HEALTH EQUITY

The purpose of the Health Equity Concept Guide is to provide further detail about health equity concepts that are particularly pertinent to the use of the Planning and Evaluation Framework (PEF). Further, this guide will outline key high level health equity considerations for each phase of the PEF.

WHAT IS HEALTH EQUITY?

The Ontario Public Health Standards include a specific Health Equity Standard that sets program outcomes and requirements to support the achievement of health equity. "Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance"(Ministry of Health & Long-Term Care, 2017).

TOOLS

- *Engage Stakeholders Concept Guide*
- *Identify Priority Populations (under development)*

Health inequities are health differences that have the potential to be positively altered by social action . These health differences are characterized as:

- Systematic: meaning that health differences are patterned, where health generally improves as socio-economic status improves;
- Socially produced: could be avoided by ensuring all people have the social and economic conditions needed for good health and well-being; and
- Unfair and unjust: opportunities for health and well-being are limited (Ministry of Health & Long-Term Care, 2017).

The Middlesex-London Health Unit (MLHU) aims to plan, implement and evaluate programs that decrease health inequities by addressing the impact of the social determinants of health on population health outcomes.

MLHU has established health equity competencies, including those for planning and evaluation, that are applicable to all disciplines.

WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH?

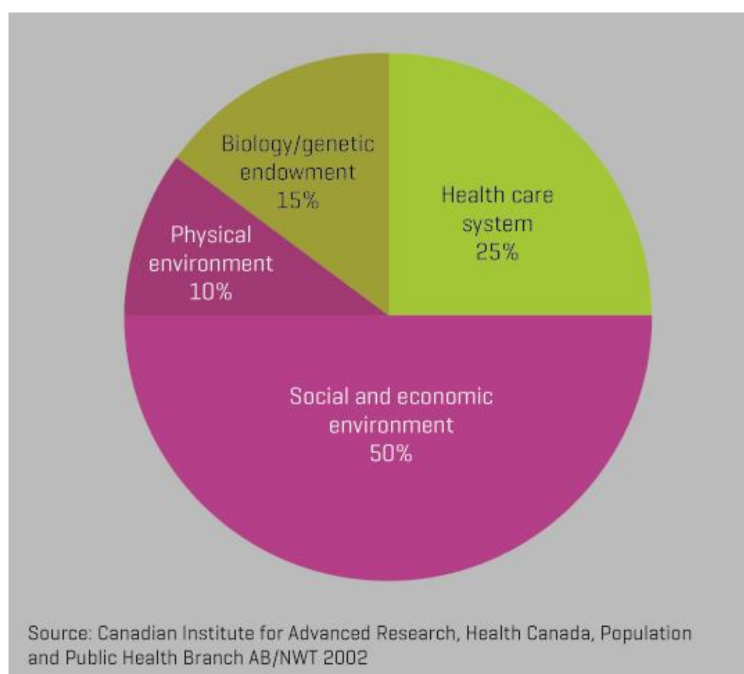
Social determinants of health (SDOH) are the circumstances in which people are born into, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (World Health Organization, 2017). The *Social Determinants of Health: The Canadian Facts* report (Mikkonen & Raphael, 2010) outlines a list of SDOH within the Canadian context (Table 1).

Table 1. Social Determinants of Health

Social Determinants of Health (Mikkonen & Raphael, 2010)
• Income and income distribution • Education • Employment and job security • Employment and working conditions • Early child development • Food insecurity • Housing • Social exclusion • Social safety net • Health services • Aboriginal status • Gender • Race • Disability

The impact of the SDOH on health outcomes is more significant than areas such as the health care system, biology/genetic endowment, and the physical environment. Figure 1 shows the proportion of the estimated impact of these categories on the health status of the population.

Figure 1: Estimated impact of determinants on health status of the population

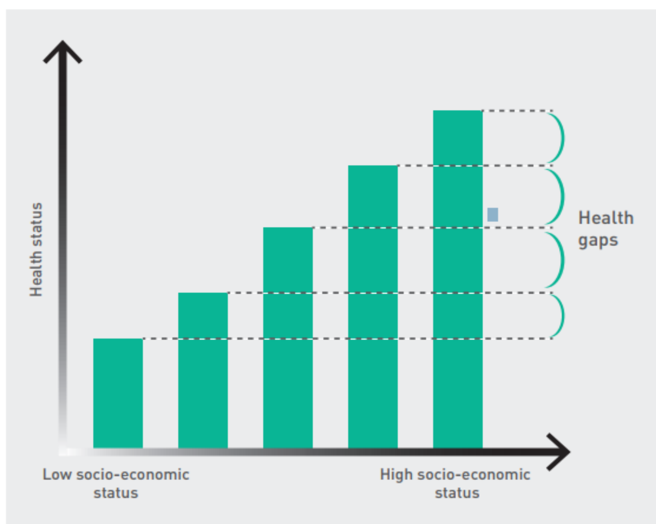


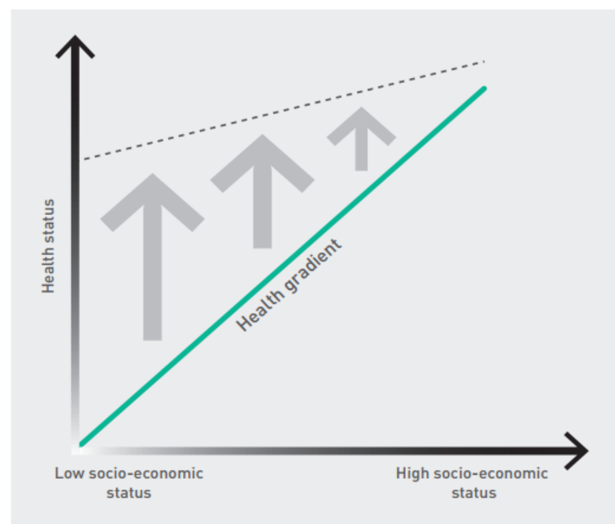
WHAT IS THE HEALTH GAP AND THE HEALTH GRADIENT?

Health Gap and Health Gradient are two methods used to represent the relationship between socio-economic status (SES) and the health status of a population. The Health Gap is the difference between the most and least healthy in a society as you move along the socio-economic status continuum.

Influencing the health gradient is important to improve population health. The Health Gradient is the linear relationship between the health status of those with the lowest and highest SES. The term "levelling up**"** refers to improving the overall health of the population by reducing the overall steepness of the Health Gradient. Figure 2 illustrates these concepts.

Figure 2. Health Gaps and Health Gradient Examples





(Source: National Collaborating Centre for Determinants of Health, 2013).

Public health uses a range of approaches and levels of intervention to close the health gap and level the health gradient.

LEVELS OF INTERVENTION

Public health has used the concept of "upstream", "midstream", and "downstream" for many years as an analogy for levels of intervention with individuals, families and communities. MLHU is responsible for public health work along the entire stream, but for individual public health practitioners the work may be focused on one area more than others.

Upstream actions advocate for greater fairness in power structures and income; they are about decreasing the causes-of-the-causes.

Example: Develop and implement a campaign to de-normalize smoking and the tobacco industry. Divest provincial investments of tobacco holdings and amend legislation to allow other institutions (e.g. Ontario universities and hospitals) to divest their tobacco holdings.

Example: Lead in the development of a poverty reduction strategy for the City, including cross-sector recommendations for all levels of government and a campaign to counteract stigma associated with poverty.

Midstream actions address material circumstances such as housing, food security, and employment; they are about changing the causes.

Example: Implement legislation limiting the use of tobacco and exposure to second-hand smoke in public places (e.g. Smoke-Free Ontario Act).

Example: Partner in a community collaboration focused on assisting women at risk of or experiencing homelessness. The plan focuses on addressing the housing, exit strategies, health and well-being of women who are involved in street-involved sex work, and/or trading sex for food, drugs or a place to stay.

Downstream actions address immediate health needs at an individual or family level; they are about changing the effects of the causes.

Example: Provide individualized smoking cessation programs that supply Nicotine Replacement Therapy to reduce the short- and long-term harms assocated with smoking.

Example: Implement the Nurse-Family Partnership, an intensive nurse home visiting program for young, low-income, first-time mothers to increase positive outcomes in child health and development.

RESOURCES

Let's Talk Moving Upstream

Social Determinant of Health Key Concepts

Let's Talk Universal and Targeted Approaches to Health Equity

Figure 3. Upstream, Midstream and Downstream Interventions for Tobacco Control

Figure 4. Upstream, Midstream and Downstream Interventions for Poverty Reduction

APPROACHES TO HEALTH EQUITY

To support health equity, public health programs and services use approaches that can be categorized as: Universal, Targeted, Targeting with Universalism, and Proportionate Universalism.

Each of these approaches has benefits and challenges which need to be considered when selecting a specific approach to use. For example, universal approaches may advantage people who are already in more favourable circumstances, and so the health gap is not decreased or may even be increased. On the other hand, targeted approaches may have little effect on the steepness of the health gradient and there is the potential for stigmatization of targeted populations. Blended strategies, such as targeting with universalism and proportionate universalism, are approaches that attempt to decrease these challenges. It is important to note that in some cases that the delivery approach for a public health program or service may be mandated or legislated provincially.

Universal strategies are directed to the entire population based on the belief that each member of society should have access to the same services to maintain or improve health.

> *Example:* MLHU participates in the Healthy Kids Community Challenge, a provincial initiative providing local funding to support the well-being of children. One part of the local Community Challenge includes public education about the benefits of water as the preferred beverage choice for all children and families.

Targeted strategies apply to prioritized sub-groups to address identified specific needs.

> *Example:* Smart Start for Babies Program is targeted to low income, pregnant women focusing on healthy eating and increased access to healthy foods during their pregnancy. Eligibility for the program is based on income and being pregnant.

Targeting with Universalism is a blended approach that can be accomplished either by developing specific strategies to address inequities in the social determinants of health or by adjusting universal interventions to increase accessibility for certain groups. Using either of these approaches increases the likelihood that those who are at the greatest risk of adverse health receive the greatest benefit.

Example of a specific strategy: The Nurse-Family Partnership is an intensive nurse home visiting program that begins in pregnancy and continues for the first two years of a child's life. The program is specifically for young, low-income, first-time mothers.
Example of adjusting a universal strategy: The Prenatal Immigrant Program (PiP) is an adapted version of the universal prenatal curriculum used at the Health Unit. It provides Arabic-speaking newcomers with culturally mindful, accessible and relevant prenatal education and supports, with an emphasis on health and food literacy.

Proportionate Universalism recognizes that to level up the health gradient, programs and policies must include a range of responses for different levels of disadvantage experienced within the population (National Collaborating Centre for Determinants of Health, 2013). In other words, those who are most in need receive greater and more intensive services and programs.
Example: Health Unit staff who work in school settings complete school assessments with each principal to determine how to most effectively work together to support the development of a healthy school community. As a result, all schools receive Health Unit services and supports, but the level of investment in each school is related to the assessed need and capacity.

UNDERSTANDING TARGET AND PRIORITY POPULATIONS

To address the health gradient or a health gap, public health often focuses its work around identified population groups based on demographic, social and/or other characteristics. For program planning purposes, MLHU has opted to use the terms target and priority populations. You will see these terms used throughout the PEF in phase and stage guides (e.g. Describe Program, Pre-Planning) and accompanying tools.

Target populations are populations at risk of adverse health outcomes, and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.

Priority populations are populations at risk of adverse health outcomes due to socially produced inequities, and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.

It is important to note that a target population is not the same as a priority population. In some instances, a program may target a population for identified reasons even if that population would not be considered a priority population. The Ontario Public Health Standards use the terminology of "priority populations" and frequently mentions the need for meaningful engagement with those populations who have been identified as "priority".

ENGAGING PRIORITY POPULATIONS

Working with identified priority populations often means working with groups that are marginalized in some way. "Marginalization" broadly refers to groups being denied opportunities to participate meaningfully in the community due to forms of oppression, in other words "being on the margins". For some groups, being labeled as "marginalized" is seen as stigmatizing. Other terms that have been used to describe priority populations such as "vulnerable", "high

When health professionals choose labels to describe community members that those members would not use themselves, they contribute further to disempowerment and stigmatization. Language is an important consideration when engaging with any community or population.

risk", "high needs", "hard-to-reach", and "disadvantaged" can also be stigmatizing.

Being able to engage meaningfully with priority populations involves investing time to build relationships and trust, building on existing strengths and assets, and fostering participation in meaningful activities. Listening to the community voice can result in improved community health and increase social inclusion. The **Engage Stakeholders Concept Guide** provides more detail to support engagement with all potential stakeholders, including priority populations.

The concepts of "cultural safety" and "cultural humility" are key to meaningful engagement with priority populations. The definition of cultural safety continues to evolve, and the actual application of this concept in professional practice is in development (Yeung, 2016). "Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care" (First Nations Health Authority, 2017).

Achieving cultural safety requires respectful and meaningful engagement, that is built on relationships and trust, with the identified priority population.

Additionally, "Cultural safety takes us beyond cultural awareness and the acknowledgement of difference. It surpasses cultural sensitivity, which recognizes the importance of respecting difference. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners." (Spence, 2001).

"Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience" (First Nations Health Authority, 2017).

Along with the recognition that there is a power and privilege imbalance between themselves as health professionals and clients, the professional does not assume their norms are "correct" or universal and that they too have cultural values that are impacting the situation. As a life-long process, cultural humility recognizes the need for ongoing individual learning that will continue to evolve based on experiences and thoughtfulness (Yeung, 2016).

KEY CONSIDERATIONS FOR PLANNING AND EVALUATION

The health equity concepts discussed in this Concept Guide may be used in all phases and stages of the PEF. The table below (Table 2) outlines key health equity considerations and guiding questions you may wish to use at each phase of the Framework. For more information about how to integrate health equity concepts at a particular stage of your program review the relevant stage guide.

To help support understanding and application of health equity concepts into planning and evaluation activities, Health Equity Core Team members are available on a consultative basis.

Table 2. Health Equity Concepts at Each Phase of the Planning and Evaluation Framework

Phase	
PLAN	**Key Considerations** • Identify priority populations for your program • Consider priority populations as stakeholders and ensure they are meaningfully engaged in planning of public health interventions • Consider the positive and negative impacts of this program on priority populations • Use community-based organizations working with the relevant population to expand your understanding about addressing the needs of this group • Increase priority population(s) participation in the development and planning process
	Guiding Questions • How does your program affect health equity for priority populations? • What are the most effective methods for engaging with the identified priority population(s)? • Are there priority populations who may experience unintended results of this program?
IMPLEMENT	**Key Considerations** • Consider how you can reduce or eliminate barriers to access (e.g. interpretation and/or translation, transportation, childcare, etc.) • Ensure appropriate reading or comprehension level for communications materials • Ensure alignment and collaboration with complementary programs or partners (e.g. local, regional, provincial, or federal organizations) both inside and outside of the health sector • Ensure program timelines and resources can accommodate the demands related to assessing and addressing potential unintended health equity impact of decision making, (e.g. additional time or resources may be required)
	Guiding Questions • How can you reduce or remove barriers and other inequitable effects? • How can you maximize the positive effects or benefits that enhance health equity? • Are you continuing to engage effectively with the identified priority population(s)? • How can you ensure appropriateness of communications and service delivery for diverse groups and audiences? • Do internal policies and procedures need to change to implement your population specific program?
EVALUATE	**Key Considerations** • Consider evaluation questions that take into account all key stakeholders including priority populations • Consider the data collection methods and content needed to be acceptable to diverse groups, and meet the needs of the priority population • Collaborating with community stakeholders can help you assess whether a message will resonate with relevant groups • Share results with relevant groups and stakeholders including priority populations • Identifying preferred and effective communication channels is critical to communicating with diverse groups. Consider the differences between and within groups, including any language preferences and cultural specifics

	Guiding Questions • For each priority population, what is the best way to reach the intended audience (e.g. type of media, personal communications, community events)? • What is the preferred language and and/or method of contact? • Does the preferred format and method of contact differ for reporting evaluation results compared to data collection?

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