



WELLESLEY INSTITUTE
advancing urban health

Backgrounder

Health Equity Into Policy Action: FAQs

Putting Health Equity into Policy Action: FAQs

Introduction

These Frequently Asked Questions (FAQs) are designed to provide a basic overview of health equity.

We provide a definition of the concept and why it is important, and also identify issues, challenges, and promising initiatives and programs designed to address health disparities.

We draw from both Canadian and international practices.

These FAQs grew out of a presentation given by Bob Gardner (Director of Public Policy, Wellesley Institute) to the Ontario Ministry of Health and Long-Term Care. (Slides from Bob's presentation are also available on the Wellesley Institute's website:

www.welleselyinstitute.com)

Frequently Asked Questions about putting Health Equity into Policy Action:

- 1. What is health equity?**
- 2. Are health inequities really a concern in Canada? Isn't this an issue only in developing countries?**
- 3. What is the connection between health disparities and the social determinants of health?**
- 4. What are some of the conditions that make greater health equity more likely?**
- 5. There has been a lot of focus recently on improving the health system and health care delivery. Can we have a similar focus on addressing health inequity?**
- 6. What are the ways that public policy can help to reduce health inequities?**
- 7. Are there innovative strategies in Canada for addressing health inequities at a regional level?**
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- 10. What can we learn from international bodies?**
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- 12. How does health equity fit in with health promotion and disease prevention?**
- 13. What is the role of primary care in reducing health disparities?**
- 14. How important is community engagement in achieving greater health equity?**
- 15. Do different financing models have an impact on health equity?**
- 16. How can research support health equity?**

1. What is “health equity”?

When most analysts talk about "health equity" they are focusing on reducing the large differences in health outcomes that are **avoidable, unfair and systematically related to social inequality and disadvantage**.

This definition:

- is clear & actionable
- it identifies the problem that policies will try to solve
- it is tied to widely accepted notions of fairness and social justice

This view sees health equity as the absence of socially structured inequalities and differential outcomes. Inequities in health put groups of people who are already socially disadvantaged - for example, because they are poor, female, and/or members of a marginalized or racialized group - at further disadvantage.

The World Health Organization describes the pursuit of health equity as:

“A concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization”.

Resources:

- [WHO Task Force On Research Priorities for Equity in Health and WHO Equity Team](#)
Priorities for research to take forward the health equity policy agenda. Bull World Health Organ. 2005, vol. 83, no. 12 [cited 2007-02-16], pp. 948-953.
- [Defining Equity in Health](#), by P.Braveman & S. Gruskin, Journal of Epidemiology and Community Health 2003;57:254-258

2. Are health inequities really a concern in Canada? Isn't this an issue only in developing countries?

Health inequities exist to varying degrees in all rich countries with highly developed health systems, including Canada. For example:

- life expectancy at birth, on average, is five to 10 years less for First Nations and Inuit peoples than for all Canadians
- while infant mortality rates have been declining overall, infant mortality rates in Canada's poorest neighbourhoods remain two-thirds higher than those of the richest neighbourhoods
- the Ontario Health Quality Council - following stroke as an indicator of health equity and using a risk-adjusted rate of death in hospitals – found a significant difference in the mortality rates between regions in Ontario with the highest and lowest rates. Mortality in the region with the worst rates was 36% higher than that in the best.
- all advanced countries – even those with best overall health – have significant disparities in health outcomes
- there is evidence that health disparities have increased in many countries and often the immediate challenge is seen to be preventing health disparities from continuing to worsen

3. What is the connection between health disparities and the social determinants of health?

There is consensus in the research literature that the roots of health disparities lie in broader social and economic inequality and exclusion. Some analysts have begun to speak of the social determinants of health inequities.

The impact of key determinants - such as early childhood development, education, employment, working conditions, income distribution, social exclusion, housing and social safety nets - on health outcomes is well established in Canada and internationally.

4. What are some of the conditions that make greater health equity more likely?

A more positive or forward-looking vision sees health equity as equal opportunities for all for good health. The pre-conditions for achieving greater health equity include:

- reduction of poverty, inequality and social exclusion
- the positioning of individual and community needs at the heart of policy, planning and service delivery
- the provision of culturally appropriate social support and health care
- the availability and accessibility of a full and seamless continuum of health and social services to all citizens
- health and human services systems that focus on the most disadvantaged individuals and population groups
- ‘up-stream’ investment in disease prevention and health promotion

5. There has been a lot of focus recently on improving the health system and health care delivery. Can we have a similar focus on addressing health inequity?

Yes, we need to be just as clear on defining and articulating an equitable health system as we are on what a well-performing health system looks like. The challenge is huge, but by no means hopeless. The European Union and a number of countries have developed comprehensive policies to address health disparities and there is much to be learned from them.

An understanding of the roots of health disparities both within the health system and in wider social inequalities can guide policy and interventions. This enables the development of a coherent and integrated policy framework that makes important connections between sectors and initiatives and grounds investments and programs.

We can begin to address health inequities in public policy by:

- identifying the key places and levers where policy change can most effectively be made to happen – and will make the most difference to health equity
- putting in place incentives and enablers to support system change and program/delivery action

- maintaining long-term commitment – one of the clearest lessons from abroad is that tackling health disparities takes time
- establishing workable indicators to guide/monitor implementation and an infrastructure and working culture to learn from and build on success and innovation

6. What are the ways that public policy can help to reduce health inequities?

Public policy on reducing health disparities can take place at three different levels:

- actions that address the needs of the most disadvantaged populations and communities – to reduce the harsh impact of health disparities
- actions that focus on narrowing the gap between the most disadvantaged and wealthiest groups – which means raising the health of the most disadvantaged faster
- coordinated actions that reduce the overall “gradient” of health disparities and involve the health and other sectors.

Reduction of the overall gradient of health disparities is considered to be the most inclusive – but few governments have taken this most comprehensive approach.

Most analysts see that action on these three levels can be complementary; many agree that addressing all these levels is key and needs to be thought of in a coordinated way.

Resources:

Reducing Health Disparities - Roles of the Health Sector: Recommended Policy Directions and Activities, prepared by the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security (December 2004) http://www.phac-aspc.gc.ca/ph-sp/disparities/dr_policy_e.html

7. Are there provincial/territorial policy frameworks in Canada that address health inequity?

Many jurisdictions in Canada and elsewhere have developed comprehensive policies and programs to address health inequity – and there are indications that these policies can be effective. These involve:

- on-the-ground initiatives that address both the underlying social foundations and the effects of health disparities

- innovative and creative approaches to connecting initiatives in a coherent and integrated way
- Intersectoral collaboration is key to addressing health inequities. Saskatchewan and Quebec in particular, provide two models for intersectoral coordination on health and social policy at the provincial level

Saskatchewan

In Saskatchewan the [Human Services Integration Forum](#) brings to together Assistant Deputy Ministers from across the provincial government to promote inter-agency collaboration and integrated planning and service delivery.

The Forum's current priorities include strengthening families' capacities, early childhood support, increased opportunities for youth, increased well-being and employment situations, improve coordination and integration of services, etc.

The Forum also develops regional coordination bodies to link wide range of agencies and activities which in turn provide space/encouragement for interesting local integration in areas such as Saskatoon.

Quebec

In Quebec health and related social services are coordinated through a single department, the Ministry of Health and Social Services. In addition, the [Health and Well-Being Council](#) encourages intersectoral action. The Council is responsible for evaluating the performance the health and social service sectors, as well as for recommending changes, and making information available to the public.

The provincial government consults broadly with the community sector in policy development. A comprehensive 10 year plan is currently in place to address social determinants and wellbeing.

Finally, all ministries are required to consult the Ministry of Health and Social Services on new legislation or regulations that could impact health and regional health authorities are required to develop integrated plans with social services; local health authorities must coordinate with non-health services.

8. Are there innovative strategies in Canada for addressing health inequities at a regional level?

Yes, there are innovative examples at regional and municipal levels of efforts to address health disparities in Canada. For example:

- Interior Health in BC has developed a social determinants-based plan, called [Beyond Health Services and Lifestyle](#).
- several Regional Health Authorities in Alberta have developed operational and planning links with local social services and one has emphasized community capacity building as key to addressing health, and non-health agencies are creating cross-sectoral planning and action forums around housing, poverty and other determinants
- the Saskatoon Health Region is developing a cross-sectoral action on health equity; the [Building Health Equity Project](#) will focus on interventions in the poorest neighbourhoods, locating services and links in schools and relying on First Nations elders to guide programming
- 18 big city Medical Officers of Health are working together on strategies to address urban health disparities
- [Le Centre Lea Roback](#) in Montreal provides determinants focused research and planning support to Montreal's public health department and other cross-sector forums

9. Are there examples of community-based services that address health inequities?

There are a number of initiatives emerging from communities across Canada that address the broad determinants of health in responding to healthcare issues. Here are two innovative examples:

- [Multicultural Health Brokers Cooperative](#),, Edmonton

The Multicultural Health Brokers Cooperative (MHBC) in Edmonton arose out of a small project initiated by public health to support the growing – and often isolated - immigrant and refugee communities in early 90s. It provides intensive pre-natal and infant support to women and families facing language and cultural barriers within health care and overall social exclusion.

The group saw that they needed to extend beyond service delivery and the idea of acting as a broker to connect clients and services emerged. MHBC connects people to a full range of health

and social services and advocates for clients. The cooperative provides continuity in a fragmented system.

The MHBC also supports innovative self-help initiatives organized by clients themselves and has developed collaborations with schools, social services and other agencies to address access gaps and barriers. Beyond providing services to the community, MHBC also provides multicultural training to agencies and service development assistance to public health and regional health authorities.

- [Street Health](#), Toronto

Street Health provides nursing and other primary care for homeless people in downtown Toronto.

As peoples' needs became clearer, Street Health expanded its program to include harm reduction, referrals to housing and other services, and support in working through the eligibility maze of the social assistance program.

Other examples of Street Health's activities beyond the health care system are:

- ID Project which helps homeless people apply for documents they need to secure eligibility for programs and provide secure places for them to store ID.
- community-based research to identify eligibility barriers to the Ontario Disability Support Program for homeless people with disabilities and pilot effective support program to help people secure assistance for which they are eligible; and a survey of the service needs/barriers of homeless people.

10. Are there examples from other countries that we can learn from?

A number of developed countries have made lessening health disparities a high national priority and have developed cross-sectoral policy frameworks and/or action plans.

Highlighted below are several among many interesting possibilities. They offer insight on how to develop an integrated policy framework and cross-sector collaboration as well as inspiration that cross-sector policy collaboration and action is possible – and can have an impact:

- *Sweden*
- *United Kingdom*
- *Netherlands*

Sweden

In Sweden social welfare policy was seen to be key to reducing health disparities. This has led to the development and implementation of a coordinated national policy to reduce the number of people at risk of social and economic vulnerability.

The national policy includes a number of components, including an inclusive labour market, anti-discrimination, childcare, affordable housing. Equitable access to improved health care is seen to be just one part of this broader package.

The Swedish model emphasizes partnerships with community service providers and organizations – in both policy development and service delivery -- and arose out of a political culture with a strong consensus on social solidarity.

For more about Sweden's public health policy and efforts to address health inequities see:

- [Sweden's New Public Health Policy](#) (PDF document)
- Interview with Dr Denny Vågerö, Professor of Medical Sociology and Director of CHES, Centre for Health Equity Studies, Stockholm
http://www.who.int/social_determinants/commissioners/interview_vagero/en/index.html

United Kingdom

The [2003 Programme for Action](#) focused on:

- raising living standards
- early childhood development
- employment
- building healthy communities
- broad national redistributive and social policies

It set out concrete targets for each area.

The program emphasizes delivering action at the local level through collaboration, targeting the most deprived areas. The focus is on social and economic policy as well as changes within the health system. Interventions were designed to improve the health of the poorest fastest – generally as part of a community/local initiative.

Examples of multi-level actions:

- Health Action Zones were particular disadvantaged neighbourhoods identified for community development, and improved access to health care and services. This initiative only operated for a few years, but the principle of locally targeted interventions remains key to English strategy
- a “Fit to Work” partnership of local government, health authority and non-profit social entrepreneur agency was developed to support health in inner-city London
- the Engaging Communities Learning Network was established to share information on what is working locally and to ‘mainstream’ equity initiatives and learning into public service

Netherlands

Health disparities were recognized as a major issue through the 1980s and the Ministry of Health launched multi-year research-based approaches in 90s. This was unique in that it was designed to systematically assess the effectiveness of targeted interventions directed to addressing socio-economic disadvantage.

The results were built into overall national strategy to address health disparities. Lessons that can be learned from the Netherlands’ experience:

- planning and progress meetings of researchers, officials and political leaders are important to building broad support and maintaining momentum
- Ministries other than the Ministry of Health will not immediately see reducing health inequalities as their responsibility until the issue is re-framed; for example, the importance of providing access to affordable housing was more understandable rather the approaching better health through better housing

Resources:

Johan P Mackenbach and Karien Stronks ,[A strategy for tackling health inequalities in the Netherlands](#) British Medical Journal, Nov 2002; 325: 1029 - 1032.

11. What can we learn from international bodies?

There is increasing international and high-level attention to the issue of health equity:

- the World Health Organization has established the [Commission on Social Determinants of Health](#)
- the European Union (EU) has included health inequalities as an important dimension of the [Health and Consumer Protection Strategy](#) proposed action program 2007-2013

- the EU's [Closing the Gap](#) project seeks to promote action in individual member countries and share information on national policies, best practices and new initiatives across Europe

Coordinated national policies are being highlighted in many European countries (see Question 10). While for many countries this is still at a high-level strategic stage and few have implemented comprehensive policies, there is a clear consensus that integrated cross-sector policy frameworks are needed that support a wide range of regional, local and community initiatives.

12. How do we target specific areas or populations so that we can address the worst effects of health disparities?

A defining principle of health equity strategies is that everyone does not need or receive the same kind of services. Addressing the worst effects of health disparities requires targeting resources and services to specific areas or populations.

This requires sophisticated analyses of particular disparities and inequities. Are the main problems underlying the particular health disparities due to:

- language barriers
- lack of coordination among providers
- lack of services in particular neighbourhoods, or other factors?

The analysis requires detailed information and good local research. The involvement of local communities and stakeholders with local knowledge is critical to understanding the real problems.

Community-based and community-driven service development has tremendous potential to be innovative and responsive.

13. How does health equity fit in with health promotion and disease prevention?

Investing in better chronic care management, preventive care and health promotion are all vital elements of health reform. All of these can be planned and implemented through an equity lens.

Examples of how equity issues can be built into health promotion disease prevention initiatives include:

- increasing health immunization and related preventive services in disadvantaged communities and under-served neighbourhoods
- ensuring that every school and multi-service neighbourhood agency in poor or under-served areas has a public health worker
- taking into account the particular social, cultural and economic factors that shape risky behaviour in poorer communities in anti-smoking, exercise and other health promotion programs
- making sustained efforts to address language, cultural and other barriers to disadvantaged communities so that they get the health promotion information and support they need

A [framework](#) to build determinants and equity into public health programming has been developed by the Sudbury & District Health Unit.

Across Canada a great deal of valuable culturally appropriate and translated health promotion work is going on through ethno-cultural and other specific community groups.

The [Ontario Prevention Clearinghouse](#), [Canadian Health Network](#) and [Shelternet](#) are examples of sources for ethno-culturally appropriate information.

13. What is the role of primary care in reducing health disparities?

In many provinces and territories in Canada, major reforms in the delivery of primary care are underway. There is considerable evidence indicating that the expansion of primary care can reduce health disparities.

Primary health reform can have a positive impact on reducing health inequities when:

- primary care is increased in areas with the poorest access or health status
- agencies working on wider determinants of health are linked to primary care services
- other forms of enhanced care are integrated into primary care practices; for example, when social workers, service brokers, and health educators are part of primary health care teams
- local community governance, i.e. community-based health care centres with community boards

14. How important is community engagement in achieving greater health equity?

Community involvement is essential. A wide range of priorities, needs, preferences and perspectives should be incorporated into health planning. Specific targeted outreach strategies may be required to bring in the voices of disadvantaged and vulnerable communities. It is important to encourage representation and accountability to all, including communities traditionally excluded.

Diversity and equity planning checklists and tools can help to ensure that agency, boards and planning bodies are representative.

Resources:

- [Health Equity Audit](#) tools, National Health Service, UK
 - [Inclusive Community Organization Toolkit](#), Ontario Health Communities Coalition
- For more resources, see the Wellesley Institute's website [Community Engagement Issue page].

15. Do different financing models have an impact on health equity?

The impact of financing – for example the balance between public and private provision/funding - can be substantial.

There is evidence that a greater private share can have adverse impact on equitable access to health care. For example, user fees can be a significant barrier for poorer peoples' access to services. Similarly, the balance between hospital and other institutional services versus community-based delivery has an impact on more disadvantaged populations; community-based services can more easily be targeted to vulnerable groups.

16. How can research support health equity?

Community-based research is critically important to inform public policy and practice. In addition, information and data collection need to go beyond the metrics collected about the performance of the healthcare system. Systematic and comparable data must also be collected to support equity and diversity planning – i.e. information about income, race, ethno-cultural, sexual orientation, etc.

Community-based research takes place in community settings and involves community members in the design and implementation of research projects. Such activities should

demonstrate respect for the contributions of success which are made by community partners as well as respect for the principle of "doing no harm" to the communities involved.

For more about Community Based Research, see the Wellesley Institute website (Community-Based Research Issue page).