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Speaking Notes

Building Action on the Social Determinants of Health

Subcommittee on Population Health
Senate Committee on Social Affairs, Science and Technology

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Introduction

The Subcommittee has identified the problem to be solved – deep-seated and damaging health disparities – and some key issues and options for action. In my remarks today, I will sketch out some ideas and directions towards the kinds of fundamental policy and programme reforms needed to create and sustain equitable health for all.

The problem -- as always -- is how to get there. I will try to pose my discussion in practical terms that are going to be useful for your purposes, by:

- addressing the Issues and Options you've identified;
- outlining policy directions that will have the most significant impact on population health and health disparities;
- concretely highlighting examples of service provider, community and government partnerships and cross-sectoral collaborations;
- detailing what, given the constitutional and jurisdictional complexities of health and social policy in Canada, the federal government can actually do.[1]

Starting Points

The Big Picture: Roadmap for Action on the Social Determinants of Health

One major focus of the Wellesley Institute has been to analyze the underlying foundations of pervasive health disparities and to identify the necessary policy changes that can build towards greater health equity. We have reviewed the extensive international and Canadian research and policy literature, policy frameworks and strategies from around the world, best practices from the enormous range of front-line service and community efforts addressing the impact of health disparities on the ground, and lessons learned from real life collaborations and initiatives. I think the main lines of an action plan or roadmap for tackling the roots of health disparities are to:

1. look widely for ideas and inspiration from jurisdictions with comprehensive health equity policies, and adapt flexibly to Canadian, provincial and local needs and opportunities;
2. address the fundamental social determinants of health inequality – macro policy is crucial, reducing overall social and economic inequality and enhancing social mobility are the pre-conditions for reducing health disparities over the long-term;

[1] Given the specific focus of today's panel and time constraints, these examples and directions will necessarily be only partial. I'm happy to follow up in whatever greater detail is needed later.

3. develop a coherent overall strategy, but split it into actionable and manageable components that can be moved on;
4. act across silos – inter-sectoral and cross-government collaboration and coordination are vital;
5. set and monitor targets and incentives – cascading through all levels of government and programme action;
6. rigorously evaluate the outcomes and potential of programme initiatives and investments – to build on successes and scale up what is working;
7. act on equity within the health system:
    - making equity a core objective and driver of health system reform – every bit as important as quality and sustainability;
    - eliminating unfair and inefficient barriers to access to the care people need;
    - targeting interventions and enhanced services to the most health disadvantaged populations;
8. invest in those levers and spheres that have the most impact on health disparities such as:
    - enhanced primary care for the most under-served or disadvantaged populations;
    - integrated health, child development, language, settlement, employment, and other community-based social services;
9. act locally – through well-focussed regional, local or neighbourhood cross-sectoral collaborations and integrated initiatives;
10. invest up-stream through an equity lens – in health promotion, chronic care and prevention, and tackling the roots of health disparities;
11. build on the enormous amount of local imagination and innovation going on among service providers and communities across the country;
12. pull all this innovation, experience and learning together into a continually evolving repertoire of effective programme and policy instruments, and into a coherent and coordinated overall strategy for health equity.

Think Big But Get Going

One problem we have all faced – from analysts and researchers through decision-makers to service providers and community advocates – is the enormity of this challenge. The social determinants of health are so pervasive and inter-connected that fundamental change can seem daunting. Everything can't be tackled at once: where to begin? How to ensure that the inter-dependence of these complex factors is taken into account in planning and priority setting? Crucial questions: but we can't let them paralyze us.

I recently developed a strategic framework for the Toronto Central Local Health Integration Network (LHIN) on how to address equitable access to health care and health disparities within

its mandate.[2] One major theme was two-fold: on the one hand, to always take the deep-seated nature of the social determinants of health into account and to recognize that fundamental change will take time; but, on the other, to make our best judgements on immediate prospects for action on health equity and act. I believe that public policy on health equity needs to:

- start by identifying, on the basis of the best available evidence and information, initiatives and opportunities that seem most promising in tackling health disparities and the needs of the most disadvantaged populations;
- invest in these promising directions and initiatives – often as small scale pilots and experiments;
- evaluate service initiatives and collaborations rigorously;
- build on the best outcomes to gradually transform equity-driven service delivery and resource allocation; and
- draw on the lessons learned – both successes and failures -- to chart the most effective strategic direction for equity reform.

By proceeding in this kind of incremental but strategic way, by carefully building innovation and momentum, public policy and investment can soon start to have a major impact on health disparities. I will sketch out several key directions, and illustrate them with concrete examples, on how this can be done.

Re-Orientating Government Policy and Planning

Comprehensive Strategic Frameworks

Many jurisdictions – throughout Europe especially and also in comparable parliamentary systems such as England, Australia and New Zealand – have developed comprehensive national strategies to address health disparities. At the same time, international bodies, most significantly the World Health Organization (and its Commission on Social Determinants of Health, research-driven knowledge networks and regional offices) and the European Union, have devoted enormous policy and research resources to the determinants of health. The precise policy mixes vary greatly and no country has advanced far enough to be sure what policy and programme combinations will work most effectively in the long run. But the fact that so much concentrated policy attention is being devoted to this issue and that there is considerable consensus on the broad lines of necessary action indicates clear lines for moving forward.

[2] Ontario's version of regional health authorities. For the report see http://wellesleyinstitute.com/health-equity-strategy-toronto-central-lhin

These policy frameworks tend to be cross-government and multi-sectoral.

- England has a comprehensive programme with specific responsibilities and targets for departments ranging from child care, employment, poverty reduction, to health. It includes mechanisms to regularly report on progress against the targets, and has established high-level centralized secretariat functions to coordinate programmes and analyses.
- Ontario has been working on a major cross-Ministry research and policy initiative to identify common directions and coordinating mechanisms to focus on health equity.

The Subcommittee could recommend that national and provincial governments in Canada develop such comprehensive policy frameworks and concretely illustrate what their main components could be.

Cross-Cutting Planning

One common element in the strategies of leading jurisdictions is cross-cutting coordination across government departments.

- An interesting mechanism in Canada has been Saskatchewan's Human Services Integration Forum of ADMs from eight major Ministries. While designed to enhance provincial coordination of social policy, practitioners have identified a second positive consequence: parallel regional coordinating bodies have enabled more focussed and integrated local planning and service delivery.
- Twenty years ago Ontario developed Primer's Councils on Health and other issues that coordinated and led cross-government efforts.
- Quebec has a sophisticated range of regional cross-sectoral planning forums.

Building health and equity into specific planning processes and approaches is also widely recognized as fundamental. There has been extensive experience with a wide array of effective planning tools that can be adapted to Canadian needs. The National Collaborating Centre for Healthy Public Policy does an excellent job of compiling and highlighting promising planning tools.

- Quebec uses a form of Health Impact Assessment in which legislation from other spheres is examined for its potential health implications. Most jurisdictions have various cost, risk management, sustainability and other check-offs in their Cabinet Submissions and other mechanisms, and it would be feasible to add health impact. Quebec experience to date indicates that it is important to combine formal requirements with flexible implementation and expert back-up to support the various Ministries in incorporating health impact into their planning.

Many governments are experimenting with different ways of thinking about managing and aligning the many different programmes and spending that affect particular policy spheres.

- British Columbia's ACTNOW brings together many government departments and health promoters, service providers, associations other stakeholders to develop coordinated strategy and action on chronic disease prevention.
- Ontario is thinking of health planning in terms of investment portfolios: seeing the various programmes and expenditures related to mental health, for example, as part of a comprehensive system that can be planned and managed in a coordinated and evidence-driven way to have the most impact.

Here also: restructuring government processes and approaches is a complex challenge. Which of these directions or mechanisms will be most effective in a particular government or setting is bound to vary. Decision-makers should assess which issues or departments are most ready for change and which areas have the most potential to build momentum and make an immediate difference; and then experiment, evaluate and adapt. For example, child poverty has become an pressing issue in recent years. The several provincial poverty reduction strategies have necessarily involved many Ministries and considerable central commitment. Lessons should be learned on how these efforts have contributed to different ways of planning and coordinating government policy.

The Subcommittee will be particularly interested in potential cross-government collaboration within the federal level. Effective collaboration and coordination from other jurisdictions operates on several levels: providing secretariat functions to support and link up initiatives going on all across government, establishing forums or mechanisms to coordinate efforts and develop common policy agendas and objectives, and ensuring sufficiently powerful leadership and monitoring:

- The Public Health Agency of Canada has developed solid research and analytical capacities and already provides such secretariat support within the federal government (and beyond, through its extensive consultations and collaborations). As the government develops a more comprehensive overall strategy for health equity, this secretariat function will need to be strengthened and made more explicit.
- In terms of more effective coordination mechanisms:
    - the Subcommittee could consider recommending the creation of a cross-Department task force to assess the current state of government policy attention to health disparities and social determinants, and to recommend means to enhance common efforts and coordination;
    - the expectation would be that, if successful, this task force would evolve into a more permanent coordination mechanism;
    - at the same time, the Subcommittee could recommend that existing high-level cross-department committees on social, economic and other policy spheres explicitly include health equity impact in their mandates;
- A clear lesson from England, Sweden and other leading jurisdictions specifically is that significant central authority for policy development, priority setting, monitoring of progress against objectives and resource allocation – usually the equivalent of our

Cabinet/Privy Council Office and Finance orbits – and significant high-level political commitment – often from a champion within the government leadership – is vital. For the government to be serious about developing a comprehensive strategy it will need to make these commitments and set out such authority. If the Subcommittee were to recommend that the federal government develop a comprehensive health disparities strategy, it could also recommend that Privy Council Office consider options for central support and leadership of such a strategy and report back.

Local Action

All the leading jurisdictions have recognized that the real impact of building social determinants into public policy and investments will be felt at the local and regional level. Varying combinations of central coordinated strategic goals and funding, with local implementation and innovation are common.

- These can often be very intensive multi-government and multi-sector (public, business and community) neighbourhood-based initiatives. Community revitalization and engagement efforts currently underway in designated high-need areas of Toronto are good examples.
- A central component of English strategy has been to identify socially deprived and health disadvantaged communities and concentrate employment, training, infrastructure, community capacity building, early years, health and many other services. Projects involve multi-stakeholder collaborations and integrated service delivery. Targets are set for reducing the health disparities between the particular region and national averages, and data is collected and monitored to assess progress.
- Regional health authorities, both across Canada and in many other countries, have played a vital role in coordinating such local health – and often related social and economic -- services towards equity objectives.

It is also at the local level that cross-sectoral collaborations and integrated planning/delivery really works.

- Winnipeg Regional Health Authority and Manitoba Family Services and Housing have been partnering on the Winnipeg Integrated Services Initiative, with a vision of integrated community-based and social services to provide efficient, effective and holistic services which are person or family focused and recognize the principles of population health and primary health care. This is to be implemented through one-stop multi-service access points providing a wide range of multi-disciplinary services.

Thinking Beyond Boundaries

The importance of local action rubs up against one of the vexing problems of Canadian constitutional and political affairs: the crucial role of municipalities, formally creatures of the

Provinces, but vital economic engines and centres of social and community innovation. Tremendously imaginative efforts are taking place in cities across the country to address social determinants and inequality at a local level.

- For example, a broad-based multi-sectoral collaboration in Calgary has been working on unaffordable housing and homelessness as a central health and social problem.
- Saskatoon municipal, health, social and education authorities and community and business stakeholders are working together to address health inequalities in core neighbourhoods.

Public health departments are often a local catalyst and connector for ground-level action on health disparities. Medical Officers of Health from 18 large Canadian cities have come together to analyze health disparities in their areas and to develop comprehensive local policies to reduce them. They have collaborated with the Canadian Population Health Initiative to produce a major report on urban health inequalities.

These examples of local collaboration and innovation highlight two areas the Subcommittee could consider:

- Funding this social investment and infrastructure will be absolutely indispensable in weathering and emerging from the current economic crisis. Stimulus packages must be social as well as economic.
- There can be great synergy in linking the important work this Subcommittee is doing to that of Senator Eggleton's on housing, poverty and health.

Acting on Health Disparities Within the Health System

I spoke earlier of how the huge weight of evidence on the impact of social determinants on health and health inequalities can seem overwhelming. A further potential blind alley is to conclude that only the broadest macro economic and social policy will make a difference. That health care has less impact on health than social and economic factors doesn't mean that how the health system is organized and how services and care are delivered are not crucial to tackling health disparities. Put most starkly, those facing the harshest impact of the social determinants end up sickest and needing the most care within the health system. The potential reparative and ameliorative function of equitable health care in addressing the damage caused by social determinants was emphasized in your report.

While all comprehensive national health equity strategies focused on social and economic policy, leading countries all also saw transforming the health system as an indispensable element of their programmes. I set out how an equitable and responsive health system can be

developed and sustained in my report for the Toronto Central LHIN. A major theme was to simultaneously:

- **build addressing health equity and reducing health disparities into everything** – into all facets of health care priority setting, programme planning, resource allocation, service delivery and performance management;
- **target** some proportion of programmes and resources to improving the health opportunities and outcomes of the most health disadvantaged individuals and populations, and to reducing the most important accessibility, language, social, cultural and other barriers to high-quality care for all.

Building Equity Into All Facets of the Health System

This must start from core objectives. All federal and provincial Ministries and Regional Health Authorities should explicitly state that equity is a fundamental strategic priority.

- Many researchers, experts, provincial health quality councils, Ministries and other leaders have emphasized equity as one crucial component of a well-performing health system.
- The Ontario Ministry of Health and Long-term Care has identified equity as one of three fundamental pillars of health transformation.

We need to always think of institutional drivers, priorities and incentives. Part of this is realizing that acting on equity is not purely an ethical or social justice issue, but also a system issue; that more equitable access is not contradictory but complementary with other objectives of patient safety, quality and sustainability. For example, research shows over-utilization of emergency rooms and hospitals by homeless and other marginalized populations, both because of the severity of their health problems and the lack of access to primary and preventative care. It is in the interests of hospitals struggling with wait times and bottlenecks to reduce such inappropriate use by enhancing primary care and up-stream intervention. Similarly, without adequate interpretation services, not only are people with language barriers more poorly served, but there can be dangers of over-prescription and misdiagnoses, potentially serious problems for hospitals.

Equity-Focussed Planning Mechanisms

Equity can be built into planning in many ways:

- Toronto Central LHIN required hospitals in its area to develop health equity plans. It is quite possible that these plans will eventually be incorporated into routine performance management systems, in which hospitals will need to deliver on identified equity as well as other targets. The process of developing the plans has proven useful in other immediate ways:

- it has raised awareness of equity issues within the hospitals and advanced the necessary process of internal dialogue to build action;
- it uncovered problems faced by all hospitals such as defining and supporting culturally competent care, effective community engagement, and understanding the needs of their most vulnerable users and communities; and
- it encouraged hospitals to share best practices.

One problem found in developing these Toronto hospital equity plans is shared by many other Canadian jurisdictions: the lack of comprehensive data on the relationships between socio-economic circumstances, ethno-cultural background, race, language, immigration situation and many other social factors, and health care access, service utilization and outcomes. Here again, looking to other jurisdictions can be insightful:

- A system of Public Health Observatories has been developed in England that collect and analyze such equity and diversity–relevant data and help to incorporate it into system planning and performance management.
- Calgary Health Region has partnered with English observatories to assess how their structures could be effectively adapted and a number of authorities and provinces are considering development of an observatory system here.
- The Toronto Central LHIN is holding workshops on how to maximize the use of existing data sets and, moving forward, will be holding a conference to help define requirements, objectives and options for collecting and analyzing better health equity data.

There is obvious potential in coordinating and scaling up these local and regional efforts at a national and provincial level. A recommendation to develop national definitions, objectives, data and infrastructure on equity-relevant health information would neatly support the Subcommittees Issue 1 of tracking outcomes and interventions.

E Health

One of the most important drivers of health system reform in the coming decade will be electronic health. Ontario has recently amalgamated its programmes on e health and developed an overall strategy. It will focus on implementing e health and EHRs (electronic health records) in three priority areas, one of which is diabetes. Diabetes is a good choice from an equity point of view because its incidence, severity and impact vary quite dramatically along a social gradient. If well planned and managed, improving diabetes management could have a disproportionately beneficial effect on the most disadvantaged. However, these equity implications are not actually acknowledged in the strategy. Unless equity is explicitly included in strategic priorities and analysis, this potential will not be realized.

The eHealth Ontario strategy sets out concrete targets and indicators. Absolutely vital, but the indicators are purely clinical and general. Given the impact of social determinants on diabetes, indicators for such markers as adequate nutrition and housing conditions are as important to measuring success in diabetes prevention and management. In addition, the goal should be not

simply to achieve overall improvement in the identified clinical markers, but to reduce disparities in these indicators and outcomes along the social gradient. For example, one target is to increase the % receiving best practice care: an additional complementary target should be reducing systemic differences in % receiving best practice care by income, language, gender, ethno-cultural background, neighbourhood or other social variables.

Equity-driven policy mechanisms can be used for e health as well:

- Specific funding under these programmes could be made available for equity-focused initiatives; for example, addressing the digital divide to ensure all can benefit from increased health information and personal health record management opportunities.
- Every proposal for funding could be required to include a health equity impact assessment; for example, indicating how EHR development will consider language and literacy barriers.
- Funding incentives and programme requirements could insist that electronic health records include not just clinical, but social determinants-relevant information.
- Potential impact on reducing health disparities and/or on disadvantaged populations could be one criteria in project approval and resource allocation decisions.

In addition, e health must be implemented in a wider context and in multi-sectoral way. For example, the federal government has committed to a broad Information Highway strategy and major investments. E health initiatives must be seen as part of this wider strategy; at the simplest, so that efficiencies in database and platform design can be enhanced and lessons learned in implementation can be shared. The worst result could be IT hardware, software or projects coming into a particular institution or service provider from one programme, only to duplicate or be contradicted by similar spending from another programme or government.

Equity-Targeted Interventions

Services

One critical way to reduce health disparities is to target programmes and services to the most vulnerable and under-served communities or populations.

- Community Health Centres have traditionally had just such a mandate of providing primary and preventative care to health disadvantaged communities. They provide an integrated continuum of services in accessible locations, considerable outreach beyond into their immediate communities and extensive engagement with users and local communities to define needs and service mixes. Evaluation research indicates positive impact on outcomes and quality of care.
- Returning to e health, an example of equity-driven innovation is the award winning CAISI (Coordinated Access to Integrated Service Information) project. An open-text database developed by downtown Toronto physicians, IT experts, hospitals, shelters and other

homeless agencies, with active participation of homeless people themselves. It captures and stores homeless peoples' records so that they have ready access at whatever hospital, agency or shelter they are receiving services and so that do not have to endlessly repeat their stories to provider after provider. It also generates real-time data on service use and consumer health status.

Both of these examples could be considered by the Subcommittee for its recommendations:

- While some provinces have extensive networks of CHCs, others do not. Providing federal funding to expand CHCs and similar multi-disciplinary community-based centres across the country would not only improve access to primary care and reduce health disparities, but would also provide needed social stimulus at this crucial time.
- Recommending that local initiatives such as CAISI be evaluated and scaled up where appropriate could build on innovation already solidly developed and prevent wasteful duplication.

Planning

Effectively targeted programmes require good policy and planning tools:

- The Ontario Ministry of Health and Long-Term Care and the Toronto Central LHIN are developing an easy-to-use Health Equity Impact Assessment tool to assist service providers and LHINs in equity-focussed planning. The Wellesley Institute is partnering with them to organize provider and community consultations to refine and test the tool.
- Many provider and community groups have developed simple equity or diversity lenses, as checklists to quickly assess the equity implications of proposals or programmes and as means of ensuring that equity is always considered in planning.

Such tools have been successfully used in many other jurisdictions. The Subcommittee could consider recommending funding for demonstration projects or evaluations of the impact of HEIA and related tools in diverse institutional and community service settings.

Build on Local Knowledge

Focussed interventions to reduce disparities require solid understanding of specific local barriers to access and quality care; be they language, culture, accessibility, distance or socio-economic status. This highlights the importance of good community-based needs assessment and research and the kind of data needed to identify and track such specific barriers, variables and populations.

Luckily, there are huge numbers of local equity initiatives that can be built on:

- The Edmonton Multicultural Health Brokers Cooperative provides navigation, counselling and other support to people, who because of language or cultural barriers have trouble making their way through the health system. It arose from a grass-roots recognition that

these barriers were increasingly important but not being addressed, and was jointly developed by the local regional health authority, public health and other stakeholders. In addition to improving access and quality of care for immigrant families and individuals, many of the brokers were internationally trained providers. Doing this work allowed them to use their skills and become familiar with the provincial system as they waited for recognition of their qualifications.

- A number of Community Health Centres in Toronto have developed community peer health ambassadors type models. Lay people from particular ethno-cultural communities or specific neighbourhoods are trained and supported out of the CHCs, and provide health promotion, navigation and child and maternal support in their particular communities.

Multi-Sectoral Interventions

Health interventions in disadvantaged communities have to necessarily take account of the wider determinants of health.

- To return to the example of diabetes: incidence and outcomes are affected by housing, nutrition, living standards, language, cultural exclusion and many other social and economic factors. An initiative in London Ontario arose out of the local Hispanic community and CHC recognizing the far higher incidence of diabetes among Spanish speaking people. Services in Spanish (and soon other languages), innovative outreach to where people gathered (including setting up tents for confidential counselling in malls), multi-disciplinary care (nurses, physicians, nutritionists, etc.) and social determinants-focused referrals and advocacy (around housing, social assistance, etc.) were developed.
- Many jurisdictions have developed hub-style multi-service centres in which a range of health and employment, child care, language, literacy, training and social services are provided out of single locations.

The Subcommittee could recommend funding for demonstration projects of such hub-type integrated service models across the country.

Equity-Driven Innovation

A great deal of innovative front-line service delivery across the country addresses the needs of health disadvantaged communities. These programs and services at Community Health Centres, other community-based agencies, hospitals, social services; and cross-sectoral collaborations have the potential to significantly ameliorate the impact of heath disparities and address their underlying foundations on a local level.

However, little systematic research has been done on the outcomes of such equity-driven service provision, the key ‘success factors’ that underlie the most dynamic programmes, and the

policy and institutional frameworks needed to enable local front-line innovation and equity-focused initiatives. Under its Research and Knowledge Translation option, the Subcommittee could consider recommending that more community-based needs assessments, service evaluation and outcomes research should be funded to focus on local equity interventions and innovation.

Similarly, the great potential of this wealth of front-line innovation is not currently being realized because there are few ways to systematically share 'best practices' and 'lessons learned' among service providers. The policy challenge here is how to systematically identify promising innovations, evaluate and assess their potential beyond their local circumstances, share information widely on lessons learned, and scale up promising initiatives where appropriate → all to create a permanent cycle and culture of front-line innovation on equity.

Knowledge Management for Equity and Innovation

Essentially, the challenge is to create an innovation knowledge management strategy.

At best this should be developed at a national level. The Subcommittee could consider recommending enhanced funding and responsibly for the Health Council of Canada, the Canadian Health Services Research Foundation and other such institutions to expand a responsive national infrastructure for innovation knowledge management.

At the provincial and regional level:

- Ministries of Health should establish expectations and resources so that Regional Health Authorities can support local experimentation and innovations;
- RHAs would be responsible for identifying and assessing promising local innovations in their areas;
- Ministries would then need to create provincial forums and infrastructures to compile and assess these regional innovations, share their results across regions and scale them up province-wide where appropriate.

All these efforts will need to focus well beyond traditional academic, clinical and medical areas to include community-based service provision and innovation; and will need to explore collaborations and new ways of working, as well as improving existing practices. And they will need to focus specifically on equity-driven innovation.

As in so many other areas, solid initiatives are already underway in many communities that can be built on.

- For example, a collaboration based out of the Scadding Court community centre in Toronto is developing an on-line equity tool kit and interactive web site. This will be a valuable resource well beyond the local area.

- The Wellesley Institute funded the development of a database by the Association of Ontario Health Centres to organize and share research conducted by individual CHCs.

Returning to previous discussions of e health and tying them to the need for knowledge management for innovation and equity and to cross-sectoral collaborations: e health should not just be about EHRs or the efficient exchange of clinical data, but must also seamlessly integrate the databases and ICT that underlie effective knowledge management. Providers must be able to exchange not just patient records but programme descriptions, needs assessments and service evaluations, and to collaborate through shared on-line tools. And these capacities must be available not just at major academic facilities and hospitals, but for the full range of community-based providers as well.

To be successful, this innovation management must be sustainable over the long run.

- An important recent cautionary tale is the fate of the Canadian Centre for Analysis of Regionalization and Health. Based in Saskatoon, the Centre organized annual conferences of practitioners and experts from across the country and beyond, undertook research on challenges and outcomes of regional planning, and provided a forum for exchanging information among regional health authorities through its newsletter and web site. Funding ran out and all this invaluable knowledge was lost.

One mechanism the Subcommittee could consider is recommending that the Public Health Agency of Canada and the various National Collaborating Centres invest in demonstration projects to create new forums and effective infrastructures for knowledge management of innovation and equity initiatives.

- Several NCCs have been making significant progress in knowledge exchange. But their efforts have focussed on their specialized spheres, activities and impact has been uneven among the Centres, and there has been little emphasis on the much less-researched /documented community-based service and innovation spheres.
- A specific demonstration project is needed:
    - to focus specifically on knowledge management/enabling of equity-focussed initiatives and innovations and community-based or front-line programme interventions;
    - with an applied perspective – creating forums for the exchange and development of useable knowledge and research to improve planning and service delivery;
    - with sophisticated and imaginative ICT approaches – to create dynamic interactive means of sharing information and building knowledge;
    - this would need to be based in an institute with considerable community-based research expertise, research and policy capacity in health equity, understanding of health disadvantaged populations, and solid connections to community-based service provision;

- This demonstration project could work in collaboration with the Health Council of Canada, the Canadian Health Services Research Foundation and other institutions mentioned above to bring equity more firmly into their efforts and to jointly develop a responsive national infrastructure for innovation and equity knowledge management.

Key Messages

The work this Subcommittee and others are doing in trying to pull together a comprehensive national strategy for addressing the social determinants of health and health inequalities is vitally important. Experience from other countries shows that developing such strategies:

- can focus and concentrate policy and programme attention on tackling health disparities as a major national problem;
- can guide and justify significant investment in interventions to reduce disparities and improve the health of the most marginalized;
- are crucial to enabling and supporting concentrated local and regional action;
- symbolize strong commitment to reducing inequality and enhancing opportunities and mobility.

We can't be naive about the challenges of developing and implementing such strategies in the Canadian context – but it is a challenge that must be kept at. And we can expect the usual Canadian way of some provinces taking the lead by developing their own strategies and frameworks. Let's just make sure these insights are shared and can inspire action from other provinces.

It will also be important to connect analyses of the foundations of health disparities to other issues as they arise – especially now to the attention being paid to poverty reduction strategies in several provinces. The foundations and solutions to reducing poverty and health disparity are remarkably similar, and such programmes and strategies need to be carefully coordinated.

I've also argued that decision makers must not let the scope of these challenges and the complexities of developing policy and political solutions paralyze them. We need to always keep the big picture in mind; but we also need to drive immediate action. I think a model of strategic experimentation and innovation has great potential: in which we start from the best available evidence, invest in a range of promising projects, evaluate and learn from what is working, share those learnings widely and scale up the most successful programmes → all to gradually build up a powerful repertoire of policy instruments and programme interventions that work.

Governments do need to do things very differently to have an impact on health disparities and social determinants:

- Part of this is the comprehensive strategic frameworks highlighted above – all Canadian governments should develop strategies to reduce health disparities and social inequality. And these strategies should be coordinated and dovetailed across the country.
- Part also is far better coordination and collaboration across often fragmented departments and programmes. Such 'joined-up' government will benefit not only health equity but many areas of public policy.
- Innovative planning and coordinating forums need to be created; examples have ranged from cross-department coordinating committees, to task forces and councils, and to health impact check-offs..
- Effective tools, such as Health Equity Impact Assessments and equity lenses, need to be built into the fabric of government planning.

Governments need to not simply engage more effectively with community and other stakeholders, but must see community action and mobilization as a crucial component of their health equity strategies:

- Communities across the country are continually pioneering cross-sectoral collaborations, joint initiatives and integrated service delivery on the ground. Governments must enable and encourage this community-based creativity and innovation through their funding and policy frameworks.
- For example, the federal government could fund demonstration projects and investments in hub-type integrated social and health service centres. Creating a network of community-based centres ensuring access to primary care and other vital social services would make a significant difference to the health and well-being of vulnerable populations.

The health system itself is a major site for action on health disparities. Strategy here is two-fold:

- Build consideration of equity and diversity into all aspects of health planning and delivery. A wider range of tools can be used: from explicit equity targets and objectives in performance management, through equity as a key criteria in priority setting and resource allocation, through Health Equity Impact Assessment and other decision making techniques.
- Concentrate some proportion of investment and programming on addressing the greater heath needs of the most disadvantaged populations and the central barriers to equitable access. There is no magic blueprint here: the nature of these needs and barriers varies from community to community. But there is an enormous base of local front-line community-based insight and experience in addressing health disparities across the country.

A crucial element of an effective strategy on health equity – and a key role for governments at all levels – is to enable and nurture this local innovation and action. We need to create forums and infrastructure where lessons learned from front-line interventions can be widely shared,

where promising initiatives can be rigorously evaluated, where the most successful can be scaled up and adapted widely, and where we continually build a cycle of improvement and innovation. We need a different kind of research – more community-based and more applied – that can help identify programme, service, community engagement and other interventions that really work to reduce health disparities.

All of this requires a more expansive view of the potential of government investments and support of community initiatives: not just funding a one-time project here or there, but developing coordinated and coherent overall strategies that can effectively link up diverse programmes and interventions; not just a series of research projects, but a comprehensive knowledge management and innovation strategy that will build on the enormous insights and solid networks that already exist; and not just isolated programmes to deal with the symptoms of child poverty or poor health, but comprehensive strategies to tackle the roots of inequality and lay the foundations for equitable health and well-being for all.