SYSTEMATICALLY INTEGRATING HEALTH EQUITY INTO THE WINDSOR-ESSEX COUNTY HEALTH UNIT

2013-2017

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This is the right time, and this is the right thing.

Thomas Moore

INTRODUCTION

This report lays the groundwork for a health equity strategy for the Windsor-Essex County Health Unit. The Health Equity Strategy Committee strongly believes that such a document is important for the Health Unit at this time. However, readiness is crucial to our success in adopting a health equity strategy.

IS THE TIMING RIGHT FOR HEALTH EQUITY TO BE A WECHU PRIORITY?

A number of factors suggest that the timing is right for WECHU to consider health equity as a priority. Provincially, there has been an increasing emphasis on health equity issues. The 2011 Annual Report of the Chief Medical Officer of Health, *Maintaining the Gains, Moving the Yardstick*, put a focus on health equity by highlighting specific measurable health indicators and identifying health disparities with a population health approach. Later, in April 2013, the Ministry of Health and Long-Term Care released its first strategic plan for the public health sector, *Make No Little Plans*, with a focus on health equity.

This increasing emphasis at the provincial level has been coupled with a formal expectation that Ontario Public Health Units address the determinants of health and the health inequities of priority populations by working with community partners. In fact, the 2008 Ontario Public Health Standards explicitly state that doing so is "fundamental to the work of public health in Ontario." As well, the Ontario Public Health Organizational Standards specify that all Health Units must, in their strategic plan, describe how "equity issues will be addressed in the delivery and outcomes of programs and services."

In addition to the formal direction taken by the ministry, now is also a time of great opportunity for health equity support from many partners. These partners include the Ministry of Health and Long-Term Care, Public Health Ontario, the National Collaborating Centre for Determinants of Health, the network of other provincially funded Social Determinants of Health Public Health Nurses, and the OPHA/alPHa Health Equity Working Group.

So yes, the timing is right.

THE TIMING MAY BE RIGHT, BUT IS OUR HEALTH UNIT READY FOR CHANGE?

Change is never easy. While the external conditions may be ripe, we also need to establish whether WECHU is ready to move toward a health equity focus at this time. While many staff have verbalized the need for our agency to address the determinants of health, and this is very important and encouraging, there are also a number of internal conditions that would facilitate such a shift.

Organizationally, WECHU has already taken steps to formally acknowledge the importance of health equity by situating it as a core value in our mission, vision and values and, by extension, in our 2012-2017 Strategic Plan. The newly formed Epidemiology, Planning, Evaluation, and Quality (EPEQ) Department is also a central source of support for health equity activities. By providing epidemiological and formal planning services, EPEQ ensures that we can more readily identify health disparities in our community and better plan programs and services to address these local needs. As well, there are two provincially funded Social Determinants of Health Public Health Nurses located in the EPEQ Department to help guide the new direction towards health equity in our organization and community.

So yes, WECHU is definitely poised for change.

SO, WHAT DO WE NEED TO DO NEXT?

Taking action will require a change at both individual and systemic levels. This document lays the foundation for where we believe we need to go next to achieve these changes. One major focus of the current health equity strategy is on staff education. We believe that it is vital for staff to be empowered with the knowledge, attitudes, and tools to move forward. In fact, the next section of this document begins to lay out some of the basic tenets of healthy equity. However, educational efforts must also work in tandem with developing a process to formally and systematically integrate health equity into our Health Unit culture and activities.

PART 1: OUR CHALLENGE - SYSTEMATIC, SOCIALLY PRODUCED AND UNFAIR HEALTH DISPARITIES

Before moving forward, it is helpful to have a good grounding in the basics of health equity. This following section provides a review of central concepts. You may also want to refer to the glossary in Appendix A.

WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH?

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (World Health Organization, 1948).
>
> *"Canadians are largely unaware that our health is shaped by how income and wealth is distributed, whether or not we are employed, and if so, the working conditions we experience. Furthermore, our well-being is also determined by the health and social services we receive, and our ability to obtain quality education, food and housing, among other factors. And contrary to the assumption that Canadians have personal control over these factors, in most cases these living conditions are – for better or worse – imposed upon us by the quality of the communities, housing situations, our work settings, health and social service agencies, and educational institutions with which we interact"* (Raphael, D., 2010, p. 7)

Health is complex and determined by the interaction and intersection of a range of social and economic factors, the physical environment, and personal circumstances (Daghofer and Edwards, 2009; Public Health Agency of Canada, 2011; Simcoe Muskoka District Health Unit, 2012; Whitehead, 1995). Collectively, these factors are referred to as the determinants of health. The Ontario Public Health Standards (2008) identifies the determinants of health as income and social status, social support networks, education and literacy, employment and working conditions, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services (access to), gender, culture, and language.

The social determinants of health refer to the socio-economic factors that influence health. They include the determinants of health listed above except biology and genetic endowment. Keon and Pepin (2009) argue that "the socio-economic environment is the most powerful of the determinants of health" (p. 7) and "fully 50% of the health of the population can be explained by socio-economic factors" (p. 8).

Throughout the literature, the determinants of health and social determinants of health are used interchangeably. However, our focus is on the social determinants of health because these are the factors that are modifiable through public health programs and services, and through collaboration with our community partners.

HOW DO THE SOCIAL DETERMINANTS OF HEALTH RELATE TO HEALTH STATUS?

According to Gardner (2012, p. 1), the social determinants of health produce “reinforcing and cumulative impacts over people’s lives and on the health of populations and communities”. To illustrate this notion, take the following example. A child born into poverty and having reduced access to resources and nutritious food may experience effects later in life when they are unable to learn adequately in school and graduate from high school. This in turn may limit the type of employment they can obtain, resulting in their having a precarious job that requires them to work long hours with no medical benefits and live in a neighbourhood with a high crime rate near a factory that spews chemicals into the air. In this case, multiple determinants work in a cumulative fashion over time to impact an individual’s life and health. As a more concrete example, Bierman et al. (2009) looked at the relationships between various determinants of health and health outcomes for Ontarians. Their research showed that the social determinants of health were linked to the following:

- Higher prevalence of overweight or obesity and physical inactivity
- Inadequate intake of fruit and vegetables
- Increased smoking
- Greater food insecurity
- Higher incidence of chronic conditions such as hypertension, arthritis, obstructive lung disease, diabetes, heart disease/stroke, and depression
- Higher probability of premature mortality

WHAT IS HEALTH INEQUITY?

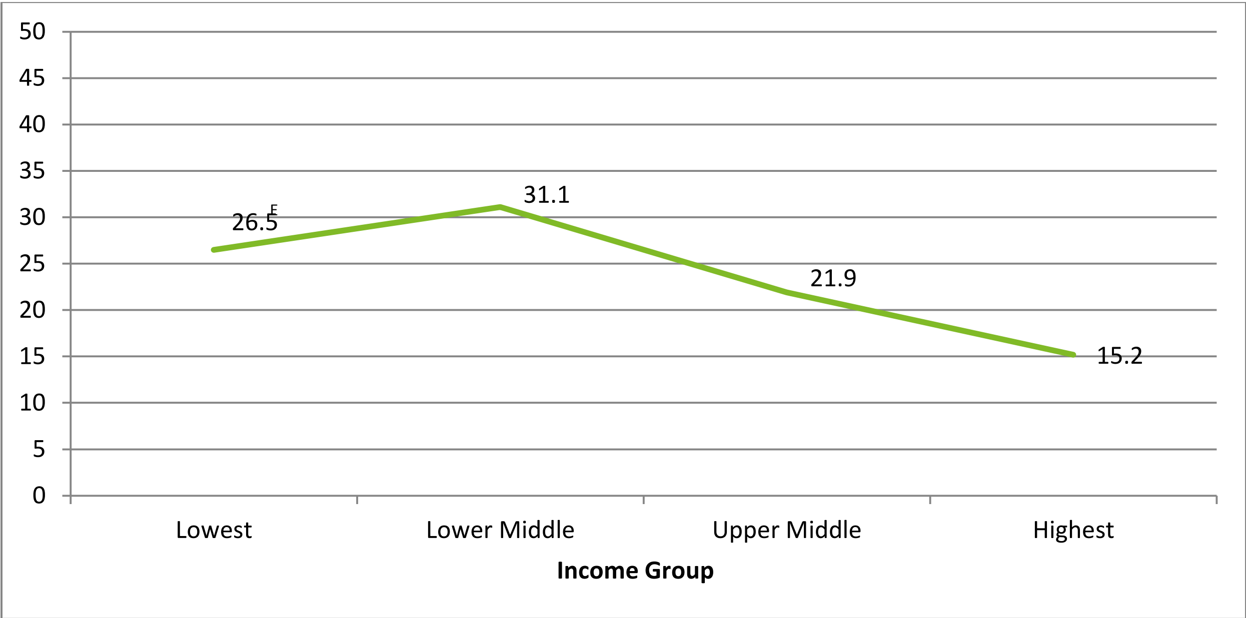
It is probably not surprising that health differences exist between various groups of people. One could easily argue that there are, and always will be, individual variations in health status because of things such as genetics, physical characteristics, or age. However, this is where the concept of health inequity becomes most salient. According to Whitehead and Dahlgren (2006), there are three conditions under which health differences become health inequities. Specifically, when differences in health status are systematic, socially produced, and unfair or unjust, these differences become inequitable. In short, health inequities are systematic differences in the health status of different population groups. For example, we know that health inequities exist in Canada and occur among people with varying incomes and education, between those who live in rural areas and those who live in cities, between different neighbourhoods, between men and women, and between Aboriginal and non-Aboriginal people (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004; Keon and Pepin, 2009; National Collaborating Centre for Determinants of Health, 2010; Public Health Agency of Canada, 2011).

WHAT IS THE SOCIAL GRADIENT IN HEALTH?

Health inequities follow a social gradient where those living in lower socio-economic circumstances are not as healthy as those at each subsequently higher socio-economic level (Chief Public Health Officer, 2008; Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004; Keon and Pepin, 2009; Kosteniuk and Dickinson, 2003; National Collaborating Centre for Determinants of Health, 2013). In other words, “health status is directly related to social status” (Kosteniuk and Dickinson, 2003, p. 263).

The implications of the social gradient in health are enormous for public health practice. Quite simply, in order to improve the health of the population we must minimize the social gradient by leveling-up the health status of the least healthy to that of the most advantaged (Whitehead and Dahlgren, 2006). Tables 1, 2 and 3 below identify crude rates of arthritis, hypertension, and asthma in Windsor-Essex County and illustrate what a social gradient in health might look like.[1, 2]

Table 1
Percentage of Population with Arthritis, Windsor-Essex County, 2007-2012, by Income Level



[E] Interpret with caution due to high sampling variability
Data Source: Canadian Community Health Survey [2007, 2008, 2009, 2010, 2011, 2012], Statistics Canada, Share File, Ontario MOHLTC.

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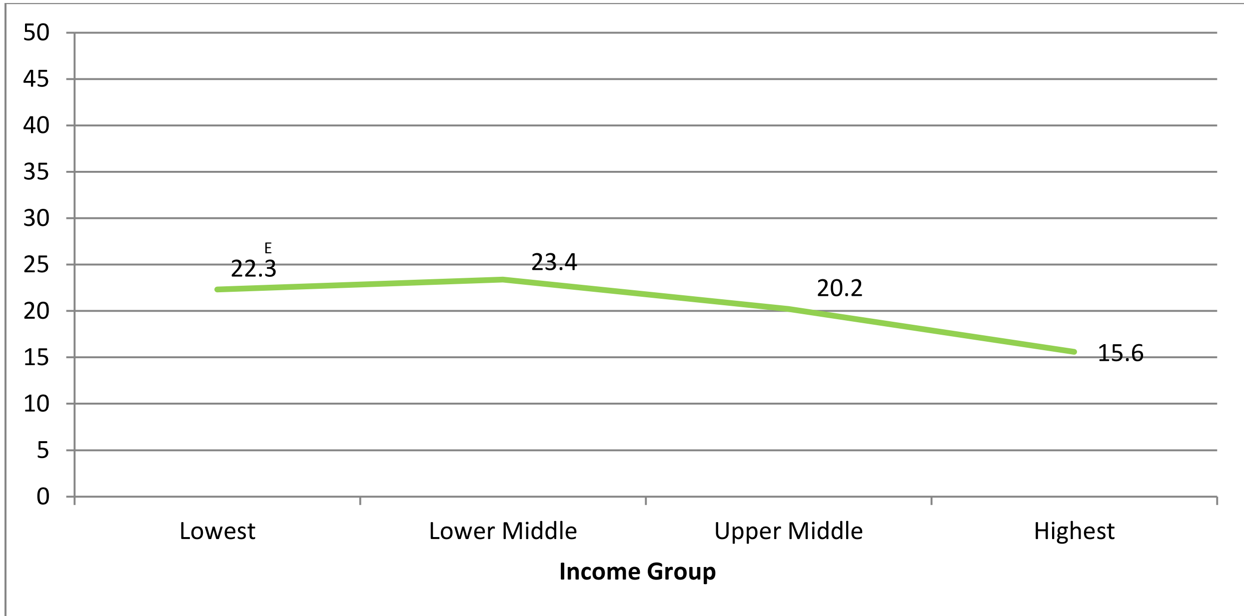
[1] Income category definitions based upon reported total household income: Lowest income = <$15,000 (1 or 2 pers.), < $20,000 (3 or 4 pers.), < $30,000 (5or more pers.). Lower middle income = $15,000-$29,999 (1 or 2 pers.), $20,000-$39,999 (3 or 4 pers.), $30,000-$59,999 (5 or more pers.). Upper middle income = $30,000-$59,999 (1 or 2 pers.), $40,000-$79,999 (3 or 4 pers.), $60,000-$79,999 (5 or more pers.). Highest income = $60,000 or more (1 or 2 pers.), $80,000 or more (3 or more pers.).

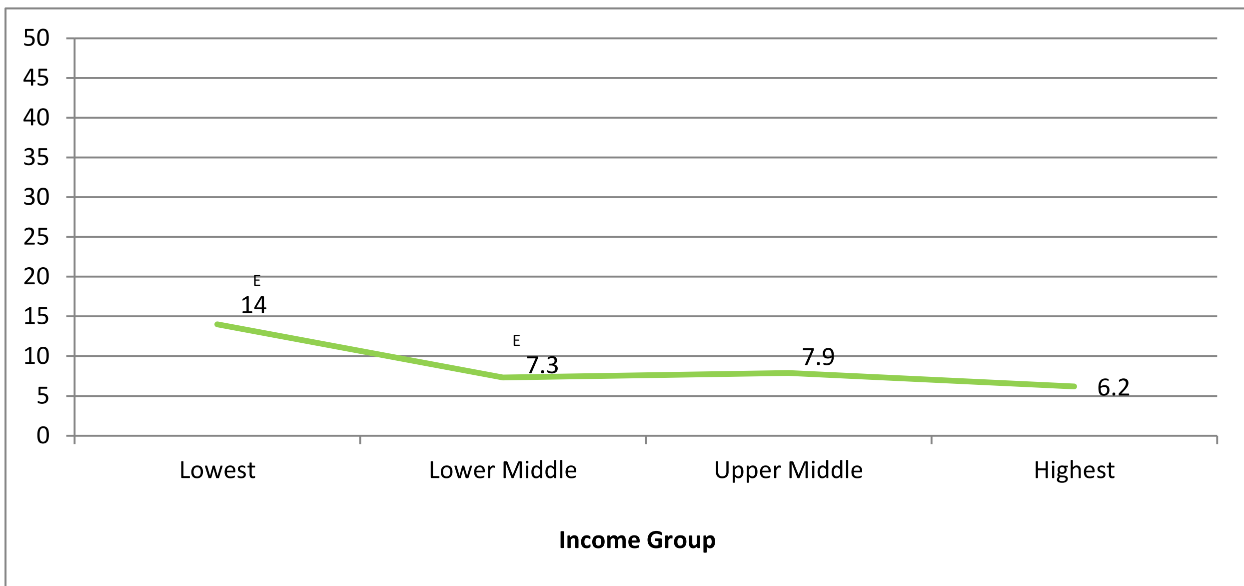
[2] Results have not yet been age-standardized

Table 2
Percentage of Population with Hypertension, Windsor-Essex County, 2007-2012, by Income Level



[E] Interpret with caution due to high sampling variability
Data Source: Canadian Community Health Survey [2007,2008,2009,2010, 2011, 2012], Statistics Canada, Share File, Ontario MOHLTC.

Table 3
Percentage of Population with Asthma, Windsor-Essex County, 2007-2012, by Income Level



[E] Interpret with caution due to high sampling variability
Data Source: Canadian Community Health Survey [2007,2008,2009,2010, 2011, 2012], Statistics Canada, Share File, Ontario MOHLTC.

WHAT IS HEALTH EQUITY?

Sitting in opposition to health inequity and the social gradient in health is the state of health equity. Health equity is the absence of systematic, socially unjust health disparities, or health differences (Whitehead and Dahlgren, 2006). Health equity aims to create opportunities for good health, remove barriers to achieving good health, and means that everyone has an equal opportunity to reach their full health potential (Braveman and Gruskin, 2003; National Collaborating Centre for Determinants of Health, 2013; Whitehead and Dahlgren, 2006). Furthermore, it means that people are not disadvantaged from achieving good health because of socially determined factors (Braveman and Gruskin, 2003; Whitehead and Dahlgren, 2006).

Promoting health equity requires taking action on the social determinants of health and addressing the health inequities among those who are socially and economically disadvantaged (National Collaborating Centre for Determinants of Health, 2013; Whitehead and Dahlgren, 2006). We should all have the same opportunities and be able to make the choices that allow us to live a long and healthy life. We should all have the same access to health care and nutritious foods, and the fair distribution of health resources. We should all have adequate housing and working conditions, and we should have any barriers to achieving good health removed. People should not be disadvantaged from reaching their full health potential because of their gender, ethnicity, age, or other socially determined circumstance (Robert Wood Johnson Foundation, 2010; National Collaborating Centre for Determinants of Health, 2013; Whitehead and Dahlgren, 2006).

Although some of our current programs and services at WECHU address the social determinants of health and target priority populations (see Appendix B), there is no formal process to address health equity. Continuing to do business as we have in the past is not an option if we want to truly address health inequities and level-up the health of the population. Thus, reducing the health gaps that exist among our most vulnerable populations will require us to transform how we do business. Accordingly, we will need to do the following (Cohen et al., 2013; EuroHealthNet, 2009; Joint OPHA/alPHa Working Group on Social Determinants of Health, 2010; National Collaborating Centre for Determinants of Health, 2010).

- Identify and monitor the health inequities in our community.
- Set targets to reduce these inequities.
- Assess, plan, deliver and evaluate programs, services and policies to address health equity.
- Increase access to programs and services by priority populations.
- Develop staff knowledge and skills regarding the social determinants of health and promoting health equity.
- Develop a sensitivity to the needs of priority populations.
- Conduct Health Equity Impact Assessments (HEIAs) on our programs, services and policies.
- Embed the promotion of health equity into the culture of WECHU.

This strategy is the beginning of a health unit-wide transformation that seeks to embed the promotion of health equity into our everyday activities so we can better serve our community needs, live our values, and move towards fulfilling our mission and vision in accordance with our Strategic Plan (WECHU, 2012).

PART 2: OUR SOLUTION - DEVELOP A FORMAL AND SYSTEMATIC PROCESS TO ENSURE THAT HEALTH EQUITY IS INTEGRATED INTO OUR HEALTH UNIT ACTIVITIES

With a firmer grounding in the importance, relevance and challenges of achieving health equity, this strategy now turns to considering how best to move forward. Our approach is based on existing best practices and tailored to our local context through the committee's joint efforts.

HOW THE HEALTH EQUITY COMMITTEE DEVELOPED THIS STRATEGY

In April 2013, an invitation was sent to all health unit staff inviting them to join a working committee to help develop a Health Equity Strategy for WECHU. The purpose was to develop a shared vision of a formal and systematic process to ensure all Health Unit programs and activities address the social determinants of health and health equity. The Health Equity Strategy Committee was established in May with the Social Determinants of Health nurses acting as facilitators.

In the early stages, the committee members were asked to answer two visioning questions:

- In 2017, what will be different at the health unit because we have been working effectively to reduce social inequities in health?
- In 2017 what will the community look like because we have been so effective in reducing social inequities in health?

Responses were recorded on a flip chart and transcribed and organized by themes. The list of visioning ideas is included in Appendix C. These ideas were then developed into priorities.

In subsequent meetings, committee members agreed upon which guiding frameworks to use and answered two further questions. These questions were used to identify the actions necessary to achieve the strategy and our indicators of success. The remaining two questions were:

- How are we going to get there?
- How are we going to measure our success?

The remainder of this document formally presents the committee's recommendations for systematically integrating health equity into the WECHU.

POPULATION HEALTH APPROACH

Consistent with the WECHU Strategic Plan 2012-2017, this health equity strategy will use the Population Health Approach as a guiding framework. The Population Health Approach has eight key elements that require us to:

- Focus on the health of the population.
- Address the determinants of health and their interactions.
- Base decisions on evidence.
- Increase upstream investments.
- Apply multiple strategies.

- Collaborate across sectors and levels.
- Employ mechanisms for health outcomes.
- Demonstrate accountability for health outcomes.

As an approach to health, population health aims to improve the overall health of the population and reduce inequities in health among population groups. The approach focuses on the determinants of health that influence the health of populations over the lifespan, identifies systematic variations in their patterns of occurrence, and develops and implements policies and actions to help improve the health of those populations (Health Canada, July 2001).

10 PROMISING PRACTICES

WECHU's Health Equity Strategy also adapts specific promising practices to level-up and reduce health inequities. These are taken from the 10 Promising Practices identified through an extensive review and analysis of the literature by Sutcliffe, Snelling and Lacle (2009) and adapted for the Sudbury & District Health Unit in 2011. While only the abridged version of the practices will be reported here, the technical briefing can be viewed by going to the Sudbury & District Health Unit website.

While we will not need to use all ten practices to achieve our priorities and objectives, we encourage the adoption of all ten practices to enable the Social Determinants of Health nurses to continue to work in the community while WECHU is building staff capacity and integrating health equity measures into our public health practices. The 10 Promising Practices include targeting with universalism, purposeful reporting, social marketing, health equity target setting, equity-focused health impact assessment, competencies/organizational standards, contribution to evidence base, early childhood development, community engagement, and intersectoral action. Each is described below.

1) TARGETING WITH UNIVERSALISM

There should be a balance of targeted approaches within universal strategies to help to improve the health of priority populations while improving the health of the whole population at the same time. If we want to level-up the health of priority populations, then we must target them specifically. Targeting within universalism provides extra benefits to disadvantaged populations and helps to fine tune universal approaches.

2) PURPOSEFUL REPORTING

This promising practice recommends intentionally reporting on health disparities to help plan and guide programs, services and policies. By doing this, the health unit can also track changes over time.

3) SOCIAL MARKETING

To help reduce health inequities, social marketing can be used for two purposes. The first is to target priority populations to try to change their behaviour (to level-up their health). The second purpose is to try to change the understanding and behaviour of decision makers and the public to take or support action to improve health inequities in the community. It is more effective to combine the two approaches.

4) HEALTH EQUITY TARGET SETTING

Although not wholeheartedly supported in the literature, when used as part of a bigger strategy such as community engagement, developing, monitoring and measuring attainable objectives (targets) ensures that health inequities are tackled explicitly and in a measurable way.

5) EQUITY-FOCUSED HEALTH IMPACT ASSESSMENT

An Equity-focused Health Impact Assessment is a tool that applies an equity lens to look at potential health impacts of a program, service, or policy. To do this, the tool walks the user through a broad range of evidence gathering to help inform the decision making process. The interpretation requires value judgments and lies with the decision makers.

6) COMPETENCIES/ORGANIZATIONAL STANDARDS

Health equity work will require new or enhanced skills for many public health staff. Some of the new skills are use of the HEIA tool, community planning, and partnership and coalition building. Furthermore, the health unit will need to make health equity and mitigating social inequities in health a priority if we are to integrate the work into our programs, provide services to level-up the health of the identified priority populations, and work on community engagement and taking intersectoral action with our community partners.

7) CONTRIBUTION TO EVIDENCE BASE

The knowledge base informing health units how to address health inequities is growing. However, this promising practice suggests that health units intentionally share knowledge through a variety of formats (e.g., journal articles and grey literature).

8) EARLY CHILDHOOD DEVELOPMENT

Early childhood experiences set the stage for learning, socioeconomic success and health throughout a person's life. Investing in early childhood development can therefore be a great equalizer. A comprehensive combination of community services, programs, and policies are necessary to help reduce health inequities.

9) COMMUNITY ENGAGEMENT

This is a key cross-cutting strategy to reduce health inequities. Communities should be consulted in all aspects of program, service, or policy development.

10) INTERSECTORAL ACTION

Many of the solutions to address health equity lie outside the health sector. Hence, it is necessary for public health to partner with agencies in other sectors to affect change.

BRINGING IT ALL TOGETHER

The Health Equity Strategy Committee members chose to use the 10 Promising Practices in addition to a Population Health Approach because it is more focused on specific actions our health unit can take to promote health equity in our community. At the same time, it complements and builds on the key elements of a Population Health Approach. Table 4 below illustrates the relationship between the Population Health Key Elements and the 10 Promising Practices. Since WECHU is in the beginning stages of formally and systematically tackling health equity, both offer valuable and effective strategies.

Table 4
Relationship Between Population Health Key Elements and 10 Promising Practices

	Focus on the Health of the Population	Address the DoH and their Interactions	Base Decisions on Evidence	Increase Upstream Investments	Apply Multiple Strategies	Collaborate Across Sectors and Levels	Employ Mechanisms for Health Outcomes	Demonstrate Accountability for Health Outcomes
Targeting with Universalism				√	√	√		
Purposeful Reporting	√	√	√					√
Social Marketing				√	√	√	√	√
Health Equity Target Setting	√	√			√			√
Equity-focused Health Impact Assessment		√	√		√			√
Competencies/ Standards	√		√			√		√
Contribution to Evidence Base			√					√
Early Childhood Development				√	√			
Community Engagement		√		√	√	√	√	
Intersectoral Action				√	√	√	√	

Note: DoH = Determinants of Health

SETTING OUR PRIORITIES

The visioning process identified two priorities to help move our organization forward over the next four years. The priorities align well with the Population Health Approach key elements and the 10 Promising Practices. Furthermore, the two priorities also support two of the health unit's strategic plan priorities – Workforce Development and Program and Organizational Planning.

PRIORITY #1 DEVELOP STAFF CAPACITY

This priority is the starting point of our health equity strategy. It will enable staff to acquire the knowledge and skills necessary to have a strong health equity foundation. We will only succeed when there is a base of knowledge and skills shared by all staff across the organization. We also see developing staff capacity as a necessary precursor to meaningfully engaging Priority #2 inasmuch as having knowledge, confidence, and a sensitivity to the plight of those who are facing health inequities is central to creating the will to make larger organizational changes.

The first objective to meeting this priority is to increase staff knowledge and awareness about the social determinants of health, promoting health equity, and establishing a commitment towards a common goal. To facilitate meeting this objective, the committee is proposing five potential actions:

- Evaluate the level of change of knowledge and awareness by conducting pre and post-surveys.
- Organize corporate-wide and department specific educational opportunities.
- Strategically apply professional development resources to increase staff knowledge and awareness.
- Provide a library of resources through Knowledge Tree.
- Use the SDoH PHN's as a catalyst for any SDoH related staff development.

The second objective for this priority is to support program planning with a health equity focus. In order to meet this objective, two potential actions were proposed:

- Use the Health Equity Impact Assessment (HEIA) tool.
- Use the SDoH PHN's to consult on program planning with regards to the SDoH.

PRIORITY #2 ORGANIZATIONAL DEVELOPMENT

This priority will help to transform how we do business as a health unit. Organizational development will be achieved through alterations to how we assess, plan, implement and evaluate our programs, services and initiatives. It will affect the way we do our reporting and, for some programs and services, it may even change their target audience. The success of this priority will help to embed the promotion of health equity into our everyday activities and ultimately make it a seamless part of our public health practice.

To achieve this priority, we must develop a formal and systematic process to ensure that health equity is integrated into our Health Unit activities. To ensure that we can achieve this objective the Committee is proposing ten potential actions:

- Support priority #1: Develop Staff Capacity.
- Use the health equity status report to identify gaps in services and guide program development.
- Ensure organizational service delivery policies, procedures and practices are assessed for their health impact on priority populations and are in place to address the SDoH.
- Assess, plan, implement, and evaluate programs and services through a health equity lens (Health Equity Impact Assessment).
- Support the SDoH PHN's work in the community.
- Establish a health equity steering committee with one representative from each department, two SDoH nurses, and an EPEQ Planner to guide the implementation of this strategy.
- Incorporate the Public Health Agency of Canada equity core competencies into Health Unit performance appraisals.
- Engage priority populations in the planning of programs and activities as per the organizational standards.
- Endorse the 10 Promising Practices to Reduce Social Inequities in Health.
- Help Health Unit staff to understand that in workplaces, including WECHU, a social gradient in health possibly exists.

FROM STRATEGY TO ACTION

Tables 5 and 6 provide more details on each of the two priorities, including the corresponding objectives, potential actions, intended impacts, and results. The proposed health equity steering committee will be able to use the recommendations from these tables to help guide the new direction.

Table 5

Priority	Objectives	Potential Actions	Intended Impacts	Results
Develop Staff Capacity	Increase staff knowledge and awareness about the social determinants of health, promoting health equity, and establishing a commitment towards a common goal.	Evaluate the level of change of knowledge and awareness by conducting pre and post-surveys. Organize corporate-wide and department specific educational opportunities. Strategically apply professional development resources to address increasing staff knowledge and awareness. Provide a library of resources through Knowledge Tree. Use the SDoH PHN's as a catalyst for any SDoH related staff development.	The relationship between the social determinants of health and the promotion of health equity will be recognized. The impact that health inequities have on the health of individuals and groups of people will be identified. A sensitivity to the needs of priority populations will be developed. Individual learning needs around health equity will be identified.	We will be equipped with the understanding, skills and access to information and knowledge to ensure that program planning, implementation, and evaluation has an equity focus. We will have a strong foundation of knowledge to move our organization forward towards promoting health equity in our community. We will increase our access to public health programs and services for priority populations. We have the opportunity to professionally grow, learn and develop in our work. We use information and evidence to improve our programs and services, including the identification of service needs, gaps and overlaps with other service providers to optimize needs being met.
	Support program planning with a health equity focus.	Use the Health Equity Impact Assessment (HEIA) tool. Use the SDoH PHN's to consult on program planning with regards to the SDoH.	Staff will have the knowledge, skills and tools to effectively plan programs and services and develop policies to promote health equity. More effective engagement with priority populations will be established.	

Table 6

Priority	Objectives	Potential Actions	Intended Impacts	Results
Organizational Development	To develop a formal and systematic process to ensure that health equity is integrated into our Health Unit activities.	Support priority #1: Develop Staff Capacity. Use the health equity status report to identify gaps in services and guide program development. Ensure organizational service delivery policies/procedures and practices are assessed for their health impact on priority populations and are in place to address the SDoH. Assess, plan, implement, and evaluate programs and services through a health equity lens (Health Equity Impact Assessment). Support the SDoH PHN's work in the community. Establish a health equity steering committee with one representative from each department, two SDoH nurses, and an EPEQ Planner to guide the implementation of this strategy. Incorporate PHAC equity core competencies into HU performance appraisals. Engage priority populations in the planning of programs and activities as per the organizational standards. Endorse the 10 Promising Practices to Reduce Social Inequities in Health. Help Health Unit staff to understand that in workplaces, including WECHU, a social gradient in health possibly exists.	We will have a clear understanding of the health disparities in our local community. Our programs and services will be modified/oriented to reduce inequities. Gaps in services will be identified for priority populations. Priority populations will have more access to our programs and services. The next time the Health Unit develops a strategic plan, health equity will play a larger role throughout the document. Staff will acquire relevant competencies to address program and organizational priorities. Community partners will see a gradual change in the way we do business. Health Unit staff will be aware that health inequities occur within workplaces.	We will use data on inequities to design and evaluate our policies, programs and services. We will see changes in our community partners because of our influence/leadership. We seek the best information available (including program and service evaluations) and use it in our decision-making processes. We will be able to demonstrate efforts to minimize barriers to access in the Operational Plan. We will be able to describe how equity issues will be addressed in the delivery and outcomes of programs and services for the yearly strategic plan review for the WECHU Board of Health. We will seek ongoing opportunities to identify activities and policies that promote work/life balance.

NEXT STEPS

The committee is proposing the following steps to move the strategy forward:

- Forward the strategy to the Senior Management Team (SMT) and HUMAT for consideration and formal adoption.
- Request that the strategy be sent to the Board of Directors for consideration and formal adoption.
- Once approved, share the strategy with WECHU staff.
- Create a steering committee to guide implementation and evaluation of the strategy. The steering committee will consist of one representative from each department, two SDoH nurses, and an EPEQ Planner.

CONCLUSION

We hope this strategy marks a beginning. That it leads to WECHU staff growing in their knowledge of health equity. That it results in our systematically embedding health equity practices into our everyday activities. That ultimately, it will work to improve health equity in our community.

The achievement of this strategy over the next four years is a significant undertaking but is quite simply, the right thing to do.

APPENDIX A: GLOSSARY

DETERMINANTS OF HEALTH

The Ontario Public Health Standards (2008) identifies the determinants of health as:

- income and social status
- social support networks
- education and literacy
- employment and working conditions
- social and physical environments
- personal health practices and coping skills
- healthy child development
- biology and genetic endowment
- health services (access to)
- gender
- culture
- language

Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes (Ministry of Health and Long-Term Care, 2008).

HEALTH DISPARITY

Health disparities are differences in health status that occur among population groups defined by specific characteristics. They mostly result from inequalities in the distribution of the underlying determinants of health across populations. Socio-economic status (SES), Aboriginal identity, gender and geographic location are the important factors associated with health disparities in Canada. These factors are interdependent (Public Health Agency of Canada, 2004).

HEALTH EQUITY

Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance (National Collaborating Centre for Determinants of Health, 2013).

Health equity "involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill" (World Health Organization, 2006, p. 5).

While striving to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations (National Collaborating Centre for Determinants of Health, 2013).

HEALTH EQUITY IMPACT ASSESSMENT

Health Equity Impact Assessment (HEIA) is a tool that has a broad application and is intended for use by organizations and health service providers who have an impact on the health of Ontarians. Thus, HEIA is not only intended for use by organizations across the Ontario health care system, such as the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs), Public Health Units (PHUs), and health service providers; but also by organizations outside the health care system whose work can have an impact on health outcomes. Examples include other Ontario social policy ministries such as the Ministry of Education, Ministry of Transportation, and Ministry of Children and Youth Services, and various non-profit organizations and community service providers. The HEIA tool also has the intention of being a bridging tool across relevant sectors to encourage creative thinking, collaboration, and practical, actionable solutions on current policies, programs, or initiatives impacting health outcomes (Ministry of Health and Long Term Care, 2012).

HEALTH INEQUALITY

Health inequality is a generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups. (Bowen, S., Botting I., Roy J., 2011).

HEALTH INEQUITY

Health inequities are health differences between population groups–defined in social, economic, demographic or geographic terms–that are unfair and avoidable (National Collaborating Centre for Determinants of Health, 2013).

Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are systematic, socially produced (and therefore modifiable) and unfair (World Health Organization, 2006).

LEVELING-UP

Leveling-up is the way to narrow the health gap in an equitable way. It brings up the level of health of the groups of people who are worse off to that of the groups who are better off (World Health Organization, 2006).

POPULATION HEALTH APPROACH

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups (Public Health Agency of Canada, 2001).

PRIORITY POPULATION

Priority Populations are those population groups at risk of socially produced health inequities and are identified using epidemiology and inequity/social factors (Sudbury & District Health Unit, 2010). Priority populations are identified by surveillance, epidemiological, or other research studies and are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level (Ministry of Health and Long-Term Care, 2008).

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health (SDH) are the interrelated social and economic factors that influence the health of the population (National Collaborating Centre for Determinants of Health, 2013).

SOCIAL GRADIENT OF HEALTH

The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that the lower an individual's socioeconomic position, the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone (World Health Organization, 2013).

SOCIAL MARKETING

According to the Sudbury & District Health Unit (2009), while definitions of social marketing can vary, three key elements commonly appear:

- First, that it is a systematic process phased to address short, medium and long-term issues.
- Secondly, that it utilizes a range of marketing techniques and approaches (a marketing mix).
- Finally, its primary aim is to achieve a particular social good (rather than commercial benefit) with specific behavioural goals clearly identified and targeted.

In the case of health-related social marketing the social good can be articulated in terms of achieving specific, achievable and measurable behavioural goals, relevant to improving health and well-being.

TARGET GROUP

The Sudbury & District Health Unit (2010) defines target group as the population group to which public health actions are directed. It can also be understood as audience. Furthermore, they clearly distinguished between target group and priority population. Many activities have a target group or audience to whom the activity is directed, but having a target group does not necessarily mean that the activity addresses priority populations. Target groups can have priority populations within them. For example, men may be a target group for a particular activity. However, there may be priority populations within that target group, such as men with low incomes, who may experience socially produced inequities in health. A target group is identified based on epidemiology. A priority population is identified through epidemiology and inequity/social factors.

TARGETED APPROACH

A targeted approach applies to a priority sub-group within the broader, defined population. Eligibility and access to services are determined by selection criteria, such as income, health status, employment status or neighbourhood. Targeted approaches are based on a belief that social constructs (for example, classism, sexism, racism and colonization) are barriers to equitable access to the determinants of health, and that interventions directed to disadvantaged members of society are needed to close the health gap (National Collaborating Centre for Determinants of Health, 2013).

TARGETING WITHIN UNIVERSALISM

Targeting within universal programming can be focused on priority populations within a universal strategy. For example, universal interventions can be adjusted to increase accessibility for certain groups, or specific strategies can be developed to address inequalities in the social determinants of health. This fine tuning of programs increases the likelihood that those who are at greater risk of adverse health receive the greatest benefit. As a result, the health of the entire population improves, but the health of priority populations improves faster—reducing health inequities (Sudbury & District Health Unit, 2012).

UNIVERSAL APPROACH

A Universal Approach applies to an entire population. Eligibility and access are based simply on being part of a defined population such as all women, all children under age six, or all people living in a particular geographic area, without any further qualifiers such as income, education, class, race, place of origin, or employment status. The approach is based on the belief that each member of society should have equal access to basic services such as education or health care (National Collaborating Centre for Determinants of Health, 2013).

UPSTREAM INVESTMENT

Efforts and investments in a population health approach are directed at root causes to increase potential benefits for health outcomes. The identification and definition of health issues and the investment decisions within a population health approach are guided by parameters based on evidence about what makes and keeps people healthy. A population health approach directs investments to those areas that have the greatest potential to influence population health status positively. A population health approach is grounded in the notion that the earlier in the causal stream action is taken the greater the potential for population health gains (Public Health Agency of Canada, 2001).

APPENDIX B: CURRENT WECHU ACTIVITIES THAT PROVIDE SERVICES ON THE SOCIAL DETERMINANTS OF HEALTH

Program Name	Priority Populations	Activities
Nurse Practitioner	Women, children, and Immigrants	• Focuses on pre and post natal women of childbearing age and their children up to 6 years of age without an OHIP card and/or those without a doctor. Many clients are new immigrants.
Comprehensive School Health	Children & youth in low income schools, female youth, and the Aboriginal community	• Injury Prevention: provides helmets to low income children • Nutrition: cooking classes in schools and community centres in low income neighbourhoods; healthy eating presentations at the Multicultural Centre and other newcomers groups • Physical Activity: Fuel Program in high schools (targets females 12-18) • Hygiene: provides resources and support to after-school hygiene classes at the Can-Am Indian Friendship Centre. • Youth Engagement tobacco prevention programming at after-school programs in low-income neighbourhoods. • Support the Gay Straight Alliances in the secondary schools for LGBT youth. • Money is available for personal hygiene products for in-need youth in all schools.
Child Health	Immigrants and low income women	• Building Blocks for Better Babies – pre and post natal teaching • Newcomer activities (request based) - Community Health Access Day: presentation regarding health unit services • Well-Baby and Child Drop-In Clinics: located in low income areas • Parenting Education: Ontario Early Year Centers located in low income areas • Prenatal Education: online Prenatal Course
Oral Health	Children 0-17 years of age from low income families	• Preventive (screening, cleaning, oral hygiene instruction, sealants, fluoride treatment) and/or Restorative (fillings) Services: Children in Need of Treatment (CINOT) Program and the Healthy Smiles Ontario (HSO) Program are offered to children 0-17 years of age from low income families. All children can be seen without an OHIP card but need an OHIP card to be treated. • Two part-time dentists work in the restorative clinics • Dental chairs for preventative services are located at the following sites for clinics intended for HSO clients: Harrow Family Health Centre Inc., Multicultural Council of Windsor, John McGivney Centre , Jackson Park Health Centre, and Windsor-Essex Community Health Centre Street Health
Healthy Babies / Healthy Children	This is a universal program with a targeted approach to offering service to those families who are identified with risk factors on the HBHC screening tool.	• All women are screened for risk factors in the hospital following delivery of their baby. As well, all are screened using the HBHC screening tool to determine eligibility for the HBHC program. Clients identified as 'with risk' are then further assessed at a home visit and if risk is confirmed then the ongoing home visiting program is offered. As well, if a mom requests a home visit – even if they have not been identified with risk on the screen, we do not deny them the visit. One of the main goals is to identify as soon as possible, actual or potential developmental delays in children and support families using a variety of strategies during home visiting – strategies can include assessment/screening, education, emotional support, and linking to other appropriate community agencies.
Chronic Disease & Injury Prevention	Tobacco users, families and individuals living on a low income, older adults some with mental health	• Tobacco: STOP on the ROAD Program; Quit kit/Prevention kits (internal program with Dental team, Sexual health, Substance Misuse, HBHC, TB Clinic, NP Clinic); Smoke-free outdoor space by-law initiative • Injury Prevention: Presentations; Health fairs (older adults, some have mental

	issues, homeless, drug and alcohol users, street workers, those with HIV, those with Hepatitis C infection, new immigrants	health issues/live on a low income); Community events (Rediscover Your Bike – all families, but target those living on a low income) • Substance Misuse: In collaboration with harm reduction partners, provide 1) Living Safer-a monthly interactive display at the Windsor Downtown Mission and in the Leamington area, 2) Peer to Peer support-a program that trains individuals to go onto the street and into high risk locations to educate and support individuals that use drugs, are street workers, or have HIV or Hepatitis C infection; W-ECHU funds the needle exchange program through the AIDS Committee of Windsor; Promote the resource "where to get help for drug and alcohol problems" to those experiencing drug and alcohol problems and want to know where and how to get help; Collaborate with the Erie St. Clair Addiction Treatment Clinic to individuals that are at risk of opioid overdose. • Physical Activity: Rediscover your Bike; W-EC in motion activities-awareness and educational resources, partnership development, advocacy, skill development opportunities for residents and service providers, coalition building, environmental supports, discounted events through partnerships; Healthy Communities; Comprehensive physical activity initiative; Windsor Bicycling Committee; CAA driver awareness initiative; W-E Parkway Development input; Age Friendly Windsor; Go For Health: Bike Friendly Workplace Awards • Early Detection/Prevention of Cancer: HEAT/HARS-Outreach to those who are more vulnerable to the heat; no access to air conditioning/cool places; New immigrants unaware of our weather, services in community and again lack of air conditioning; screening initiatives may be limited for those without health care providers or unaware of services in community (new immigrants).
Chronic Disease Prevention & Workplace Wellness	Low income families, immigrants	• Food Security: Nutritious Food Basket data gathering, interpretation and advocacy • Food Security Coalitions: Food Education & Skills Working Group working to improve nutrition and food access to residents of Windsor-Essex County by developing and offering food skills classes; Food Advisory Network is developing a food charter for Windsor-Essex County; Locally Driven Collaborative Project addressed the question, What aspects and meanings of food skills are most important in two different priority populations, and how could they influence food choices and the risk of chronic disease? • Cultural Diversity Committee of Go For Health: focusing on improving the health and wellness of newcomers in WEC. • Market Dollars Program- in conjunction with community partners, we are providing a pilot project targeted at providing low income populations in WEC the opportunity to make their own food choices with the emphasis on buying local whole foods. (i.e., distributing through Ontario Works $20 worth of market vouchers to each family/individual that can be redeemable at the Downtown Windsor Farmer's Market.) • Living Wage Policy- Partnership with Pathway to Potential to launch/create a living wage certification program to encourage workplaces (large and small) to pay living wage.
Clinical Services	Adults and adolescents without an OHIP card, low income women, immigrant men, homeless male youth	• Provide the following services to adults and adolescents without an OHIP card or a family physician: counseling around sexual health/birth control/pregnancy options, testing and treatment of sexually transmitted infections, and immunizations to people who qualify. • BCP at cost or free (through a compassionate program) • Sexual Health Teaching (e.g., STI's, blood born infections): new immigrant men; homeless shelter for male youth
Vaccine Preventable	Mennonites	• Education upon request to Mennonites regarding publically funded vaccines and the School Pupils Act
Health Inspection	Adults and youth with low literacy, adults and youth with English as a second language, those living with a low income	• Food Handlers Course: course material and exam written at grade level 5-7, course available in different languages, and oral exams are offered. Expenses associated with the course can be offset for those living on a low income.

Social Determinants of Health Nurses (EPEQ)	Those living with a low income, youth aged 16-19 at-risk and without children, 16-25 year old pregnant females or young families with at least one child with at least one social determinant of health risk factor, homeless, immigrants	• Facilitated the development of, and wrote, this Health Equity Strategy. Members of the following coalitions: • Poverty Reduction Coalition: Pathway to Potential (Windsor-Essex's Poverty Reduction Strategy Coalition) • Food Security Coalitions: 1) Food Education & Skills Working Group working to improve nutrition and food access to residents of Windsor-Essex County by developing and offering food skills classes; 2) Locally Driven Collaborative Project addressing the question, What aspects and meanings of food skills are most important in two different priority populations, and how could they influence food choices and the risk of chronic disease? • Homeless Coalition • Cultural Diversity Committee of Go For Health: focusing on improving the health and wellness of newcomers in WEC. • Local Integration Partnership (LIP): encouraging communities across Ontario to develop a comprehensive plan for the delivery of newcomer services.
Communicable Disease Team	Low German community in Leamington, low income families, single parent families, English as a second language, new immigrants	• Will direct clients to services when the need is identified, i.e., link them with a doctor or make appointments for them directly. The nurses have identified a health promotion need to educate and support the health of the Low German Community, and have been providing telephone counseling. • Identify barriers to care – the nurses work through issues with the client such as transportation, logistics with family members, childcare, and lack of family doctor to make sure linkages are formed
Tuberculosis	Immigrants, refugees, those with English as a second language	• It is mostly foreign born clients who have active TB cases; written material is provided in different languages; most clients have translators who come to the Health Unit with them however, the Health Unit does have a process for obtaining translators through the Multicultural Centre (at a cost) and informally through Health Unit staff who speak languages other than English.

APPENDIX C: VISIONING IDEAS

At the outset of the Committee's work, members were asked to answer two visioning questions:

- In 2017, what will be different at the health unit because we have been working effectively to reduce social inequities in health?
- In 2017, what will the community look like because we have been so effective in reducing social inequities in health?

The following details the vision that emerged for the Committee:

INTERNAL

Programs

- There will be a formal integration of health equity into the planning cycle.
- Strategies we use will change our programs and services.
- Existing programs may be removed and new ones added.
- We should be able to look at our programs and see a shift.
- Priority populations will have more access to our programs.
- Gaps in services will be identified for priority populations.

Cultural Shift

- The way we report will change. Instead of reporting the # of activities we do we will be highlighting the inequities of activities.
- There will be a change in the way we speak/shift in what we say in terms of health equity.
- There will be a change in how we represent ourselves i.e. priority populations- do our brochures actually reflect our community?
- There will be a change in our internal review (CRD)
- There will be a cultural/organizational shift.
- The next time the Health Unit does a Strategic Plan, health equity will be interlaced into it.

Health Equity Lens

- We will have a health equity tool.

Staff Capacity

- Education in Health Unit.
- Knowledge exchange around health equity.

EXTERNAL

Community

- Our priority populations will be identified.
- Education of community residents.
- Community Partners will know our philosophy and why we're doing what we're doing.
- We will see a relationship change with the media.
- Priority populations will have access to more appropriate Health Unit programs.
- Community awareness.
- We will see changes in our community partners because of our influence/leadership.

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