

International Review of Health Equity Strategies

By Wellesley Institute for Health Quality Ontario

Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

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On behalf of Wellesley Institute For Health Quality Ontario

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Introduction

This review of health equity strategies was produced for Health Quality Ontario. Health Quality Ontario has developed its equity plan to better support the system to provide equitable, high-quality care to everyone. The *International Review of Health Equity Strategies* aimed to inform Health Quality Ontario's Health Equity Plan.

Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are. Jurisdictions across the world have adopted strategies to enhance health equity. Some have developed approaches to promote health equity within their health systems while others have developed intersectoral approaches to tackle social determinants of health within and beyond the health sector.

Wellesley Institute's previous review for Health Quality Ontario signals that there are significant gaps in health outcomes and service use for different populations across the province. For example, Ontarians living in low-income areas have a life expectancy 4.5 years lower than those who live in high-income areas. Life expectancy also varies widely by Local Health Integration Networks (LHINs). In addition to income-related and regional disparities, we found that multiple factors such as immigration status, language, homelessness, gender and age contribute to the current status of health inequities in Ontario.

Health Quality Ontario is well-positioned to promote health equity through the health care system and to be a leader in developing intersectoral health equity strategies that crosscut other sectors impacting the health of all Ontarians.

The aim of this report is to identify and describe strategies that have been developed by Canadian and international jurisdictions to enhance health equity within and beyond the health sector. A number of different terminologies, such as strategy, approach, plan, and framework, are often (though not always) used interchangeably to describe the national or provincial/state-wide efforts to enhance health equity. Throughout this report, we use the term "strategy" to describe such efforts.

Methods

We examined documents outlining national and provincial/state-level strategies developed in high-income countries that are considered comparable to Canada: North America, Europe, Australia, and New Zealand. We retrieved grey literature, largely documents from governments and health authorities, through web searches and consultations with health equity experts in Canada and internationally.

Our initial aim was to review *health equity* strategies. In our preliminary search, however, we found that *health equality* was the terminology used for the core or main focus of several international strategies. We then expanded the scope of our search to include both health equity-focused and health equality-focused strategies. Our search criteria included publications that:

- Present a national or provincial/state-level strategy that promotes health equity or equality;
- Present detailed descriptions of a strategy, including the vision, strategic goals and directions, and specific equity-focused action plans;
- Do not exclusively target a specific focus area such as mental health or chronic disease;
- Were published between 2001 and 2016; and
- Are published in English.

We retrieved information about European strategies from the European Portal for Action on Health Inequalities and searched the Policy Database in the European Portal to locate national policy initiatives addressing health equity or equality. The initial search produced 211 results of national-level policies and programs that have been developed in 32 European countries. We then searched identified government and health authority websites and Google to locate specific publications presenting national-level strategies.

We identified Canadian strategies from the National Collaborating Centre for Determinants of Health (NCCDH)'s recent reports on health equity initiatives across Canada (NCCDH, 2010; 2013). We searched Google and Canada's provincial health ministries' websites to find further provincial official documents on health equity. We used health equity-related search terms, including health equity, health inequities, health disparities, health equality, and health inequalities, paired with respective province names. We also consulted experts from Alberta Health Services and the NCCDH.

We gathered information about Australia, New Zealand, and the U.S. through a combination of Internet searches and consultation. We searched government websites and Google searches using the health equity search terms and the name of country and state. For the U.S., we also searched the Office of Minority Health's Resource Centre Library, within the U.S. Department of Health and Human Services. We then consulted with a director at the Resource Centre to identify federal and state-level initiatives across the U.S.

After retrieving all the documents that met our search criteria we conducted a content analysis of the collected documents to discover patterns and trends of health equity or equality strategies and to develop content categories among the reviewed strategies. For the purpose of our review to inform the development of a health equity strategy in Ontario, we focused on identifying emerging principles shared by Canadian and international strategies. In our analysis we were particularly interested in specific approaches that other jurisdictions adopted to reduce health inequities or inequalities and to improve health equity or equality: how health equity or equality is addressed; whether non-health sectors are engaged; which population groups are identified; whether targets are presented; how the progress is monitored and evaluated; and which specific levers are used to implement proposed strategies.

Results

In total, sixteen national or provincial/state-level strategies were included in our review. We identified seven national-level European strategies, one provincial-level Canadian strategy, three national-level Australian strategies, one national-level New Zealand strategy, and two national-level and two state-level U.S. strategies. All sixteen strategies are summarized in Appendix 1.

Based on a review and synthesis of collected documents and information, we largely grouped the strategies into two categories based on whether they present a) an intersectoral approach or b) a health system approach. The first group of strategies involve action to achieve health equity or equality in multiple sectors within and beyond the health sector and across several social determinants of health. The second group of strategies aims to promote equity or equality mainly, but not exclusively, within health systems. Eight strategies, developed in England, Scotland, Finland, Ireland, Wales, Norway, Australia, and the U.S. (California), took an intersectoral approach (e.g., Health Equity in All Policies or Health in All Policies), while eight strategies, developed in Canada (Alberta), U.S., Australia, New Zealand, and Scotland, adopted a health system approach.

In the following sections, the intersectoral approaches are presented in Part A and the health system approaches are presented in Part B. Other main findings, summarized in both Part A and B, include i) who issued the strategy report; ii) whether “health equity” or “health equality” is the terminology used to describe the central target; iii) which target groups are identified; iv) whether quantified targets are set; v) how the strategy monitors and evaluates the progress; and vi) which mechanisms and tools are used to support implementation. Each section provides a synthesis of the common strategic goals and actions between all reviewed strategies. Each section also presents three case studies selected to highlight a range of approaches taken in Canada and internationally. Case studies were selected to include those from a variety of geographical regions, focusing on a range of target groups, and for a balance of intersectoral and health system approaches.

A. Intersectoral Approaches

This review identified eight national and state-level strategies that have adopted an intersectoral approach to promote health equity or equality through their work across a wide range of social determinants of health. For example, England’s Tackling Health Inequalities: A Programme for Action was ratified by twelve departments and a number of regional and local authorities that were committed to fighting against the underlying causes of health inequalities such as child poverty, housing, transport, education and training. Intersectoral action for health has an important objective of achieving greater awareness of the health and health equity consequences of policy decisions and organizational practice in different sectors and through this moving in the direction of healthy public policy and practice across sectors (World Health Organization, n.d.). The World Health Organization’s Framework for Action on the Social Determinants of Health (2010; see Box 1) provides a framework for tackling health inequities using an

intersectoral approach.

Table A: Summary Table for Health Equity/Equality Strategies – Intersectoral

Jurisdiction	Name of strategy	Published by (year)	Focus	Listed target groups	Quantified target	Data Monitoring and evaluation	Tools and mechanisms for implementation
England	Tackling Health Inequalities: A Programme for Action	Department of Health (2003)	Equality as core focus	Yes	To reduce the gap in life expectancy and infant mortality by 10 percent by 2010	-Public Health Observatories for data monitoring -The Scientific Reference Group on Health Inequalities for independent assessment	-Public Service Agreement -Cross-cutting spending reviews -Mandatory Health Impact Assessment -Equity Audit
Norway	National Strategy to Reduce Social Inequalities in Health	Ministry of Health and Care Services (2007)	Equality as core focus	Yes	No	-Comprehensive monitoring system on mortality and morbidity (developed by the Institute of Public Health) -Annual policy reviews	-Public Health Act -Planning and Building Act -Health Impact Assessment -Grants for local authorities working in health
Finland	National Action Plan to Reduce Health Inequalities	Ministry of Social Affairs and Health (2008)	Equality as core focus	Yes	To reduce the gap in mortality in population by 20 percent by 2015	-Online monitoring system -“bilateral dialogues” for evaluation	-Public Health Act -Multisectoral National Committee -All ministries legally required to collaborate on the Public Health report
Scotland	Equally Well: Report of the Ministerial Task Force on Health Inequalities	Scottish Government (2008)	Equality as core focus	Yes	No	-Monitoring national indicators (absolute and relative measures) -8 test sites -Progress Reviews	-Fairer Scotland Fund -Health Inequalities Impact Assessment -Community health partnership
Wales	Fairer Health Outcomes for All: Reducing Inequities in Health Strategic Action Plan	Welsh Assembly Government (2011)	Equity as core focus	No	To close the gap between each quintile of deprivation by an average of 2.5 percent by 2020	-Public Health Wales Observatory to identify a small number of targets and indicators to monitor -Welsh Assembly Government to develop an approach to measuring and monitoring the 2.5% target	-One Wales Policy Gateway Tool -Health Inequalities Impact Assessment and Health Impact Assessment
Ireland	Healthy Ireland: a Framework for Improved Health and Wellbeing 2013-2015	Department of Health (2013)	Equality as one of five goals	No	No	-Healthy Ireland Outcomes Framework (work in progress)	-Health Impact Assessment -Social Impact Assessment
Australia	National Aboriginal and Torres Strait Islander Health Plan 2013-2023	Australian Government (2013)	Equality as core focus	Yes	To close the life expectancy gap by 2031	- High-level annual reports to the Australian Parliament -Closing the Gap Report; Health Performance Framework reports	-Supporting various national initiatives with specific focus -National Partnership Agreement
California (US)	California Statewide Plan to Promote Health and Mental Health Equity	Department of Public Health (2015)	Equity as core focus	Yes	No	-Healthy Communities Data and Indicators Project, aligned with the Healthy Communities Framework (work in progress)	(Preliminary stage)

Approach

The eight reviewed strategies have been developed mostly, but not exclusively, in Europe. In 2003, the Department of Health published *Tackling Health Inequalities: A Programme for Action*, the national health inequalities strategy for England. In 2007, the Norwegian Ministry of Health and Care Services published a *National Strategy to Reduce Social Inequalities in Health*. In 2008, the Scottish government published *Equally Well: Report of the Ministerial Task Force on Health Inequalities* and Finland launched a *National Action Plan to Reduce Health Inequalities*. In 2011, the Welsh government launched a national plan, *Fairer Health Outcomes for All: Reducing Inequities in Health Strategic Action Plan*. In 2013, the Ireland's Ministry of Health published a new national framework, *Healthy Ireland: a Framework for Improved Health and Wellbeing 2013-2015*. In addition, in 2013, the Australian government published the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Most recently, in 2015, the California Office of Health Equity, within the California Department of Public Health released the *California Statewide Plan to Promote Health and Mental Health Equity*, a preliminary plan for reducing health inequities.

A.1. Key Components of Intersectoral Approaches

Equity/Equality as Core Focus

Within the eight strategies, all but Ireland's *Healthy Ireland* plan specifically targets health equity or equality as their core focus. The *Healthy Ireland* plan provides a general framework for improved health and well-being, with “reducing health inequalities” as one of its five goals. The other seven strategies adopted a Health Equity in All Policies or Health Equality in All Policies approach. A Health Equity in All Policies approach is “a policy strategy which targets the key social determinants of health through integrated policy response across relevant policy areas with the ultimate goal of supporting health equity” (Equity Action, n.d.). While a Health in All Policies approach also aims to improve population health through intersectoral action, it may not effectively tackle health inequities without clear goals and actions for the intersectoral work to achieve health equity.

California's Statewide Plan to Reduce Health Inequities is a plan which forms the groundwork for developing an intersectoral health equity strategy. This plan targets the root causes of inequities in California and is the product of the state's newly created Office of Health Equity (OHE), situated in the California Department of Health. It is closely aligned with the State's Health in All Policies Strategy, developed in 2010.

Four European countries and Australia have developed detailed strategies to improve health equality. England's *Tackling Health Inequalities*, and its subsequent follow-up documents such as *Health Inequalities: Progress and Next Steps*, is specifically focused on health inequalities, and makes recommendations across all areas of government. Scotland's *Equally Well* and Finland's *National Action Plan to Reduce Health Inequalities* also aim specifically to reduce health inequalities through intersectoral action. Norway's strategy used the language of reducing social inequalities in health. Australia's *National Aboriginal and Torres Strait Islander Health Plan* adopted language of realizing health equality.

Wales' national plan, *Fairer Health Outcomes for All* is the only European plan to use the language of a health equity approach. It explicitly states that its approach is in line with the government's aim to create a fair and just society. The language used in this plan emphasizes the moral aspect – that it is unjust to

tolerate health disparities.

Target population groups

The strategies reviewed take a variety of approaches in identifying and naming specific target groups for intervention.

Australia's *National Aboriginal and Torres Strait Islander Health Plan* was developed to improve the health of all Aboriginal and Torres Strait Islander people and to achieve health status and life expectancy equality between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

California's *Statewide Plan* targets inequities in health faced by a range of vulnerable communities including: women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and who have been incarcerated, individuals with disabilities, those with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient, and LGBTQQ communities. It also recognizes the intersectionalities in these communities, identifying that combinations of these populations are also target communities in their own right.

England's strategy for *Tackling Health Inequalities* similarly targets inequalities faced by a wide range of disadvantaged groups. It acknowledges inequalities between different geographical areas, genders and ethnic communities, and between other social and economic groups. It also recognized that reducing health inequalities requires more than focusing exclusively on the most disadvantaged and socially excluded: to achieve its targets, the health of the poorest 30–40 percent of the population must be improved.

Scotland's *Ministerial Task Force on Health Inequalities* references income, age, disability, gender, race, religion or belief, sexual orientation and other factors as critical characteristics to consider in implementing its equity-focused actions. One of its key recommendations is to focus on early years and young people in order to minimize health inequalities over the life course.

Finland's *National Action Plan to Reduce Health Inequalities* focuses specifically on social and economic exclusion, targeting low-income groups and poverty. Seniors and immigrants are highlighted as groups needing specific programmatic focus, and homelessness is identified as an issue to target, but the range of specific target groups is not specified.

Norway's *National Strategy to Reduce Social Inequalities in Health* targets disadvantaged groups broadly. Specifically it focuses on those population groups with long-term social problems (e.g. prisoners, long-term recipients of social assistance, heavy drug addicts, alcoholics, some immigrant groups, people with reduced functional capacity – most of whom do not have access to the National Insurance Scheme); children and young people at risk; immigrants; people living alone; and areas with Sami and Norwegian settlements.

Ireland's *Healthy Ireland* and Wales' *Fairer Health Outcomes for All* aim to focus on population groups experiencing the greatest disparities, but neither is specific about which groups these are.

All the strategies recognize axes of disadvantage beyond ethnicity and income, although some are clearer than others. Finland, Norway and Wales mention only very broadly social and economic exclusion, but leave open the possibility that specific populations will be considered. England, Scotland, and Ireland all produce more extensive lists, with California explicitly naming a range of populations facing inequity – consistent with the U.S. national equity strategies (Department of Health and Human Services, 2011).

Quantified Targets

Four strategies present quantified targets, in addition to a set of indicators.

England's strategy aims to reduce inequalities in health outcomes by 10 percent as measured by infant mortality and life expectancy at birth by 2010, which is underpinned by two more detailed targets: i) starting with children under one year, by 2010 to reduce by at least 10 percent the gap in mortality between the routine and manual group and the population as a whole; ii) starting with local authorities, by 2010 to reduce by at least 10 percent the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

Finland's strategy supports implementation of the national *Health 2015* program aiming to extend people's healthy and functional life and reduce health inequalities between population groups. The *Health 2015* program is the first Finnish program to set a quantitative target: to cut mortality inequalities between different vocational and educational groupings by one fifth by 2015.

Wales' strategy aims to improve healthy life expectancy for the entire population and to close the gap between each quintile of deprivation by an average of 2.5 percent by 2020.

Australia's *National Aboriginal and Torres Strait Islander Health Plan* presents detailed national targets (that are developed under the *Closing the Gap* framework): i) to close the life expectancy gap by 2013; ii) to halve the gap in mortality rates for Indigenous children under five by 2018; iii) to ensure all Indigenous four-year-olds in remote communities have access to early childhood education by 2013; iv) to halve the gap for Indigenous students in reading, writing and numeracy by 2018; v) to halve the gap for Indigenous people aged 20-24 in Year 12 attainment or equivalent attainment rates by 2020; vi) and to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians by 2018.

Other strategies have developed or have a plan to develop specific indicators to measure, but not quantified targets. For example, the Scotland's *Equally Well* report does not present quantified targets, but the Scottish Government has developed a set of medium-term health inequalities outcomes and associated indicators on four priority areas of focus, including early years; mental wellbeing; alcohol, drugs and violence; and big killer disease outcomes. Scotland's *Equally Well Implementation Plan* specifically notes that they do not attempt to produce numerical targets "because of the complex range of factors that contribute to change."

Box 2: England's National Headline Indicators (Department of Health, 2003)

1. Access to primary care: Number of primary care professionals per 100,000 population
2. Accidents: Road accident casualties in disadvantaged communities
3. Child poverty: proportion of children living in low-income households
4. Diet – 5 a Day: proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution
5. Education: proportion of those aged 16 who get qualifications equivalent to 5 GCSEs at grades A to C
6. Homelessness: number of homeless families with children living in temporary accommodation
7. Housing: proportion of households living in non-decent housing
8. Influenza vaccinations: percentage uptake of flu vaccinations by older people (aged 65+)
9. PE and school sport: percentage of schoolchildren who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum
10. Smoking prevalence – manual groups/in pregnancy: prevalence of smoking among people in manual social groups, and among pregnant women
11. Teenage conceptions: rate of under-18 conceptions
12. Mortality from the major killer diseases: age-standardized death rates per 100,000 population for the major killer diseases (cancer, circulatory disease), ages under 75 (for the 20 percent of areas with the highest rates compared to the national average)

The 2012 Statistics Canada analysis of immigrants' labour market experiences during recession provides a comparator for these results. Table 2 shows some data from that analysis.^[10] That study is focussed on the 25 to 54 year old immigrant labour force, rather than racialized workers and the period under consideration is 2008 to 2011. While the population groups and time periods do not match exactly, there is a large overlap. The changes in the labour force participation rate for immigrants who had been in Ontario for more than five years is similar to that of racialized Ontarians. The change in the participation rate for Canadian-born workers was similar in magnitude to the decrease in participation rates as for non-racialized Ontarians. The sharper decline in the employment rates in the NHS data is consistent with the high unemployment rates that younger Ontarians have been experiencing. The changes in the unemployment rates also show similar patterns. The data show a greater negative impact on recent immigrants than on the racialized population, which does raise concerns.

Data Monitoring and Evaluation

All strategies acknowledge the importance of developing a robust monitoring and evaluation system to track the progress and to achieve the targets and goals more effectively. In England, the London Public Health Observatory has a national lead role of monitoring data on health inequalities. A number of online datasets and tools are available online (www.lho.org.uk), such as Index of Multiple Deprivation 2010, Marmot Indicators, Basket of Indicators, and Health Inequalities Target Data to monitor progress towards reducing health inequalities in local areas. England has also published reports to review developments in health inequalities. The initial *Programme for Action* developed by the Department of Health (2003 – see

Box 2) identified 12 key indicators. In 2009, *Tackling Health Inequalities: 10 Years On* was then developed with the oversight and advice of the Scientific reference Group on Health Inequalities.. Other countries have also produced review reports on their progress. In 2010, Scotland published the *Equally Well Review* to review progress and highlight areas for more intense effort. The Ministerial Task Force on Health Inequalities reconvened in 2012 to review national and local progress against its recommendations. Norway has published the Annual Report from the Directorate of Health on the Efforts to Reduce Social Inequalities in Health, annually until 2017.

Ireland and California are currently developing their monitoring systems. In Ireland, a cross-sectoral working group is developing a *Healthy Ireland Outcomes Framework*, a tool that sets out specific indicators for each goal and the role of responsible partners (Healthy Ireland, n.d.). This framework will allow an objective assessment of the impact of *Healthy Ireland* by monitoring population health and wellbeing, associated lifestyle related risks, and the wider determinants of health and wellbeing. In California, the Healthy Places Team in the Office of Health Equity has been working on building the Healthy Communities Data and Indicators (HCI) Project to enhance public health by providing data, a standardized set of statistical measures, and tools that multiple sectors can use for planning and by evaluating the impact of interventions.

Implementation Tools and Mechanisms

Impact assessment tools, such as Health Impact Assessment (HIA), are widely used across our reviewed intersectoral strategies. In England, the use of HIA has been a mandatory practice for all new legislations since 2004. Norway has promoted the use of HIA as a decision tool across all levels of governments. Scotland and Wales employ a Health Inequalities Impact Assessment. In Wales, the One Wales Policy Gateway Tool, a policy impact assessment process, aims to ensure that policies from all portfolio areas contribute to delivering the government's broader objectives, such as reducing inequities in health (Ward, 2011). The Irish government has committed to incorporating poverty impact assessment as part of an integrated Social Impact Assessment, with health impacts as core feature of this new tool.

In addition to the use of impact assessment tools, European governments have developed various ways of supporting and reinforcing collaborative work and policy coherence through legislation, regulations, joint agreements, financial support, and other mechanisms and tools (St-Pierre et al. 2009). Norway has updated its Public Health Act to place responsibility for public health work on the entire government and entire municipality. The Public Health Act 2011 names Health in All Policies as one of its five fundamental principles. Norway also uses the existing Planning and Building Act as a lever to facilitate local and county authorities in their social and land-use planning to tackle inequalities.

England has developed some innovative management mechanisms to achieve its national goals to tackle health inequalities. In the late 1990s, the government introduced Public Service Agreements (PSAs), long-term performance objectives with associated targets for both departmental and cross-departmental policy issues (James & Nakamura, 2013). The Department of Health had a PSA to deliver on the health inequality targets. The PSAs were linked with the cross-cutting spending reviews, led by the Treasury and involved departments, units, and agencies across the whole of government. England's strategy also required that NHS service planning be informed by a health equity audit, a mechanism to use evidence about health inequalities to inform service planning and delivery.

A.2. Strategic Goals and Action

The reviewed intersectoral approaches to health equity and health equality share several characteristics. Each recognizes the need to focus both within the health system and beyond. Several emphasize developing capacity and working from within communities, and the need to improve research and evaluation capacity in order to better target and monitor programs is addressed to some degree in each.

The following identifies the key strategies outlined in all or some of the documents:

1. Engaging multiple sectors, within and beyond the health sector, and developing multi-level actions. Embedding health equity or equality into institutional practices and policies across fields with potential health partners beyond the traditional boundaries of public health.
 - Strong and effective leadership
 - Cross-departmental collaboration
 - Clear identification of responsibility for each strategy and actions across departments
 - Effective mechanisms and tools to support and enforce implementation through legislation, regulation, and partnerships
2. Addressing the wide-ranging social determinants of health. The reviewed frameworks identified many areas of focus:
 - Educational attainment and skill development
 - Income
 - Unemployment
 - Working conditions, including health promotion within the workplace
 - Social housing
 - Fuel poverty
 - Safety of spaces
 - Cleanliness of environments
 - Early years supports, day cares, child welfare clinics
 - Access to public services, including immigrant services in disadvantaged communities
 - Supporting healthy lifestyles: reducing alcohol, drug, and violence, promoting healthy diet and exercise
 - Rehabilitation services
 - Health literacy
3. Embedding equity or equality into institutional policies and practices between departments within the health sector.
 - Improving access to and services in deprived areas for those with mental health challenges
 - Improving preventive health services for at-risk groups
 - Improving communication, translation, and interpreting strategies within health systems
4. Empowering Communities
 - In health inequity and disparity reduction initiatives
 - In generating data on health disparities and inequities
5. Research, Evidence and Evaluation
 - Improve research and evaluation capacity
 - Develop specific indicators and measurement strategies
 - Strengthening the evidence base

A.3. Case Studies: Intersectoral Approaches

Case 1: England

The Acheson report, *Inequalities in Health: Report of an Independent Inquiry*, has been a cornerstone for action on health inequalities in the U.K. since it was published in November 1998. This report reviewed evidence on inequalities in health and made several recommendations across all areas of government, giving high priority to strategies targeting the early years of life. In 2001 the government set national targets for the first time, and in 2003 *Tackling Health Inequalities: A Programme for Action* – the national health inequalities strategy – was adopted.

The intersectoral approach to improve health equality has been widely adopted, and health equality is one of the top NHS England priorities. The strategy's vision, "to tackle inequalities to create a fairer and more just society that will allow all individuals and communities to fulfill their potential and benefit more equitably from public services investment", underscores the strategy's focus on public services outside the health sector.

The strategy takes a determinants of health approach to tackling inequalities, targeting determinants such as poverty, poor educational outcomes, unemployment, poor housing, homelessness, and problems associated with disadvantaged neighbourhoods. The strategy presents focused targets and twelve national indicators to measure and clearly identifies responsible departments for each strategy and action item.

The specific target selected to measure the impact of the strategy is to "by 2010 reduce inequalities in health outcomes by 10 percent as measured by infant mortality and life expectancy at birth."

The plan identifies five key operating principles:

- Preventing health inequalities from worsening
- Working through the mainstream
- Targeting specific interventions
- Supporting action from the centre and through the regions
- Delivering at the local level.

This framework is not specifically focused on health systems – it acknowledges the importance of the broader determinants of health. Nonetheless, health systems interventions are central in addition to interventions targeting housing and other environmental determinants of health. In addition to these principles, there are four themes to this strategy:

- Supporting families, mothers, and children
- Engaging communities and individuals
- Preventing illness and providing effective treatment and care
- Addressing the underlying determinants of health.

The actions highlighted focus on the life expectancy and infant mortality outcomes, and overall have a focus on health care, housing, and early childhood education.

To decrease the gap in life expectancy, the plan recommends action in four areas:

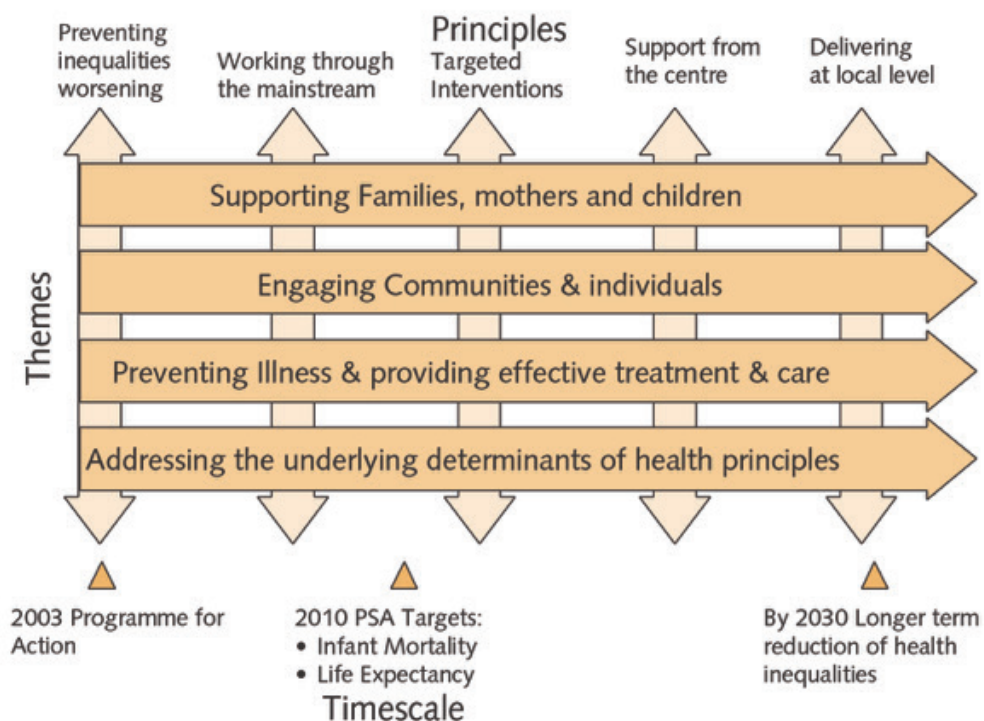
- Smoking cessation and other tobacco control programs
- Preventing and managing other risk factors such as poor diet and obesity, physical activity and high blood pressure
- Improving environmental health, including housing conditions and reducing accident risk
- Targeting adults over 50.

To decrease the gap in infant mortality:

- Improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
- Reducing smoking and improving nutrition in pregnancy and early years
- Preventing teenage pregnancy and supporting teenage parents
- Improving housing conditions, especially for children in disadvantaged areas.

This approach also acknowledges the importance of policy, legislation and intervention beyond the health sector and clearly presents a shared vision for multi-level, intersectoral actions to tackle health inequalities. The government provides support for local implementation. For example, the Department of Health, in partnership with the Association of Public Health Observatories, has introduced a Health Inequalities Intervention Toolkit to inform evidence-based local service planning and commissioning so that the national targets to reduce health inequalities can be achieved.

Figure 1: Tackling Health Inequalities: A Program for Action



Case 2: Norway

The Norwegian Ministry of Health and Care Services published its *National Strategy to Reduce Social Inequalities in Health* in 2007. This report, along with two other reports, *Employment, Welfare and Inclusion* and *Early Intervention for Lifelong Learning*, formed part of the Government's comprehensive policy for reducing social inequalities, inclusion and combating poverty.

This strategy takes a comprehensive health equality in all policies approach, taking steps in policy, regulation, and programming across all sectors of government that impact the social determinants of health.

The four strategic goals are:

1. To reduce social inequalities that contribute to inequalities in health
2. To reduce social inequalities in health behaviour and use of the health services
3. To develop targeted initiatives to promote social inclusion
4. To develop knowledge and cross-sectoral tools.

This is one of the most comprehensive of the reviewed strategies, targeting a wide range of interventions. It has four priority areas each of which has several sub-areas for action.

The first priority area is to reduce social inequalities that contribute to inequalities in health. It has three sub-areas of focus that present detailed strategies:

- Reduced economic inequalities through efforts to ensure that taxation does more to promote a fairer income distribution across Norwegian society and a wide range of other measures to eliminate poverty.
- Safe childhood conditions and equal development opportunities for all children through full kindergarten coverage, school improvements to ensure all children acquire basic skills regardless of their background, improvements to existing maternal and child health centres, improved mental health supports, and improvements to the child welfare system.
- Inclusive working life and healthy working environments through enhanced legislation and regulations to protect workers from harmful physical and mental influences and ensure equality of treatment at work and healthy and inclusive work environments.

The second priority area is to reduce social inequalities in health behavior and use of health services. It has two sub-areas of focus that present detailed strategies:

- Reduced social inequalities in health behavior through pricing and taxation policy instruments to reduce social inequalities in diet, improved school meal systems, assessing measures to limit tobacco availability, promoting physical activity, and investing in lifestyle guidance in the health service;
- Equitable health and care services through decreasing user charges for services, ensuring all individuals have equal and easy access to medical products, and optimizing the governance and organization of the health service.

The strategy also highlights that improved research and evaluation will ensure the optimization of the health service governance and organization by surveying social inequalities in the use of health services, strengthening research on factors that contribute to social inequalities in the accessibility and quality of health services, and developing indicators of quality and priority in the specialist health services. In particular, new ways of measuring social inequalities are recommended.

The third priority area is targeted initiatives to promote social inclusion:

- Better living conditions for the most disadvantaged people through supplementing universal schemes with services and schemes tailored to the individual with special needs so that everyone has access to equitable services.

Broadly, the strategy calls for targeted initiatives to promote social inclusion. Inclusion in the labour market is identified as vital to social inclusion. Policy instruments proposed include a mix of universal and targeted approaches, e.g. welfare schemes alongside initiatives aimed at specific groups facing inequalities. Measures such as low-threshold measures for certain specialist health services, health services without user charges, and cross-sectoral partnerships between the state and other actors in deprived areas are proposed. Changes to housing policy and to prevent homelessness are proposed, particularly focusing on housing for those from disadvantaged populations.

The fourth priority area is to develop knowledge and cross-sectoral tools. It has four sub-areas of focus:

- Conducting annual policy reviews through a systematic overview of developments in the work on reducing social inequalities in health
- Developing and strengthening cross-sectoral tools through using national and local health impact assessments, bolstering the system of incentive funds for regional and local partnerships for public health, and establishing intersectoral collaboration
- Advancing about causes of and effective measures against social inequalities in health through establishing a system of monitoring trends, strengthening research, and evaluating implemented measures
- Assessing economic and administrative consequences of the measures in connection with the annual budgets

Case 3: California

California has developed a preliminary health equity plan that adopts an intersectoral approach. The Office of Health Equity (OHE), situated within the California Department of Public Health, aims to decrease health inequities within California's diverse population. The vision of the plan is to ensure everyone in California has equal opportunities for optimal health, mental health and well-being. It will be carried by focusing on equitable social, economic, and environmental conditions. While this plan was developed within the Department of Public Health, its focus goes far beyond the health system.

The plan represents the first stage of an intersectoral approach to achieve health equity: the goal of the plan is to develop from its current stage as a strategic conversation to a tactical one. This next stage will be developed via three five-year strategic priorities:

- Through assessment, yield knowledge of the problems and the possibilities.
- Through communication, foster shared understanding.
- Through infrastructure development, empower residents and their institutions to act effectively.

The first strategic priority is assessment, which will enable the OHE to generate data and analysis to best develop a health equity strategy. The plan states that a focus on collecting data for smaller marginalized communities to fill existing gaps in knowledge and help understand the challenges faced by a wide range of marginalized communities. The plan also emphasizes the importance of collecting both qualitative and quantitative data to ensure that a wide range of perspectives are captured and that the most powerful data are collected to describe the present state of inequities.

The second strategic priority, communication, aims to ensure that no efforts are taking place in isolation, and that cross-sectoral work develops efficiently.

The third priority, infrastructure, emphasizes the importance of developing a workforce in the state that has the capacity to effectively dismantle health inequities, via education, training, guidance, support, and accountability at various levels throughout multiple sectors.

The plan also identifies three strategic intervention targets:

- Health partners: targeting partners outside the traditional boundaries of public health and health care by focusing on determinants of health such as education, income, housing, and safe and clean environments.
- Health field: raising awareness across a wide range of health and social services; synchronizing efforts with the National Culturally and Linguistically Appropriate Service Standards to increase cultural and linguistic competence; improving health insurance coverage across the state.
- Empowering communities: building alliances across local public health departments, county mental

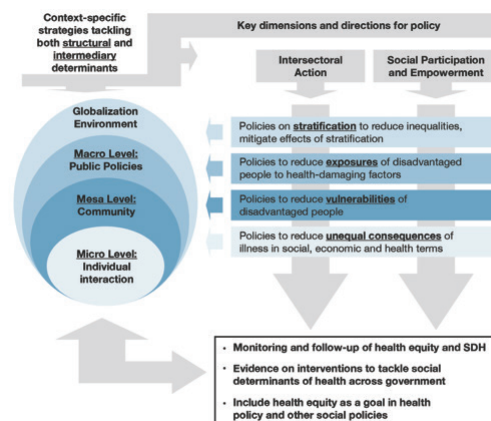
health departments, local social services, or other local agencies that address key health determinants – including housing, education, economic development, and others.

Box 1: WHO's Commission on the Social Determinants of Health: A Framework for Action on the Social Determinants of Health (2010)

The World Health Organization (WHO)'s Commission on the Social Determinants of Health has called for closing the health gaps, between those in the poorest social circumstances and better off groups, in a generation by taking collaborative action on the social determinants of health (SDoH) (Commission on Social Determinants of Health, 2008). After an extensive review of existing frameworks for understanding the SDoH, the WHO Secretariat proposed a conceptual framework on SDoH inequities (WHO, 2010). The Commission's framework on SDoH inequities shows how socio-economic, political mechanisms produce a set of socioeconomic positions, whereby populations are stratified according to their positions. This in turn shapes specific "structural determinants" of health status. The underlying SDoH inequities also operate through a set of "intermediary determinants of health", such as material circumstances, psychosocial circumstances, behavioral and/or biological factors, and the health system, to shape health outcomes. The WHO also conceptualizes the health system itself as an important SDoH. It recognizes the critical role of the health system in mediating the differential health outcomes through the issue of access, which incorporates differences in exposure and vulnerability, and through intersectoral action led from within the health sector. In this framework, the concepts of social cohesion and social capital cut across the structural and intermediary dimensions.

Building on the conceptual framework on the SDoH, the Commission also developed a Framework for Action (Figure 2) that proposes three broad policy directions to tackle SDoH. This framework places particular emphasis on tackling health inequities. The first aim is to promote context-specific strategies to tackle structural as well as intermediary determinants. The second aim emphasizes that intersectoral approaches are required to achieve such health equity strategies, because determinants can only be addressed by policies that reach beyond the health sector. A wide range of sectors has the potential to influence the determinants of health, such as housing, environment, food and nutrition, education, gender and women's rights, labour market and employment policy, and welfare and social protection. The third aim is to ensure that policies are crafted so as to engage and empower civil society and affected communities.

Figure 2: A Framework for Action on the Social Determinants of Health



B: Health System Approaches

This review identified eight national or provincial/state-wide strategies within health systems aimed at promoting health equity or equality. These strategies were developed mostly in North America, New Zealand and Australia between 2010 and 2013. One Canadian province-wide health authority, Alberta Health Services (AHS), published an equity-focused framework and action plan. In the U.S., a number of national and state-level governments such as the U.S. Department of Health and Human Services (HHS) and the Maryland Department of Health and Mental Hygiene, have developed strategies, at different levels, to enhance health equity within their health systems. There are two national-level health equity strategies in Australia targeting specific populations. In 2000, New Zealand's Ministry of Health published the *New Zealand Health Strategy*, with reducing inequalities in health status as one of the main priority areas. In Europe, the NHS Health Scotland's corporate strategy 2012-2017 provides a case of the health-system approach to tackle health inequalities.

B.1. Key Components of Health System Approaches

Equity/Equality as Core Focus

The majority of health system approach documents present strategies described specifically as addressing health equity, although specific terminologies used in describing their main objectives vary. Alberta Health Services uses the terms *promoting health equity* and *reducing health inequities*. The US National Stakeholder Strategy uses the language of *achieving health equity*. The US HHS Action Plan, US National Stakeholder Strategy, and Maryland Plan, all equity-focused strategies, have adopted the language of *health disparities*. While US HHS uses the language of *reducing* health disparities and Maryland and the US National Stakeholder Strategy use *eliminating* health disparities language.

Two strategies are described as tackling *health inequalities*: *A Fairer Healthier Scotland* and *New Zealand Health Strategy*.

Although Australia's *National Primary Health Care Strategic Framework* and New Zealand's *Health Strategy* are not equity or equality specific, both documents identify equity or equality as one of their strategic goals. The *National Primary Health Care Strategic Framework* listed *improve access and reduce inequity* as one of its four strategic outcomes and one of New Zealand's *Health Strategy* priority areas is to *reduce inequalities in health status*.

There are regional trends evident: while across Europe the language of *health inequalities* is primarily used (e.g., NHS Health Scotland), in North America, *equity/inequity* language is used more widely.

Table B: Summary Table for Health Equity/Equality Strategies – Health System Approach

Jurisdiction	Name of strategy	Published by (year)	Focus	Listed target groups	Quantified target	Data Monitoring and evaluation	Tools and mechanisms for implementation
New Zealand	New Zealand Health Strategy	Ministry of Health (2000)	Equality as one of ten goals	Yes	No	-Annual reporting on the progress: Implementing the New Zealand Health Strategy	-Toolkits for District Health Boards -Public Health and Disability Act
US National	HHS Action Plan to Reduce Racial and Ethnic Health Disparities	Department of Health and Human Services (2011)	Equality as core focus	Yes	No	-Healthy People 2020 initiative -Regular monitoring and publicly reporting on disparity measures	-The Affordable Care Act -New Access Point grant awards for underserved areas -CLAS Standards Enhancement -Health disparity impact assessment (pilot)
US National	National Stakeholder Strategy for Achieving Health Equity	Department of Health and Human Services (2011)	Equality as core focus	Yes	No	-Health Equity Report Cards by ten Regional Health Equity Councils	-NPA Toolkit -Regional Blueprints -Health Equity Partnerships
Maryland (US)	Maryland Plan to Eliminate Minority Health Disparities: Plan of Action	Maryland Department of Health and Mental Hygiene (2010)	Equality as core focus	Yes	No	-Maryland Chartbook of Minority Health and Minority Health Disparities Data	-House Bills, Health Care Services Disparities Prevention Act -Health Disparities Reduction Demonstration Pilot Projects -Health Impact Assessment
Scotland (NHS)	A Fairer Healthier Scotland (AFHS): Our Strategy 2012-2017	NHS Health Scotland (2012)	Equality as core focus	No	No	-NHS Health Scotland's Equality Outcomes for 2013-2017; products and services; workforce; and systems and premises	-Equality Act 2010 -Health Inequalities Impact Assessment -AFHS Inequalities Audit -Inequalities Statement
Australia	National Primary Health Care Strategic Framework	Standing Council on Health (2013)	Equality as one of four goals	Yes	No	-Healthy Communities Reports	-National Health Reform Agreement; National Healthcare Agreement -State-specific bilateral plans
Australia	Department of Health Agency Multicultural Plan 2013-2015	Department of Health (2013)	Equality as core focus	Yes	No	-Performance indicators: service accessibility and employment diversity and equity -Department's annual reporting -Whole-of-government biennial reporting	-Grant guidelines and contracts (e.g. Rural Health Outreach Fund) clauses requiring service providers to address the needs of CALD communities
Alberta	Promoting Health Equity Framework	Alberta Health Services (2013)	Equality as core focus	No	No	Work in progress	Work in progress

Target population groups

Six strategies developed targeted approaches, with specific interventions aimed at improving the health of targeted population groups who are at risk of experiencing poorer health compared to overall population.

Across jurisdictions, ethno-cultural populations are the most commonly identified target group. Australia's *Department of Health Agency Multicultural Plan 2013-2015*, for instance, specifically aims to improve access to services for people from culturally and linguistically diverse (CALD) backgrounds. In the U.S., reducing racial and ethnic health disparities is the central focus of many health equity strategies at both national and state levels, including the Department of Health and Human Services *Disparities Action Plan* and Maryland's *Maryland Plan*.

Other strategies also acknowledge the importance of additional efforts to meet the specific needs of vulnerable or underserved populations. For example, Australia's *National Primary Health Care Strategic Framework* targets specific population groups such as parents of young children, young people, older people, those in remote areas, Aboriginal people, low socio-economic status people, refugees, and people from CALD backgrounds. New Zealand's *Health Strategy* identifies the needs of people from lower socioeconomic groups, Māori and Pacific peoples.

Alberta Health Services' *Promoting Health Equity Framework* is based on the principle of both universal and targeted approaches. It emphasizes that a balance of universal and targeted approaches is necessary to advance the health of the entire population, and also to improve health outcomes for vulnerable groups.

Quantified Targets

The reviewed strategies presented no quantified targets.

Data Monitoring and Evaluation

Most health system strategies reviewed have developed specific plans for data monitoring. In the U.S., the *Affordable Care Act* has provided a strong foundation not only for health insurance coverage and access to care but also for data collection and reporting. The national health department developed the *Healthy People 2020* initiative to assess health disparities in the U.S. populations by tracking rates of death, chronic and acute diseases, injuries, and health behaviours for sub-populations. To track the progress of the implementation of the *National Stakeholder Strategy*, the U.S. Department of Health and Human Services also established a regional reporting system on health disparities, led by ten Regional Health Equity Councils. To monitor the progress of the *Action Plan to Reduce Racial and Ethnic Health Disparities*, the Department of Health and Human Services developed 14 Key Disparity Measures (Box 3).

In Scotland, progress reporting has been legally mandated by the *Equality Act 2010* and (Scotland) Regulations 2012. NHS Health Scotland produces Equality Outcome Reports on three areas: products and services; workforce; and systems and premises. Equality outcomes have been used as an important measure of how NHS Scotland delivers on public sector equality duty and its *A Fairer and Healthier Scotland* strategy.

Since the publication of its first *Plan to Eliminate Minority Health Disparities* in 2006, Maryland has published the *Maryland Chartbook of Minority Health and Minority Health Disparities Data*. Also published are Annual Highlight Reports that showed changing health disparities trends in minority infant mortality and cardiovascular disease in the state as a whole and in selected jurisdictions, to identify where health disparities resources should be targeted. In partnership with the Maryland Health Care Commission,

racial and ethnic data have been incorporated into their annual healthcare quality reports.

Box 3: Plan to Reduce Racial and Ethnic Health Disparities (U.S Department of Health and Human Services 2011)

Key Disparity Measures

All indicators are to be displayed by race, ethnicity and income.

1. Transform Health Care
 - Percentage of the U.S. nonelderly population (0-64) with health coverage
 - Percentage of people who have a specific source of ongoing medical care
 - Percentage of people who did not receive or delayed getting medical care due to cost in the past 12 months
 - Percentage of people who report difficulty seeing a specialist
 - Percentage of people who reported that they experienced good communication with their health care provider
 - Rate of hospitalization for ambulatory care-sensitive conditions
 - Percentage of adults who receive colorectal cancer screening as appropriate
2. Strengthen the Nation's Health and Human Services Infrastructure and Workforce
 - Percentage of clinicians receiving National Health Service Corps scholarships and loan repayment services
 - Percentage of degrees awarded in the health professionals, allied and associated health professionals fields
 - Percentage of practicing physicians, nurses and dentists
3. Advance the Health, Safety, and Well-Being of the American People
 - Percentage of infants born at low birthweight
 - Percentage of people receiving seasonal influenza vaccination in the last 12 months
 - Percentage of adults and adolescents who smoke cigarettes
 - Percentage of adults and children with healthy weight

Implementation Tools and Mechanisms

A wide range of levers have been developed and used to support the implementation of proposed strategies and actions in the reviewed jurisdictions.

The *New Zealand Health Strategy*, together with the *New Zealand Disability Strategy*, was developed to support the *Public Health and Disability Act 2000*, which restructured the health system by creating twenty-one District Health Boards. The *Act* requires District Health Boards to consult their resident populations on the significant aspects of district strategic plans before determining or amending those plans. The *Health Strategy* highlights thirteen population health objectives for the Ministry of Health and District Health Boards that are held accountable for delivering the strategy through their annual funding agreements with the Minister of Health. To support the work of each District Health Board, toolkits were developed for each of the thirteen objectives to set out evidence-based actions, best practice, and performance indicators to measure.

In the U.S., Maryland has passed a series of legislative acts to support the action plans since the publication

of its first statewide plan to reduce minority health disparities. For example, House Bill 524 established a workgroup on cultural competency and workforce development for mental health professionals. House Bill 788 allowed health insurers to collect race and ethnicity data in order to evaluate quality of care outcomes and performance measures. The *Health Care Services Disparities Prevention Act* established the Maryland Office of Minority Health and Health Disparities.

At the U.S. national level, as mandated by the *Affordable Care Act*, the Department of Health and Human Services (HHS) established offices of minority health in six agencies. The HHS has also committed to make enhancements to the National Standards for Culturally and Linguistically Appropriate Services in Health Care, the first national standards for culturally competent health care service delivery that was released in 2000. To support the work of the *National Stakeholder Strategy*, the HHS has made the NPA (National Partnership for Action) Toolkit for Community Action accessible online to help individuals, communities and organizations to make immediate actions to address health disparities.

NHS Health Scotland has introduced the A Fairer Heathier Scotland (AFHS) Inequalities Audit, which audits the business plan and budget against the aims of AFHS. As well, all work programs have been required to complete an Inequalities Statement describing how they will tackle health inequalities and how they will make sure they do not perpetuate or exacerbate inequalities linked to “protected characteristics” as part of business planning. The protected characteristics include age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race and ethnicity, religion and belief, and sexual orientation.

In Australia, bilateral plans are the “primary vehicle” for implementing the *National Primary Health Care Strategic Framework*. The Commonwealth has made partnership agreements with each state and territory to develop state-specific bilateral plans that specify the actions to address the issues most relevant to each individual state. The *National Health Reform Agreement 2011* identifies the need for the partnership to develop the *National Primary Health Care Strategic Framework* in order to guide policy directions across priority areas in primary health care.

B.2. Strategic Goals and Actions

The reviewed national and provincial/state-level health system strategies focus their efforts on a number of different avenues to address health equity or equality. Although each strategy differs in its organization of goals and actions (see Appendix 1), seven common themes and action items are evident in all or most of the strategies.

1. Leadership:
 - Gaining senior leadership support
 - Strengthening and broadening leadership for addressing health equity or equality at all levels
2. Collaboration, engagement, multi-sectoral actions:
 - Developing partnerships with various stakeholders
 - Joint commitments and actions taken by health systems, various government sectors, communities, representatives from private, voluntary, and non-profit groups
3. Equitable access and utilization:
 - Developing standards and guidelines for policies and services that are responsive to the needs of all populations
 - Advancing the accessibility of mainstream health care services for target populations

- Delivering programs and services in community languages
- 4. Equitable quality of care:
 - Ensuring that services meet the needs of underserved populations
 - Providing effective patient/provider interactions
- 5. Capacity building:
 - Improving workforce capacity through enhanced awareness of health disparities and specific needs of diverse populations, skills training and knowledge exchange
- 6. Cultural and linguistic competency:
 - Supporting staff with cultural competency training
 - Increasing diversity and competency of health workforces
- 7. Data, research and evaluation for evidence-informed planning and decision-making:
 - Increasing availability and quality of data collected and reported on health inequities or inequalities
 - Regularly monitoring performance

B.3. Case Studies: Health System Approaches

Case 4: US National Stakeholder Strategy for Achieving Health Equity

The U.S. Department of Health and Human Services (HHS), Office of Minority Health published its *National Stakeholder Strategy for Achieving Health Equity* in April 2011. The *Strategy* is the initial and primary product of the National Partnership for Action (NPA) to End Health Disparities, which was established to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity. It provides an overarching roadmap for eliminating health disparities through cooperative and strategic actions. This roadmap complements the HHS *Action Plan to Reduce Racial and Ethnic Health Disparities*, which was the first-ever departmental health disparities strategic action plan. Together with the HHS *Strategic Action Plan*, the *National Stakeholder Strategy* creates a framework for federal leadership for addressing health equity.

The vision of the *National Stakeholder Strategy* is to promote systematic and systemic change that improves the overall health of the nation and its most vulnerable populations. The *Strategy* sets out five key strategic goals and 20 strategies for action to end health disparities (see Figure 3), based on the process of community and stakeholder collaboration.

Four cross-cutting, fundamental principles are central to the goals of the National Stakeholder Strategy.

1. Change at the individual or community level is not sustainable without community engagement and leadership;
2. Partnership development is critical in any action plan to eliminate disparities. Partnerships allow the pooling of resources, mobilization of talents, and use of diverse approaches. They can also limit duplication of efforts and fragmentation of services;
3. Healthcare provider and healthcare educator cultural and linguistic competency has a powerful impact on the success or failure of any efforts to help individuals achieve optimum health;
4. The requirement of non-discrimination in healthcare access and delivery is not only mandated by federal civil rights laws but also is a moral imperative and a practical necessity for achieving health equity. It must be present in actions, services, leadership, and partnerships.

The ‘National Stakeholder Strategy for Achieving Health Equity’: Consultation Process

The U.S. Office of Minority Health sponsored the development process of the *National Stakeholder Strategy for Achieving Health Equity*. The process included a series of activities that engaged a wide range of government sectors, communities, and stakeholders across the country. A variety of meetings and events were held throughout the process, including:

- A National Summit of nearly 2,000 leaders who were challenged to consider how best to collectively take action to effectively and efficiently address health equity. The Office of Minority Health produced a draft version of the goals and principles of the National Partnership for Action based on the shared concerns of the Summit participants.
- Regional Conversations with stakeholders in the ten HHS health regions in order to define, refine, and collaborate on a plan through cooperative and strategic actions.
- Focused stakeholder meetings to review and finalize National Partnership for Action and National Stakeholder Strategy goals, principles, and strategies.
- Public review and incorporation of public input into the National Stakeholder Strategy - the draft version of the National Stakeholder Strategy was posted online and approximately 2,200 comments were submitted.
- Analysis, discussion and planning throughout all of the divisions within HHS.

Figure 3: Summary of National Stakeholder Strategy for Achieving Health Equity

Exhibit 3 2: SUMMARY OF NPA GOALS AND STRATEGIES		
Goal #	Goal Description	Strategies
1	AWARENESS— Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. Healthcare Agenda Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas
		2. Partnerships Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan
		3. Media Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically-isolated individuals—to encourage action and accountability
		4. Communication Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	LEADERSHIP— Strengthen and broaden leadership for addressing health disparities at all levels	5. Capacity Building Build capacity at all levels of decision-making to promote community solutions for ending health disparities
		6. Funding Priorities Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services
		7. Youth Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives
3	HEALTH SYSTEM AND LIFE EXPERIENCE— Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. Access to Care Ensure access to quality health care for all
		9. Children Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care
		10. Older Adults Enable the provision of needed services and programs to foster healthy aging
		11. Health Communication Enhance and improve health service experience through improved health literacy, communications, and interactions
		12. Education Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits
		13. Social and Economic Conditions Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes
4	CULTURAL AND LINGUISTIC COMPETENCY— Improve cultural and linguistic competency and the diversity of the health-related workforce	14. Workforce Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities
		15. Diversity Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems
		16. Ethics and Standards, and Financing for Interpreting and Translation Services Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services
5	DATA, RESEARCH, AND EVALUATION— Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. Data Ensure the availability of health data on all racial, ethnic, and underserved populations
		18. Community-Based Research and Action, and Community-Originated Intervention Strategies Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities
		19. Coordination of Research Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities
		20. Knowledge Transfer Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

Case 5: Alberta Health Services – Promoting Health Equity Strategy

Alberta Health Services (AHS) provides province-wide comprehensive health services as a single health authority for the province of Alberta. Upon its creation in 2008, the AHS Promoting Health Equity team was tasked with developing a strategy to advance health equity and health equity became one of the organization's strategic priorities in April 2012. *Promoting Health Equity: Proposed Framework* was published in January 2013 to provide the conceptual foundation for the development of the Promoting Health Equity Strategy, which outlines a long-term plan of action for AHS. The *Health Equity Action Plan* that stemmed from the framework further articulated concrete deliverables that were expected to be achieved within a three-year time frame. The AHS's health equity work, however, has not evolved past this point.

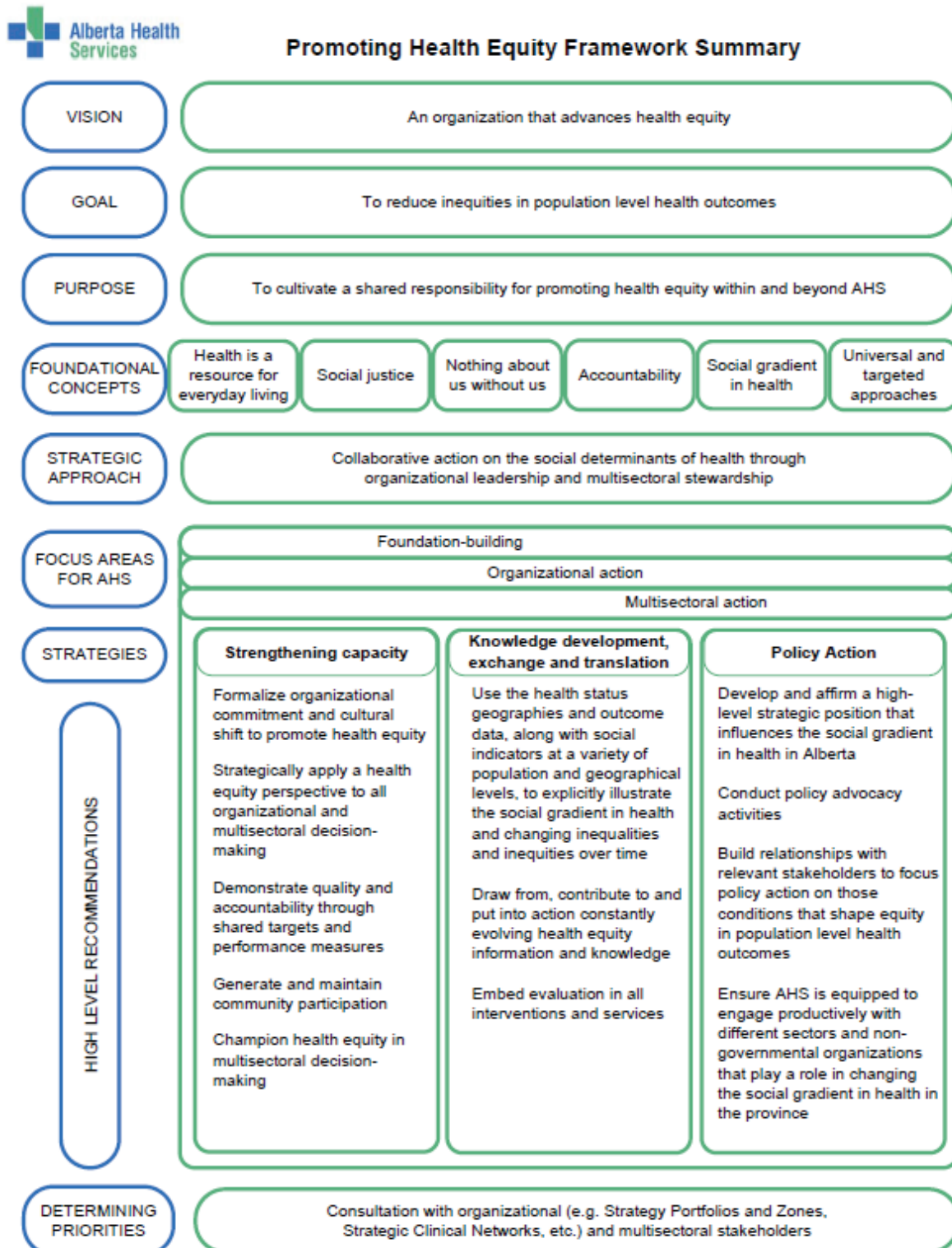
The vision of the *Promoting Health Equity* framework is for AHS to become an organization that advances health equity. It specifically aims to reduce inequities in population-level health outcomes. The purpose is to cultivate a shared responsibility for promoting health equity within and beyond AHS. The framework is based on six foundational concepts including health as a resource for everyday living; social justice; community engagement; accountability; social gradient in health; and universal and targeted approaches. The framework proposes to advance health equity by using three broad, overlapping strategies:

1. Strengthening capacity
 - Building and strengthening assets within AHS and among individuals, organizations and communities throughout Alberta
2. Knowledge development, exchange and translation
 - Processes that result in the creation, sharing, interpretation and uptake of new knowledge and inform decision-making at every level
3. Policy action
 - Advocacy with external partners aimed at public policy change, as well as internal policy change processes to improve equity in the healthcare functions of AHS

For each strategy, the Framework also presents high-level recommendations (see Figure 4).

The three broad strategies cut across the key areas of focus for AHS: foundation building, organizational action, and multi-sectoral action. First, foundation-building refers to the capacity and structures required within AHS to support and fulfill its organizational and multi-sectoral actions to achieve health equity, including human resources, structures, tools, strategic planning documents, policies, accountability mechanisms, and resource allocation. Second, organizational action refers to embedding health equity into all AHS strategic commitments and action taken by all levels of AHS. Third, multi-sectoral action refers to the joint commitments and action taken by AHS, communities, employers, other government sectors, and representatives from private, voluntary and non-profit groups to improve health equity.

Figure 4: Alberta Health Services – Promoting Health Equity Framework



Case 6: Australia – Department of Health Agency Multicultural Plan 2013-2015

Australia's Department of Health's equity approaches target the various health needs of people from culturally and linguistically diverse (CALD) backgrounds. The Department has established initiatives to address communities' specific needs and has incorporated cultural diversity principles into the design and implementation of many programs and services. In 2013, the Department published its *Agency Multicultural Plan (AMP) 2013-2015*, which guides the activities of the Department of Health and other agencies including the Australian Sports Anti-Doping Authority; the National Health and Medical Research Council; the National Health Performance Authority; and the Private Health Insurance Ombudsman.

The vision of the Department of Health is to deliver high-quality health care programs, policies and services that are accessible and responsive to the needs of all Australians, including those from CALD backgrounds. There are five key strategic goals for 2013-2015:

1. Effective leadership in delivering quality health care programs, policies and services;
2. Effective engagement with stakeholders to ensure that the policies and programs developed and delivered are successful;
3. Develop mechanisms to measure and assess performance to continue delivering high quality health care programs, policies and services;
4. Provide staff with skills and training necessary to support the government in its reform of the health system;
5. Develop policies and programs that are responsive to the diverse needs of Australians.

The AMP presents six areas of focus, minimum obligations and action items for each focus area. Each action item is also accompanied with specific targets and timelines.

Action items relating to leadership emphasize ensuring the executive team is engaged and leading work related to the AMP, and that multicultural access and equity considerations are made within the context of strategic planning. Unlike frameworks in other jurisdictions, this does not focus on developing a new generation of leaders from CALD communities. Instead, community engagement action items seek to ensure that representatives of CALD communities have opportunities to engage in the development of policy, services, and social marketing campaigns. The focus is specifically on providing appropriate services to CALD communities and ensuring communities are aware of the programs available.

To improve capability, the plan focuses on training to ensure staff and organizations providing services have the skills and knowledge to engage with people from CALD backgrounds, and on conducting research to inform appropriate policy and program development. Performance actions include developing indicators to assess performance, and consultations with CALD staff and communities on the appropriateness and accessibility of management processes and health services.

To ensure the needs of all Australians are taken into account from an equity standpoint, the plan calls for the development of standards and guidelines for health policies to meet this goal. The stated goal is to continue to advance the accessibility of health services for people from CALD backgrounds. This includes ensuring programs and services are available in community languages.

The final strategic goal, openness, will be met by providing government and the public with information on how equity and access goals are met, and making culturally and linguistically diverse data available to other agencies and the public. Further, this goal will be met by continuing to demonstrate the commitment of the Department and Portfolio agencies to the Access and Equity Policy.

Conclusions

Our review of sixteen strategies developed in Canada and internationally provides several comprehensive examples of intersectoral approaches targeting health inequality and health inequity. In many cases, these approaches begin in the health sector, but to succeed they require intersectoral partnership. Norway provides an example of a comprehensive approach that emphasizes the importance of work across government to address social inequalities. This approach applies a framework that governs various Ministries' budgetary, management, legislation, and regulation guidelines. It also establishes guidelines for interministerial collaboration, organizational measures, and other available policy instruments. It remains to be seen, however, whether these strategies will in the long-term impact health inequity or inequality.

This review exclusively examined national and state/provincial-level strategies for promoting health equity and health equality. Due to the exclusion criteria, several more focused approaches have been missed, both in terms of approaches, and in terms of region. From a regional standpoint, there has been significant progress in health equity strategies in municipal health regions across Canada. The cities of Saskatoon and Winnipeg, for example, have both developed detailed equity strategies, which were excluded from this review. From a content standpoint, more targeted strategies like the UK's Delivering Race Equality in Mental Health Care (Wilson, 2009) has been excluded from this review.

It is worth highlighting the delicate balance between implementing universal measures that are essential to improve population health, and targeted approaches aimed at improving health outcomes for marginalized populations. Targeted approaches are necessary in order to include those who are otherwise excluded from education, employment, or other areas because of existing societal barriers. Further, these approaches must be carefully designed to avoid further stigmatization of already marginalized populations.

The regional differences in target populations are notable, and will have an effect on the impact of a given framework. In the United States, the Office of Minority Health does comprehensive work to ensure visible minorities achieve equity. A similar focus is evident in Australia and New Zealand, where a history of oppression of Indigenous peoples renders equity or equality strategies to improve health outcomes in those populations essential. Similarly, Scandinavian countries such as Norway and Finland name social and economic inequalities, but deliberately do not name particular groups. Failing to name marginalized populations in these documents may result in a lack of programs and policies targeting groups in need. California and England provide strong examples, including lists of marginalized population groups are explicitly provided, which brings attention to groups such as LGBTQQ populations or those with mental or physical disabilities that are not explicitly named in other frameworks. California also recognizes the importance of intersectionality within its plan – that intersecting identities, such as ethnic and sexual identities, create their own specific vulnerable populations that need targeted attention. In addition to including a wider range of vulnerable populations within health equity strategies, the reviewed strategies would improve their impact by acknowledging the impact of intersecting identities.

This review analyzed several health system approaches to health equity, such as the US National Stakeholder Strategy for Achieving Health Equity and Alberta Health Services' Promoting Health Equity Framework. These approaches are well-developed and attempt to encompass all components of the health system. These approaches demonstrate that while targeting policies outside the health system is essential to improving health inequities, significant progress can be made from within health care systems. For

example, action in several jurisdictions to develop a new generation of leaders representing a wide variety of disadvantaged groups in the health and policy fields is an excellent way to drive long-term change. Similarly, the development of indicators and data collection processes in the health system can help track progress in health inequities, and also help uncover the areas that need further attention. It was beyond the scope of this review to include an evaluative analysis of the progress to date of the reviewed strategies. However, the strong focus on data, research and evaluation evident in most of the strategies will enable better targeting of programs, and monitoring and evaluation of the effectiveness.

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Appendix 1: Directory of Health Equity/Equality Strategies

Canada:

1. Alberta [Promoting Health Equity Framework](#)

Europe:

2. England [Tackling Health Inequalities: A Programme for Action](#)
3. Norway [National Strategy to Reduce Social Inequalities in Health](#)
4. Finland [National Action Plan to Reduce Health Inequalities 2008-2011](#)
5. Scotland [Equally Well: Report of the Ministerial Task Force on Health Inequalities](#)
6. Scotland - NHS Health Scotland [Fairer Healthier Scotland: Our Strategy 2012-2017](#)
7. Wales [Fairer Health Outcomes for All: Reducing Inequities in Health Strategic Action Plan](#)
8. Ireland [Healthy Ireland: a Framework for Improved Health and Wellbeing 2013-2015](#)

United States:

9. [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)
10. [National Stakeholder Strategy for Achieving Health Equity](#)
11. [Maryland Plan to Eliminate Minority Health Disparities: Plan of Action 2010-2014](#)
12. [California Statewide Plan to Promote Health and Mental Health Equity](#)

Australia:

13. [Department of Health Agency Multicultural Plan 2013-2015](#)
14. [National Primary Health Care Strategic Framework](#)
15. [National Aboriginal and Torres Strait Islander Health Plan 2013-2023](#)

New Zealand:

16. [New Zealand Health Strategy](#)

1. Alberta - Promoting Health Equity Framework (Alberta Health Services, 2013)

Vision: An organization that advances health equity.

Objectives: To reduce inequities in population-level health outcomes; to cultivate a shared responsibility for promoting health equity within and beyond AHS.

Principles: Health is a resource for everyday living; Social justice; Nothing about us without us; Accountability; Social gradient in health; Universal and targeted approaches.

Priority Areas:

1. **Foundation building:** referring to the capacity/structures required within AHS to support and fulfill its organizational and multi-sectoral actions to achieve health equity, including human resources, structures, tools, strategic planning documents, policies, accountability mechanisms, and resource allocation.
2. **Organizational action:** referring to embedding health equity into all AHS strategic commitments and action taken by all levels of AHS. This will improve health equity decision-making, program and service planning, and policy development.
3. **Multi-sectoral action:** referring to the joint commitments and action taken by AHS, communities, employers, other government sectors, as well as representatives from private, voluntary and non-profit groups, to improve health equity.

Summary of Strategies and Actions:

- Strengthening capacity
 - Formalize organizational commitment and cultural shift to promote health equity
 - Strategically apply a health equity perspective to all organizational and multi-sectoral decision-making
 - Demonstrate quality and accountability through shared targets and performance measures
 - Generate and maintain community participation
 - Champion health equity in multi-sectoral decision-making
- Knowledge development, exchange and translation
 - Use health status geographies and outcome data, along with social indicators at a variety of population and geographical levels, to explicitly illustrate the social gradient in health and changing inequalities and inequities over time
 - Draw from, contribute to and put into action constantly evolving health equity information and knowledge
 - Embed evaluation in all interventions and services
- Policy action
 - Develop and affirm a high-level strategic position that influences the social gradient in health in Alberta
 - Conduct policy advocacy activities
 - Build relationships with relevant stakeholders to focus policy action on those conditions that shape equity in population level health outcomes
 - Ensure AHS is equipped to engage productively with different sectors and non-governmental organizations that play a role in changing the social gradient in health in the province

2. England - Tackling Health Inequalities: A Programme for Action (Department of Health, 2003)

Vision: The Government is determined to tackle inequalities to create a fairer and more just society that will allow all individuals and communities to fulfil their potential and benefit more equitably from public services investment.

Objectives: To reduce health inequalities by tackling the wider determinants of health inequalities. This

approach is supported by a national health inequalities Public Service Agreement target:

- By 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

This is underpinned by two more detailed targets:

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

Principles:

- Preventing health inequalities worsening;
- Working through the mainstream;
- Targeting specific interventions;
- Supporting action from the centre and through the regions;
- Delivering at local level

Priority Areas:

- Supporting families, mothers and children
- Engaging communities and individuals
- Preventing illness and providing effective treatment and care
- Addressing the underlying determinants of health

Summary of Strategies and Actions:

For life expectancy:

- reducing smoking in manual social groups through smoking cessation services and other tobacco control programmes
- preventing and managing other risk factors such as poor diet and obesity, physical inactivity and high blood pressure
- improving environmental health, including housing conditions and reducing the risk of accidents
- targeting the over-50s – among whom the greatest short-term impact on life expectancy will be made

For infant mortality:

- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
- reducing smoking and improving nutrition in pregnancy and early years, including increasing the number of mothers who breastfeed
- preventing teenage pregnancy and supporting teenage parents
- improving housing conditions, especially for children in disadvantaged areas

3. Norway - National Strategy to Reduce Social Inequalities in Health (Ministry of Health and Care Services, 2007)

Vision: A fair distribution of resources is good public health policy. The primary goal of future public

health work is not to further improve the health of the people that already enjoy good health. The challenge now is to bring the rest of the population up to the same level as the people who have the best health.

Objective: To reduce social inequalities in health by levelling up

Priority Areas:

- Social inequalities that contribute to inequalities in health
- Social inequalities in health behaviour and use of the health services
- Targeted initiatives to promote social inclusion
- Develop knowledge and cross-sectoral tools

Summary of Strategies and Actions:

- Reduced economic inequalities through efforts to ensure that taxation does more to promote a fairer income distribution across Norwegian society and a wide range of other measures to eliminate poverty.
- Safe childhood conditions and equal development opportunities for all children through full kindergarten coverage, school improvements to ensure all children acquire basic skills regardless of their background, improvements to existing maternal and child health centres, improved mental health supports, and improvements to the child welfare system.
- Inclusive working life and healthy working environments through enhanced legislation and regulations to protect workers from harmful physical and mental influences and ensure equality of treatment at work and healthy and inclusive work environment.
- Reduced social inequalities in health behavior through pricing and taxation policy instruments to reduce social inequalities in diet, improving school meal systems, assessing measures to limit tobacco availability, promoting physical activity, and investing in lifestyle guidance in the health service.
- Equitable health and care services through decreasing user charges for services, ensuring all individuals have equal and easy access to medical products, and optimizing the governance and organization of the health service.
- Better living conditions for the most disadvantaged people through services and schemes tailored to the individual with special needs so that everyone has access to equitable services.
- Conducting annual policy reviews through a systematic overview of developments in the work on reducing social inequalities in health.
- Developing and strengthening cross-sectoral tools through using national and local health impact assessments, bolstering the system of incentive funds for regional and local partnerships for public health, and establishing intersectoral collaboration.
- Advancing understanding about causes of and effective measures against social inequalities in health through establishing a system of monitoring trends, strengthening research, and evaluating implemented measures.
- Assessing economic and administrative consequences of the measures in connection with the annual budgets.

4. Finland - National Action Plan to Reduce Health Inequalities 2008-2011 (Ministry of Social Affairs and Health, 2008)

Objectives: To reduce inequalities between different socio-economic population groups in terms of their work ability and functional capacities, self-rated health, morbidity and mortality by levelling up.

The National Action Plan supports implementation of the national 'Health 2015' programme, aiming to extend people's healthy and functional life and reduce health inequalities between population groups. The Health 2015 programme is the first programme to set a quantitative target:

- To cut mortality inequalities between difference vocational and educational groupings by one fifth by the year 2015.

Principles: To achieve both a good health standard and an even distribution of good health among the various population groups, universal services must be supplemented with measures aimed specifically at the most disadvantaged people.

Priority Areas:

1. Social policy measures
2. Strengthening the prerequisites for healthy lifestyles
3. Improving the availability and good quality of social and health care services for everyone

Summary of Strategies and Actions:

- General social policy actions to reduce health inequalities and prevent social exclusion
 - Reducing poverty
 - Improving ways in which comprehensive schools can prevent and reduce health inequalities
 - Promoting the health and well-being of youth at vocational schools
 - Ensuring that youth receive sufficient support at key transition points between schooling and working life
 - Providing work for the long-term unemployed and those living on disability pensions or rehabilitation assistance
 - Making health promotion a permanent feature at the workplace
 - Reducing homelessness
- Influencing lifestyles through policy
 - Reducing excessive drinking
 - Reducing smoking
 - Promoting a healthy diet and exercise
- Developing social welfare and health care services
 - Developing social work and basic health care and cooperation between the two
 - Improving opportunities of day care services and child welfare clinics to prevent health inequalities as a part of networked services
 - Developing timely and need-based rehabilitation for people of working age
 - Safeguarding health services that support the working ability of the long-term unemployed and other people of working age that are outside of the occupational health service network
 - Developing and strengthening mental health services
 - Ensuring equal services for older people
 - Developing and strengthening immigrant services

5. Scotland - Equally Well: Report of the Ministerial Task Force on Health 5. Inequalities (the Scottish Government, 2008)

The Scottish Government takes an integrated approach across three social policy frameworks and published jointly with COSLA (the Convention of Scottish Local Authorities) *Equally Well* (on health inequalities), the *Early Years Framework* (on children's start in life) and *Achieving Our Potential* (on tackling poverty). Each framework supports the others and sets out the specific action needed to meet shared long-term health and other outcomes.

Principles:

- Improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health.
- Addressing the inter-generational factors that risk perpetuating Scotland's health inequalities from parent to child, particularly by supporting the best possible start in life for all children in Scotland.
- Engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health.
- Delivering health and other public services that are universal, but also targeted and tailored to meet the needs of those most at risk of poor health. We need to prevent problems arising in the future, as well as addressing them if they do

Priority Areas:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental well-being.
- The "big killer" diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

Summary of Strategies and Actions: The Scottish Government's National Performance Framework sets five strategic objectives in order to achieve a common public service focus on building Scotland's economic prosperity. The *Equally Well* report made 78 recommendations for actions, including 62 specific recommendations targeting these five objectives (see Annex 4 in the Scottish Government, 2008).

- Smarter Scotland: Early years and young people
- Wealthier and Fairer Scotland: Tackling poverty and increasing employment
- Greener Scotland: Physical environments and transport
- Safer and Stronger Scotland: Harms to health and well-being: alcohol, drug and violence
- Healthier Scotland: Health and wellbeing

7. Scotland – Fairer Healthier Scotland: Out Strategy 2012-2017 (NHS Scotland, 2012)

Vision: A Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives.

Objectives: To reduce health inequalities and improve health. To do this NHS Health Scotland will influence policy and practice, informed by evidence, and promote action across public services to deliver

greater equality and improved health for all in Scotland.

Principles:

- Person-centred – understanding and working with Scotland’s diverse population through research and direct engagement, and seeking to maximise mutual respect and fairness and to eliminate discrimination in all we do.
- Safe – providing accurate information that is accessible and understandable to all it might benefit, and minimising unintended negative consequences for people or the environment.
- Effective – advocating and contributing to policies and actions for improving health and reducing health inequalities that are evidence-informed, carefully designed and evaluated, and sustainable in use of resources and impact on the environment.

Summary of Strategies and Actions:

1. Better collaboration
 - Bring together agencies and networks, promote dialogue and collaboration and enlist expert evidence to ensure that equality is at the heart of policy making and service delivery
 - Promote collaboration across the whole system and
 - Utilise new technologies to produce effective information, resources, guidance and tools
2. Evidence-informed decision making through producing rigorous national and local level data, analysis, research and evaluation
3. Better designed programmes and services
 - Build on expertise and strengthen relationships with NHS Boards, local authorities and third sector organisations to ensure that reducing health inequalities is core to local delivery, so that services reach those in greatest need
 - Offer tailored support to help local partnerships understand and tackle persistent health inequalities and improve local outcomes
4. Improved workforce capacity
 - Provide systematic support to health improvement leaders in the NHS, to employers, to local government and to the third sector
 - Develop networks to connect frontline practitioners and help them share experience and gain access to the best evidence and tools
5. Organisational excellence and innovation
 - Realign internal systems to the corporate strategy
 - Improve quality, foster learning, be accountable to be central to the performance culture
 - Organise and develop NHS Health Scotland’s resources in a way which maximises effectiveness and efficiency to deliver this strategy
6. Measuring improvement and impact
 - longer-term surveillance of health and inequalities outcomes and shorter-term measures
 - Support managers in accountability and reporting and teams in assessing and improving performance.

8. Wales - Fairer Health Outcomes for All: Reducing Inequities in Health Strategic Action Plan (The Welsh Assembly Government, 2011)

The Welsh Assembly Government has adopted a dual strategy involving action outside the NHS, or in partnership with the NHS, to address socio-economic determinants of health inequalities, as well as

action within the NHS to reduce inequalities in access to services.

Vision: Improved health and well-being for all, with the pace of improvement increasing in proportion to the level of disadvantage.

Objectives: By 2020, to improve healthy life expectancy for everyone and to close the gap between each quintile of deprivation by an average of 2.5%. Progress to the achievement will also link to the Health Gain targets and a range of existing targets and indicators in the Child Poverty Strategy for Wales and Tobacco Control Action Plan for Wales.

Principles:

1. A long term evidence based approach
2. Action across the social gradient in health
3. Action across the social determinants of health and well-being
4. Action across the life course

Priority Areas:

- Building health into all policies and all policies into health
- Giving every child a healthy start
- Developing health assets in communities
- Improving health literacy
- Making health and social services more equitable
- Developing a healthy working Wales
- Strengthening the evidence base

Summary of Strategies and Actions: The Plan lists supporting 57 action items for the seven priority areas (see Appendix 2 in the Welsh Assembly Government, 2011 for detailed action items). The Welsh Assembly Government has been working with various delivery partners and stakeholders, including Public Health Wales, Local Health Boards, and other organizations, to develop a timeline for the actions.

As an example, following public consultation in Spring 2012, a steering group was involved in developing “More than just Words,” a Strategic Framework to strengthen Welsh language services in health, social services and social care (Action 5.16 under “Making health and social services more equitable”). The Strategic Framework is supported by three-year Action Plans (2013-2016) – one for the NHS and one for Social Services. A follow-on strategic framework to ‘More than just Words’ with updated objectives and actions was released in December 2015 for public consultation. More information from <http://gov.wales/consultations/healthsocialcare/more-than-just-words/?lang=en>

9. Ireland - Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025 (Department of Health, 2013)

Vision: A Healthy Ireland, where everyone can enjoy physical and mental health and well-being to their full

potential, where well-being is valued and supported at every level of society and is everyone's responsibility

Objectives: The Framework sets out four high-level that are interlinked, interdependent and mutually supportive. One of four central goals of the Framework is to reduce health inequalities.

- To increase the proportion of people who are healthy at all stages of life
- To reduce health inequalities
- To protect the public from threats to health and well-being
- To create an environment where every individual and sector of society can play their part in achieving a healthy Ireland

Ethical Principles: Equity; Fairness; Proportionality; Openness and Accountability; Solidarity; Sustainability

Guiding Principles for Implementation: Better governance and leadership; Better use of people and resources; Better partnerships; Better systems for healthcare; Better use of evidence; Better measurement and evaluation; Better programme management

Summary of Strategies and Actions:

- Governance and Policy (10 action items) – to influence the broader determinants of health, a whole-of-government and whole-of-society approach is required. Under the healthy Ireland Framework, governance for health considerations across policy domains will be led at the highest level of Government.
- Partnership and cross-sectoral work (14 action items) – the achievement of the goals set out in the Healthy Ireland Framework depends on the participation of many sections of society. The establishment of a Healthy Ireland Council at national level reflects the emphasis and priority being placed on partnership and cross-sectoral involvement. This Council will hold its inaugural meeting during Ireland's Presidency of the EU.
- Empowering people and communities (12 action items) – a range of mutually-reinforcing and integrated strategies and actions are required to encourage, support and enable people to make better choices for themselves and their families.
- Health and health reform (13 action items) – An effective health system is a prerequisite for improved health and well-being and a competent, skilled and multi-disciplinary workforce is the most important resource for delivering health and well-being services.
- Research and evidence (6 action items) – the objectives, programmes, funding strategies, communication strategies, interventions, work practices and actions within this Framework will be based on robust evidence, and resources will be directed to evidence-based initiatives where possible.
- Monitoring, reporting and evaluation (9 action items) – ongoing and new data-collection methods need to be identified, and sufficient controls and quality assessments must be in place to ensure that the datasets reliably capture what they are designed to measure. A defined number of reliable indicators and data are required to ensure accountability and performance can be monitored accurately.

10. US HHS Action Plan to Reduce Racial and Ethnic Health Disparities (Department of Health and Human Services, 2011)

Vision: A nation free of disparities in health and health care

Objectives:

- To transform health care
- To strengthen nation's health and human services infrastructure and workforce
- To advance the health, safety and well-being of the American people
- To advance scientific knowledge and innovation
- To increase efficiency, transparency and accountability of HHS programs

Priority Areas:

- Access and heighten impact of all HHS policies, programs, processes and resource decisions to reduce health disparities
- Increase the availability, quality and use of data to improve the health of minority populations
- Measure and provide incentives for better healthcare quality for minority populations
- Monitor and evaluate the department's success in implementing the HHS disparities action plan

Summary of Strategies and Actions

- Transform health care:
 - Reduce disparities in health insurance coverage and access to care
 - Reduce disparities in access to primary care services and care coordination Reduce disparities in the quality of health care
- Strengthen nation's health and human services infrastructure and workforce
 - Increase ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities
 - Promote the use of community health workers and promoters
 - Increase diversity of the healthcare and public health workforces
- Advance the health, safety and well-being of the American people
 - reduce disparities in population health by increasing availability and effectiveness of community-based programs and policies
 - Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs
- Advance scientific knowledge and innovation
 - Increase availability and quality of data collected and reported on racial and ethnic minority populations
 - Conduct and support research to inform disparities reduction initiatives
- Increase efficiency, transparency and accountability of HHS programs through streamlining grant administration for health disparities funding and monitoring and evaluating implementation

11. US - National Stakeholder Strategy for Achieving Health Equity (Department of Health and Human Services, 2011)

The National Stakeholder Strategy complements the HHS Action Plan to Reduce Racial and Health Disparities

Vision: Provides a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities – and other underserved groups – reach their full health

potential.

Mission: To increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action.

Objectives:

- To increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.
- To strengthen and broaden leadership for addressing health disparities at all levels.
- To improve health and healthcare outcomes for racial, ethnic, and underserved populations.
- To improve cultural and linguistic competency and the diversity of the health-related workforce.
- To improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

Principles: Community engagement; Partnerships; Cultural and linguistic competency; Non-discrimination for healthcare access and delivery

Summary of Strategies and Actions:

- Awareness of health disparities: ensure ending health disparities is a priority on local, state, tribal, regional and fed healthcare agendas; develop and support partnerships; leverage media outlets to encourage action and accountability; and create messages and use communication mechanisms tailored for specific audiences to encourage action in public health
- Leadership: build capacity at all levels of decision making to promote community solutions to end health disparities; improve coordination, collaboration and opportunities for community input on funding priorities; and invest in young people to prepare them to be leaders and practitioners
- Health system and life experience: ensure access to quality health care for all; ensure provision of needed services for at-risk children; ensure provision of needed services for older adults; enhance and improve health service experience through improved health literacy, communications, interactions; increase high school graduation rates; support and implement policies that improve social and economic conditions
- Cultural and linguistic competency: cultural and linguistic competency training in workforces; increase diversity and competency of health workforce; and improve ethics and standards for interpreters, translators, and bilingual staff
- Data, research and evaluation: ensure availability of health data on all racial, ethnic, underserved populations; invest in CB-PAR and evaluation; support and improve coordination of research on health disparities; expand and enhance transfer of knowledge generated by research and evaluation

12. Maryland Plan to Eliminate Minority Health Disparities: Plan of Action 2010-2014

Maryland's first plan to eliminate minority health disparities was published in 2006. This second action plan provides a roadmap for the implementation efforts of each action step.

Objectives:

- Increase awareness

- Strengthen and broaden leadership
- Improve health and health system experience
- Improve Cultural and Linguistic Competency
- Improve Coordination and use of research and evaluation outcomes

Process: Form an action team for each of the five plan objectives; Develop an action plan for the team; Present an action step to the stakeholder; Finalize the action step; Begin action step implementation

Summary of Strategies and Actions:

- **Awareness:** disseminating information; identifying interventions that address reduction of health disparities; targeting health disparities messages information to be applicable across the life cycle; engaging non-traditional partners in health disparities activities and discussions; providing assistance to individuals lacking awareness navigating health care system
- **Leadership and Capacity Building:** developing leadership within communities; promoting development of learning opportunities for youth and community leaders specific to health and health disparities; including cultural competency training in health provider trainings; encouraging development of action plans in all public sectors for health disparities; increasing minority community participation in decision making roles; participating in health-related activities; encouraging public-private partnerships to enhance health of minority communities
- **Health and Health System Experience:** encouraging use of SDOH framework in health disparities interventions; promoting equitable quality of care for marginalized populations; exploring best practices to reduce transportation barriers to health care and improve access to health care; establishing ways to support the training of community health workers who serve communities in need; collaborating with stakeholders to promote establishment of equitable environments
- **Cultural and Linguistic Competency:** enhancing partnerships; providing assistance for cultural competency training and services and education on health disparities for students and communities; developing health career pipeline programs for diverse students; identifying and promoting strategies to increase representation of minorities in senior level faculty and administrators at institutions of higher education; improving outreach and recruitment of foreign trained professionals and adult education opportunities for minorities seeking careers in health care
- **Research and Evaluation:** supporting data collection for targeted minority populations, including race/ethnicity, country of origin, preferred language in data collection systems; identifying best practices; promoting the use of health impact assessments for a broad range of policy decisions; disseminating reports and resources as they become available.

13. California Statewide Plan to Promote Health and Mental Health Equity (Department of Public Health, 2015)

Vision: Everyone in California has equal opportunities for optimal health, mental health, and well-being

Mission: To promote equitable social, economic and environmental conditions to achieve optimal health, mental health and well-being for all.

Central Challenge: mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.

Objectives:

- Through assessment, yield knowledge of the problems and possibilities
- Through communication, foster understanding
- Through infrastructure development, empower residents and their institutions to act effectively

Summary of Strategies and Actions:

- Strategic Intervention Target 1: Health Partners - targeting partners outside the traditional boundaries of public health and healthcare by focusing on determinants of health such as education, income, housing, and safe and clean environments.
 - Embed health and mental health equity into institutional policies and practices across fields with potential
 - Health in all policies (HiAP) task force: Fostering a HiAP approach to embed health equity criteria in decision making, grant programs, guidance documents, and strategic plans
- Strategic Intervention Target 2: Health Field - raising awareness across a wide range of health and social services; synchronizing efforts with the National Culturally and Linguistically Appropriate Service Standards to increase cultural and linguistic competence; improving health insurance coverage across the state.
 - Embed equity into institutional policies and practices across the health field
 - Initially, facilitate a common understanding of health and mental health equity and SDOH between departments, boards, and offices within CA Health and Human Services.
- Strategic Intervention Target 3: Communities - building alliances across local public health departments, county mental health departments, local social services, or other local agencies that address key health determinants – including housing, education, economic development, and others.
 - Empower communities in inequity and disparity reduction initiatives.

14. Australia – Department of Health Agency Multicultural Plan 2013-2015 (Department of Health, 2013)

The Multicultural Plan covers the Department Health, and will also be adopted by the following agencies: The Australian Sports Anti-Doping Authority; the National Health and Medical Research Council; the National Health Performance Authority; and the Private Health Insurance Ombudsman.

Vision: The Department of Health is committed to delivering high quality health care programs, policies and services that are accessible and responsive to the needs of all Australians, including those from culturally and linguistically diverse (CALD) backgrounds.

Objectives:

- Effective leadership in delivering quality health care programs, policies and services
- Effective engagement with stakeholders to ensure that the policies and programs developed and delivered are successful
- Develop mechanisms to measure and assess performance to continue delivering high quality health

- care programs, policies and services
- Provide staff with skills and training necessary to support the government in its reform of the health system
- Develop policies and programs that are responsive to the diverse needs of Australians.

Summary of Strategies and Actions:

Leadership

- Executive engaged and leading work around Agency Multicultural Plan
- Increased awareness within the department of access and equity obligations
- Embed multicultural access and equity considerations within strategic planning

Engagement

- Representatives of CALD (culturally and linguistically diverse) communities have opportunities to engage development of policy, services, social marketing campaigns
- Work with those providing services to address needs of CALD communities
- Improved communications of health policies and programs to people from CALD backgrounds

Performance

- Indicators are available to assess performance and identify areas requiring further attention and improvement
- Consult with CALD staff on appropriateness and accessibility of management processes
- CALD communities provide feedback on accessibility and appropriateness of health services

Capability

- Ensure staff and organizations providing services have skills and knowledge needed to effectively engage with people from CALD backgrounds
- Data on CALD groups is available to assist research and inform policy and program development

Responsiveness

- Develop standards and guidelines for health policies and services that are responsive to the needs of all Australians, taking equity considerations into account
- Programs and services are available in community languages
- Continue to advance the accessibility of mainstream health and aged care services for people from CALD backgrounds

15. Australia – National Primary Health Care Strategic Framework (Standing Council on Health, 2013)

The framework builds on the *National Primary Health Care Strategy*, which was released in May 2010. This is the first national statement presenting an agreed approach for a stronger, more robust primary health care system in Australia. The framework specifically acknowledges the need to improve equity of access to health services and is designed to encompass the full range of health care services provided in home and community setting. Also it recognizes needs of specific population groups, including parents of

young children, young people, older people, those in remote areas, Aboriginal people, low socio-economic status people, refugees, and people from culturally and linguistically diverse (CALD) backgrounds.

Objectives:

- Build a consumer-focused integrated primary health care system
- Improve access and reduce inequity
- Increase the focus on health promotion and prevention, screening and early intervention
- Improve quality, safety, performance and accountability

Summary of Strategies and Actions:

For Strategic Outcome #2: Improve access and reduce inequity

- Promote health systems models that facilitate long term relationships between consumers and general practices to enhance the health and well-being of individuals and their families throughout their lives
- Work together with primary health care providers and professional organizations to promote development of multidisciplinary teams in which all members are supported to fully develop their potential
- Explore funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations through primary and secondary prevention.
- Translate both new and existing health system intelligence, including research, economic modelling and needs assessments, into evidence based planning and service delivery.
- Maximise the opportunities of eHealth, including the Personally Controlled Electronic Health Record (PCEHR) and Secure Messaging initiatives.

For Strategic Outcome #3: Take action to tackle the social determinants of health

- Identify ways to address the social determinants of health - such as social status, geographic location, health literacy, housing, education, employment and access to health services - which contribute to poor health outcomes.

16. Australia – National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (Australian Government, 2013)

Vision: The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realize health equality by 2031.

Objectives: Targeted, evidence-based action that will contribute to achieving equality of health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2031.

Principles: Health Equality and a Human Rights Approach; Aboriginal and Torres Strait Islander Community Control and Engagement; Partnership; Accountability

Priorities: Whole of Life - Maternal Health and Parenting; Childhood Health and Development; Adolescent and Youth Health; Healthy Adults; Healthy Ageing

Summary of Strategies and Actions:

The social determinants of health

- Governments work together across all building blocks to: leverage existing frameworks and strategies to achieve the Closing the Gap targets; take action across key social determinants such as health, housing, education and employment; and align program goals across sectors of government.
- Support innovative local programs that create opportunities for effective collaboration between local services from different sectors to address social inequalities and determinants of health and that reflect local priorities and need.

A culturally respectful and non-discriminatory health system

- Implement the National Anti-Racism Strategy 2010-2020; Significantly improve the cultural and language competency of health services and health care providers; Identify, promote and build on good practice initiatives to prevent and reduce systemic racism

Health system effectiveness and clinically appropriate care

- Continue efforts under the Closing the Gap agenda and health reform to contribute to improved health outcomes; Improve the clinical effectiveness of the health system for Aboriginal and Torres Strait Islander people to contribute to improved health outcomes; Enhance health system performance; Improve access to health information; Continue to fund and support improvement of Aboriginal and Torres Strait Islander community controlled health organisations

Mental health and social and emotional well-being

- Continue to implement the Roadmap for National Mental Health Reform 2012-2022, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013, and the renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework; continue support for counselling, health promotion and early intervention services

Human and community capability:

- Improve workforce capability; implement the relevant aspects of the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People; Increase access to culturally appropriate health services; support initiatives that encourage individuals to pursue employment and professional careers

17. New Zealand Health Strategy (Ministry of Health, 2000)

Goals and objectives:

- A healthy social environment
- Reducing inequalities in health status
- Māori development in health
- A healthy physical environment

- Healthy communities, families and individuals
- Healthy lifestyles
- Better mental health
- Better physical health
- Injury prevention
- Accessible and appropriate health care services

In addition to thirteen population health objectives for the Ministry of Health and District Health Boards, the Strategy sets out three specific objectives to reduce inequalities in health status.

- Ensure accessible and appropriate services for people from lower socioeconomic groups
- Ensure accessible and appropriate services for Māori
- Ensure accessible and appropriate services for Pacific peoples

Principles:

- Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi
- Good health and well-being for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high-performing system in which people have confidence
- Active involvement of consumers and communities at all levels

Summary of Strategies and Actions: To reduce inequalities for all New Zealanders, including Maori and Pacific peoples, the Ministry of Health and District Health Boards will:

- Identify community-driven initiatives that are achieving results or that have the potential to do so
- Identify ways they can respond to communities' needs and interests
- Advise communities and provide them with information to help them meet their needs and fulfil their interests
- Help communities to access the optimum mix of resources to achieve their own goals
- Adapt policies, programmes and funding to support successful community initiatives
- Implement programmes to reduce health inequalities
- Liaise with other government agencies on a national and local basis to build more co-ordinated policies and programmes
- Support provision of by Māori for Māori services
- Support 'by Pacific for Pacific' initiatives
- Focus on result