi-sector collaboration and community learning and change. The implementation of the 3 year strategy enabled the City to exceed its targets and help more than 2000 local people move out of poverty. The Strategy was renewed in 2008.<sup>5</sup>

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<sup>3</sup> The five mayors of Greater Saint John are working together to promote a *True Growth* strategy to ensure a supportive, economically thriving and enriching community where people, ideas and investment come to stay (Caledon Institute of Social Policy, p2)

<sup>4</sup> The Vibrant Communities initiative is led by the McConnell Foundation, Caledon Institute of Social Policy and Tamarack Institute for Community Engagement. Saint John is one of six Trail Building communities across the country implementing poverty reduction initiatives ([www.vibrantcommunities.ca](http://www.vibrantcommunities.ca))

<sup>5</sup> The Province of New Brunswick, encouraged in part by Saint John's experience, has recently introduced a multi-sector leadership team to develop a Poverty Reduction Plan.

Saint John's 10 year poverty trend (LICO before taxes) has dropped from 27% (1996) to 20.8% (2006) and the number of children in poverty has been reduced from 35% to 28%. The BCAPI prepares an annual Report Card to chart progress on all priorities and track the ongoing changes in poverty incidence in Saint John and the province.

## **Cross-Sectoral Action**

### **Roundtable on Socio-Economic Determinants of Health**

The Conference Board of Canada was aware that a growing global dialogue around the determinants of health was beginning to change the traditional perceptions of health and what makes people healthy. However, it was of the view that there has been little attention given within the business community to the importance of addressing health issues, that the participants of this global dialogue were largely public health experts, and that the insights from this dialogue had yet to begin to find their way into public discourse and into the health policy of many governments or into the thinking of business, to any significant degree.

Accordingly, in 2006 the Conference Board created the Roundtable on the Socio-Economic Determinants of Health on the premise that integrated policies and actions across all sectors, and greater collaboration to achieve shared goals, can significantly improve the health of Canadians and contribute directly to improved productivity and economic growth for the country.

The Roundtable affords an opportunity to engage businesses of all varieties to understand the importance of improving health outcomes by addressing the determinants of health; to strengthen their capacity to make a tangible commitment to population health; and to work collaboratively with government, other businesses and communities on issues pertaining both to the health care system and to the social and economic inequalities that affect health. Membership is comprised of leaders from business, federal and provincial governments, academia and local communities and from across such diverse sectors as education, health, housing, transportation and urban development.

The work of the Roundtable is organized around several key areas of intervention:

- ▶ **Research:** Building insights and marshal the evidence through research and dialogue about successful policies and practices that address socio-economic determinants of health.
- ▶ **Collaboration:** Combine the knowledge and experience of multiple stakeholders and promote collaboration among business, government and other organizations by identifying solutions to health challenges that they can jointly undertake for maximum impact.
- ▶ **Government action:** Determining priority areas and identifying opportunities for the Roundtable to provoke government action.
- ▶ **Private sector and employer action:** Stimulate employers and business groups to influence public policy and to build on their capacity to improve profits and competitiveness through investments in the determinants of health.

► Communication: Create a heightened awareness across Canada regarding what determines health, and communicate to decision-makers.

Thus far, the Roundtable has developed an Operational Work Plan and has concentrated its efforts on a number of important communications activities including a submission to the Senate Subcommittee on Population Health and production of its own benchmark report, *Healthy People, Healthy Performance, Healthy Profits The Case for Business Action on the Socio-Economic Determinants of Health* (December 2008). It is also in the process of completing a research project on affordable housing.

In addition, the Roundtable is developing a long-term communications and engagement strategy - *DeterminACTION* © - to promote awareness and to enable business leaders and other stakeholders to act on the socio-economic determinants of health. The strategy will be comprised of five elements: (i) *concept development*; (ii) strategies to secure *stakeholder and sponsor engagement*; (iii) design of a *logo* and development of a *website/e-portal*; (iv) development and launch of a variety of *products and services* (e.g. research initiatives and an awards program); and (v) *communications initiatives* designed to spread the *DeterminACTION* © brand and message.

The Conference Board facilitates three meetings per year corresponding with the Work Plan endorsed by members of the Roundtable. In addition to face-to-face meetings, the Roundtable includes a program of webinars and other alternative activities.

### **Section 54 of Quebec's Public Health Act**

In December 2001 a new Public Health Act was approved Quebec National Assembly. The legislation confirmed the importance of the public health functions associated with health promotion, prevention, surveillance and protection, and called for the engagement of all sectors of government and society in developing public policies to improve population health and to reduce health disparities.<sup>6</sup>

Section 54 affirms the role of the Minister of Health and Social Services as advisor to the government on all matters pertaining to public health and requires all ministries and agencies to consult with the ministry (MSSS) when they are formulating laws and regulations that could have an impact on the health and well-being of the residents of Quebec.

Development of the new Act was motivated in part by limitations in the previous legislation (1972). Section 54 specifically reflected a desire to strengthen the legislation to support an emerging population health approach associated with the new vision of public health embodied within the Ottawa Charter for Health Promotion and contained within various European and Scandinavian initiatives. As well the unique integration of health and social services responsibilities within one government portfolio in Quebec and the establishment of a Health and Well-being Council to mobilize public and community stakeholders on social conditions

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<sup>6</sup> In 2002 the National Assembly also passed the Act to Combat Poverty and Social Exclusion. The idea of a legal framework to combat poverty was initiated by a broad-based citizens' movement, making Quebec the only jurisdiction in Canada having a legislative basis for combating poverty. (Collins, 2007)

across the province are considered to have influenced the new legislation. In addition, the legislation was one of three ‘integrated and comprehensive policy instruments’ introduced over two decades by the Government of Quebec to serve as the infrastructure for Quebec’s healthy public policy and as tools to address the social determinants of health. (Chomik,2007)<sup>7</sup>

To implement Section 54, the public health department (within the MSSS) developed a strategy consisting of two complementary components. The first involves support for research, including funding to develop tools to examine the effects of public policies on health and to support knowledge transfer. The second involves an intra-governmental health impact assessment (HIA) process consisting of five steps that all ministries and agencies must work through to assess the health impacts of their policies: screening, framing and preliminary assessment, in-depth analysis, adjustments and decision-making, and assessment and follow up. (Chomik, 2007)

A legislative committee has been established within MSSS to guide the HIA process; it evaluates policies being developed within ministries and in consultation with them, helps to improve health impacts and/or to develop a means to protect people from the adverse effects of planned policies. Each ministry has a designated person who serves as a link between itself and the MSSS and who works closely with the legislation committee to foresee and evaluate the health impacts of their respective ministry’s work (Chomik, 2007)

The main mechanism for accountability of Section 54 is the health impact assessment. If ministries do not perform an HIA, they may see their projects blocked by the council of ministers. However, there are no specific incentives or disincentives to prompt ministries to integrate public health concerns and criteria. Conversely, the windows of opportunity for engaging other ministries comes either through the tabling of an Act or regulation, which activates the HIA mechanism, or through a process of consultation and dialogue between MSSS and experts of the INSPQ which may result in relevant public health research and recommendations. (Gagnon et.al.2008)

In 2005, an assessment of the implementation of Section 54 was conducted within MSSS. The overall conclusion was that while there had been some modest implementation of the HIA provisions, a general lack of understanding of the mechanism itself and of the factors that contribute to health and well-being remained key obstacles to greater implementation. As well, the acceptability of the HIA mechanism varied from one organization to another with those organizations having a ‘social’ mandate adhering more closely to the process than others. In the final analysis it was considered too early to draw any conclusions about the capacity of Section 54 to effect significant change and a series of measures were identified for strengthening future efforts across the government.

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<sup>7</sup> The other two were the establishment of the Institut national de santé publique du Québec (INSPQ), the public health institute, and implementation of a ten-year public health program to ensure similar services in all regions of the province. (Chomik,2007)

## **Research, Knowledge Development and Exchange, Monitoring and Evaluation**

### **Indicators of Health Inequalities**

A priority of the Pan-Canadian Public Health Network is the development of a set of indicators that will facilitate collaborative and efficient action on population health and the establishment of measures to enable jurisdictions to assess progress in the reduction of health inequalities. To this end the Population Health Promotion Expert Group (PHPEG) of the Network has been charged to develop a list of 10-20 measurable indicators of inequalities in health status in Canada and the determinants of health over the course of the year.

In 2000, First Ministers agreed on the importance of reporting to Canadians regularly on the performance of our health care system. Since then, there has been growing attention to the development of population health indicators, including indicators on the determinants of health and health disparities.

In 2004, the (then) Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security established a Health Disparities Task Group in 2004 to explore the development of a set of indicators. This Group was comprised of members from government (ministries of health and statistics), social development, research and academia and the non-government sector. Drawing on the deliberations from two earlier and related events, the Task Group produced a report titled *Reducing Health Disparities-Roles of the Health Sector: Discussion Paper*. The report made the case for the importance of addressing health disparities in Canada and proposed that the efforts of the health sector focus on four policy directions: make health disparities reduction a health sector priority; integrate disparities reduction into health programs and services; engage other sectors in health disparities reduction; and strengthen knowledge development and exchange activities.

In 2005, the Pan-Canadian Public Health Network (PHN) – and Council – was created along with six Expert Groups, including the Population Health Promotion Expert Group (PHPEG).<sup>8</sup> The PHPEG advises the PHN Council on strategic directions and priorities for population health promotion in Canada. The PHN Council readily took up the interest in health disparities and charged the PHPEG to develop a set of indicators for health disparities as a priority in its work plans, beginning in 2006-2007.

In 2006, under the leadership of the PHPEG, a workshop involving a cross-sector mix of experts was convened to establish the groundwork for developing a set of indicators. As a result of that event, three broad categories of potential indicators were identified as being desirable: (i) indicators of inequalities in the determinants of health; (ii) indicators of inequalities in health status; and (iii) indicators of the impact of health inequalities on the economy, communities, families and individuals, and the health care system.

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<sup>8</sup> Further information on PHN and its other Expert Groups is available at [http://www.phn-rsp.ca/About\\_e.html](http://www.phn-rsp.ca/About_e.html)

Following the workshop, the PHPEG commissioned a report that was intended to provide a platform for its further deliberations. Among other things, the report identified a common set of measurable health disparities indicators and a possible approach to their implementation in the Canadian context. In January 2009, and working in collaboration with the Healthy Living Issue Group of Pan-Canadian Public Health Network Healthy Living Strategy, the PHPEG convened a follow-up meeting to develop indicators in the first two categories: inequalities in the determinants and in health status.<sup>9</sup> Participants were drawn largely from the statistics and health sector, with the latter including federal, provincial/territorial and regional health authorities.

The indicators being developed as a result of the January 2009 workshop will be forwarded to the Canadian Institutes of Health Information and Statistics Canada for a 3<sup>rd</sup> National Consensus Conference on Public Health Indicators in March 2009. This Indicators project is an ongoing collaborative effort between Statistics Canada and the Canadian Institute for Health Information and provides health regions, health care providers and the public with reliable and comparable data on the health of Canadians, the health care system and the determinants of health.

### **Equity Lens for Public Health Interventions**

Interior Health (IH) is one of five geographically-based health authorities in BC. It is responsible for ensuring health services to a population of about 720,000 people (including 55 First Nations communities) in the Southern Interior of BC.

In early 2008, the Public Health Directors of IH approved recommendations to develop a systematic, supported approach for the application of an ‘Equity Lens’ to core public health programs within IH. A process is presently underway to implement the measures.

BC, like other jurisdictions, established core public health functions and a related framework that defines the core activities of a comprehensive public health system. The key components of the framework – established in 2005 - include the core public health programs themselves; strategies to implement the programs; lenses through which the health needs of specific populations are assessed and addressed; and system capacity elements i.e. the resources required to apply the strategies and implement the core programs.

At the time of developing the new framework, the government acknowledged that inequalities in health status were widespread in BC and often rooted in the social, economic, cultural and environmental determinants of health. Accordingly, an equity lens (at the time it was called an ‘Inequalities Lens’) was incorporated within the core functions framework on the grounds that it “concerns public health’s duty, as one of its fundamental tasks, to work to reduce inequalities in health.” (A Framework for Core Functions, 2005)

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<sup>9</sup> The HLIG was created in June 2006 and reports to the PHPEG. Among other duties, it provides advice to PHPEG on policy issues related to healthy living and fosters strong communications with healthy living stakeholders across the country and across all sectors of the Pan-Canadian Healthy Living Strategy.

Interior Health's approach to an equity lens has included two key components: a 'gap analysis' (health equity assessment) that includes a tool (i.e. a series of questions) to help to illuminate equity gaps and a 'performance improvement plan' that includes a section devoted to health equity issues relevant to the core program and that considers strategies to promote health of vulnerable populations.

Despite some progress in applying the lens within IH, several limitations called for a more systematic, supported approach to its ongoing implementation. These limitations included the lack of better alignment and integration of the lens into core and other programming; a lack of clarity around how to address Aboriginal health equity issues; a need for better information about effective interventions to reduce health inequities; and lack of knowledge, capacity and skills to address and/or support health equity.

The 2008 recommendations are expected to strengthen implementation of the lens in several ways. They will:

- ▶ *Provide a working definition of the equity lens* i.e. An approach to program planning, delivery, monitoring and evaluation that requires the systematic application of guidelines and tools in order to implement and develop better practice evidence to reduce health inequities, especially those experienced by vulnerable populations;

- ▶ *Identify the essential elements of a 'supported approach,'* including leadership and support for health equity as a public health priority; adoption of better practices and a strategy for knowledge development and exchange; development of an HR strategy; improved surveillance; and a strategy for engagement with vulnerable populations;

- ▶ *Clarify the approach to Aboriginal health equity,* including endorsement of an 'Aboriginal lens' and whether and how it will apply to core programming; articulation of an approach to Aboriginal health across core programs with a strong focus on certain key program areas; and clarification of expectations for the public health role with First Nations communities. (Correspondence with staff of IH)

While development of the lens is the work of Interior Health, the resulting tool provides an important guide for addressing health inequities within the region. And to this end, IH has been unequivocally clear that it will work in close collaboration with stakeholders who are often positioned outside of the health sector.

## **4. A Few Concluding Questions**

The above initiatives suggest that very complex challenges (which contemporary literature states often take very complex solutions for resolution) can indeed be addressed and sustained – at least for the short term so far (i.e. 5-10 years and counting in some jurisdictions) – through multi-sectoral, integrated and reasonable comprehensive strategies and actions. Perhaps they also suggest that the scope, nature and complexity of each initiative is unique to the history, culture and capacities of each space and that, in the final analysis, it is not complexity that is the obstacle for success but rather the lack of a driving force to sustain the momentum!

What is the ‘art of the possible’ when it comes to reducing health inequalities? A few questions may provoke thinking prior to the March 18-19 discussions. Undoubtedly, many more will arise in the course of the Working Session.

► How will these promising efforts to reduce health inequalities be sustained? What considerations and/or conditions need to be in place to ensure that they continue? What impact do/will the current economic conditions have on ongoing efforts? Will they be a facilitator or impediment to action?

► How important is it to try to find a common language across the country to continue the dialogue on health inequalities/inequities or do these initiatives suggest that this is not so much a challenge? What kinds of communications strategies do appear to be desirable?

► With the technologies that allow us to ‘twitter,’ engage in communities of practice and participate in virtual networks and constellations, can technology be better harnessed to communicate and advance the work on reducing health inequalities in Canada?

► What roles can the public health sector play to continue to promote this work? It is suggested that public health must ensure equitable access to public health services; mediate the impact of the determinants of health for people using public health services; and participate in upstream work to address the determinants and to reduce health inequalities/inequities. How well is public health doing in each of these areas and how can it be more effective in the future?

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