Ministry of Health and Long-Term Care

Health Equity Guideline, 2018

Population and Public Health Division,
Ministry of Health and Long-Term Care

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Ontario

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1 Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1,2] The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Guidelines are program and topic-specific documents which provide direction on how boards of health shall approach specific requirement(s) identified within the Standards.

2 Purpose

This Guideline is intended to assist boards of health in implementing the requirements established in the Health Equity Standard within their processes for planning, implementation, and evaluation. It establishes the minimum expectations for strategies and approaches that boards of health shall consider. Content is organized as follows:

- Sections 1 Preamble, 2 Purpose, and 3 References to the Standards provide a brief orientation to this guideline.
- Section 4 Context provides a high-level introduction to health equity, and a brief overview of key concepts and frameworks to inform public health practice.
- Section 5 Roles and Responsibilities identifies core links between requirements for health equity and related requirements in the foundational and program standards.
- Section 6 Required Approaches outlines required approaches that boards of health shall consider in implementing the *Health Equity Standard*. This includes considerations for assessing and reporting on population health, modifying and orienting public health interventions, engaging in multi-sectoral collaboration, and advancing healthy public policies.

Approaches to board of health engagement with Indigenous communities and organizations share many common factors with a health equity approach. However, there are many different Indigenous communities across the province, including many different First Nation governments, each with their own histories, cultures, organizational approaches, and jurisdictional realities that need to be considered. These relationships must be fostered in a culturally safe way, building on trust, mutual respect, understanding, and reciprocity, and are well served by the provision of a separate guideline. Where appropriate, references will be made throughout this Guideline to related advice within the *Relationship with Indigenous Communities Guideline, 2018* (or as current), as well as other relevant protocols and guidelines under the Standards.

3 Reference to the Standards

This section identifies the standards and requirements to which this guideline relates.

Health Equity Standard

Requirement 1. The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

Requirement 2. The board of health shall modify and orient public health interventions to decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current), and by:

a) Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities; and
b) Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.

Requirement 3. The board of health shall engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities in accordance with the *Health Equity Guideline, 2018* (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the *Relationship with Indigenous Communities Guideline, 2018* (or as current).

Requirement 4. The board of health shall lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current).

4 Context

This section provides a high-level introduction to **health equity**,* along with an overview of key concepts and frameworks that boards of health shall consider to inform planning, implementation, and evaluation of health equity within public health practice. In order to support the establishment of a common understanding of health equity throughout Ontario's public health sector, additional terms and concepts are defined in the Glossary. Health equity must be grounded in an understanding of a particular **community's** values, identities, and lived experiences, as well as the economic, social, environmental, and

* Terms marked **in bold** are defined the Glossary.

political context, in order to be inclusive and responsive to diverse partners and community members.

Health equity means that all people can reach their full health potential without disadvantage due to social position or other socially determined circumstance, such as ability, age, culture, ethnicity, family status, gender, language, race, religion, sex, social class, or socioeconomic status.[3]

Systemic differences in health status exist across population groups, and these are often referred to as health inequities. **Health inequities** are health differences that are:

- Systematic, meaning that health differences are patterned, where health generally improves as socioeconomic status improves;
- Socially produced, and therefore could be avoided by ensuring that all people have the social and economic conditions that are needed for good health and **well-being**; and
- Unfair and/or unjust because opportunities for health and well-being are limited.[3]

Health is influenced by a broad range of factors, including social determinants that affect the conditions in which individuals and communities live, learn, work, and play. At the provincial level, health equity is linked to the following key **social determinants of health**:[4,5]

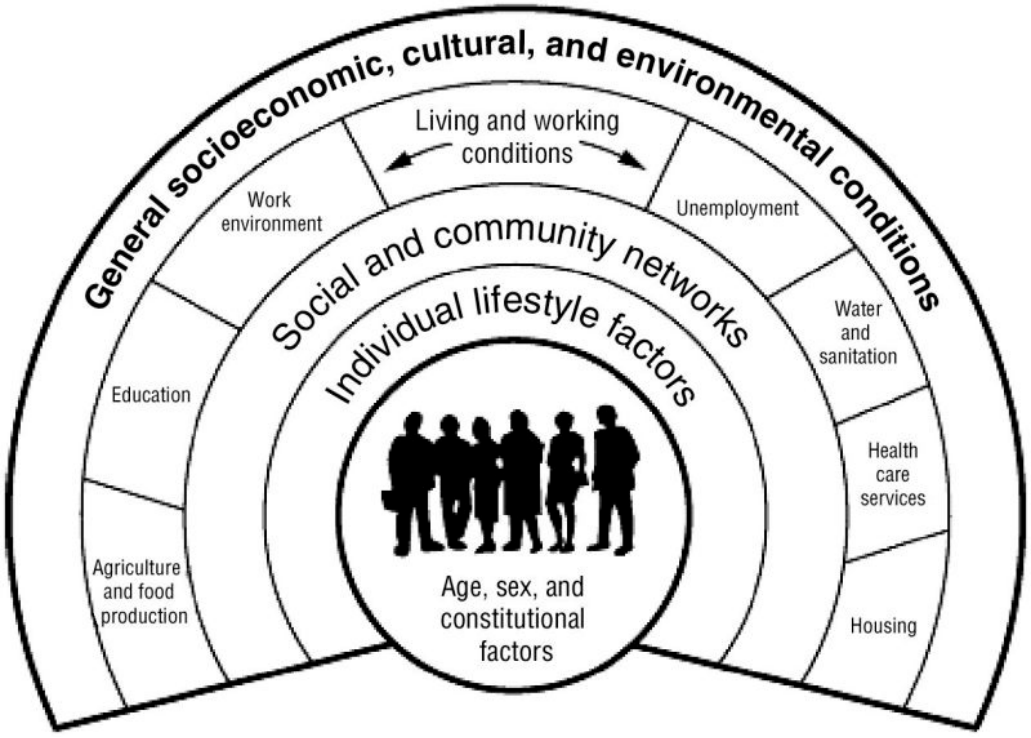
Table 1: Key Social Determinants of Health

- Access to health services
- Culture, race, and ethnicity
- Disability
- Early childhood development
- Education, literacy, and skills
- Employment, job security, and working conditions
- Food insecurity
- Gender identity and expression
- Housing
- Income and income distribution
- Indigenous status
- Personal health practices and **resiliency**
- Physical environments
- Sexual orientation and attraction
- Social inclusion/exclusion
- Social support networks

Individuals, communities, and populations may experience these factors differently based on social or economic conditions, putting some at a disadvantage and greater susceptibility to poor health outcomes. Reducing the negative impact of social determinants that contribute to health inequities is fundamental to the work of public health. The *Wider Determinants of Health Model* (Figure 1) below illustrates how various health-influencing factors are embedded within the broader aspects of society.[6]

Additional frameworks for consideration may be found in the Canadian Council on the Determinants of Health's "A Review of Frameworks on the Determinants of Health."[7]

Figure 1: Wider Determinants of Health Model



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Evidence-based “upstream" approaches to health—those that address people's access to the social determinants of health—are imperative to decreasing health inequities (see Table 2). A health equity approach applies to all levels, with interventions tailored to the needs and **assets** of locally-identified **priority populations**.

Table 2: Levels of Interventions[8]

Upstream Interventions	Midstream Interventions	Downstream Interventions
Seek to reform the fundamental social and economic structures that distribute wealth, power, opportunities, and decision-making. These changes generally happen at the macro policy level: national and transnational. ***They are about diminishing the causes-of-the-causes.***	Seek to reduce exposure to hazards by improving material working and living conditions, or to reduce risk by promoting healthy behaviours. These changes generally occur at the micro policy level: regional, local, community or organizational. ***They are about changing the causes.***	Seek to increase equitable access, at an individual level, to health and social services. These changes generally occur at the service or access to service level. ***They are about changing the effects of the causes.***

5 Roles and Responsibilities

Boards of health are required to engage in public health practice that results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances. As goals and outcomes related to health equity are established in a foundational standard, as well as within the overarching Policy Framework for the Standards, boards of health are responsible for applying a health equity approach systematically, as an integral part of all aspects of their work.

In addition to the specific requirements of the *Health Equity Standard*, which are addressed directly in Section 6 of this guideline, the foundational standards on *Population Health Assessment* and *Effective Public Health Practice* outline requirements that are relevant to the topic of health equity, including the following:

- Under the *Population Health Assessment Standard*, boards of health are required to assess and report on the health of local populations, which includes assessing health inequities and social determinants of health, priority populations and demographic indicators, **risk and protective factors**, and other information relevant to public and **population health**.
- Under the *Effective Public Health Practice Standard*, boards of health are required to employ public health practice that is transparent, responsive to current and emerging evidence, and which emphasizes continuous quality improvement. This requirement supports awareness among public health practitioners, policy-makers, community partners, and health care providers of the factors that determine the health of the population, which includes factors relating to health equity and the social determinants of health.

Additionally, board of health roles and responsibilities for health equity apply holistically to the planning, implementation, and evaluation of all public health services and **programs of public health interventions**. Various program standards articulate additional requirements relating to the overarching goal of reducing health inequities, and program/topic-specific guidance regarding required approaches is provided in corresponding protocols and guidelines.

6 Required Approaches

This section provides an overview of the approaches that boards of health shall consider, at minimum, when implementing the requirements established in the foundational *Health Equity Standard*. Board of health decision-making and prioritization regarding health equity shall be guided by the four principles established by the overarching Policy Framework: Need; Impact; Capacity; and Partnership, Collaboration, and Engagement.

As a foundational standard, health equity represents a cross-cutting vision and fundamental philosophy to guide public health practice in Ontario. It is recognized that the

public health sector is one of many contributors to health equity, and action across multiple sectors is required in order to fully realize this vision.

In order to operationalize the four requirements under the *Health Equity Standard*, boards of health shall apply a health equity approach to continuously identify and address systemic and institutional factors affecting health equity, including the underlying causes. Boards of health shall apply a health equity approach within all aspects of their work, including processes for community inclusion and engagement, training, planning, implementation, and evaluation, by:

- Recognizing how the social determinants of health, and their root causes, influence the distribution of health and well-being across communities;[9]
- Seeking opportunities to address population diversity when planning, implementing, adapting, and evaluating public health programs and policies;[9]
- Enhancing capacity to apply **anti-racist**, **anti-oppressive**, and **culturally safe** approaches to public health practice;[9-12]
- Fostering organizational capacity for health equity action; [13]
- Planning and implementing public policy approaches to support health equity;
- Undertaking **community engagement** and inter-sectoral action strategies to address health inequities;
- Considering the use of performance management and quality improvement principles to continuously improve policies, processes, programs, and services that advance health equity; and
- Promoting the use of health equity tools for assessment, audit, program planning, and evaluation.

6.1 Assessing and Reporting

Requirement #1 of the *Health Equity Standard* requires boards of health to assess and report on the health of local populations[†] describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities.

In operationalizing this requirement, and in alignment with board of health requirements under the *Population Health Assessment Standard*, boards of health shall:

- Employ relevant assessment and surveillance tools for health equity, to identify and communicate the needs and assets of priority populations;
- Seek opportunities to conduct or participate in local or provincial evaluation studies, or research on new and existing public health programs and services developed and implemented for priority populations;
- Seek opportunities to engage priority populations in the design and implementation of assessment, surveillance, research, and evaluation processes, including the collection, maintenance, and disposition of data.

[†]For guidance on assessing and reporting on population health, refer to the *Population Health Assessment and Surveillance Protocol*, *2018* (or as current).

- Distribute and/or make available to the public, as appropriate, population health assessment and surveillance information products with respect to health equity, in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

6.2 Modifying and Orienting Public Health Interventions

Requirement #2 of the *Health Equity Standard* requires boards of health to modify and orient public health interventions to decrease health inequities by:

a) Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities; and
b) Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.

In operationalizing this requirement, boards of health shall consider alignment with related requirements under the *Effective Public Health Practice Standard*, as referenced above.

6.2.1 Engaging Priority Populations

In operationalizing the requirement to engage priority populations in order to understand their unique needs, histories, cultures, and capacities, boards of health shall consider the ways in which these communities experience the root causes of health inequities that affect the social determinants of health.

Informed by principles of anti-oppressive practice and cultural safety, boards of health shall develop and implement strategies to engage priority populations in the planning, implementation, and evaluation of public health programs and services, in order to advance health equity. The board of health shall employ community engagement frameworks and approaches that are informed by evidence and best practice, and are responsive to local needs and assets. In particular, community engagement strategies shall be guided by the following principles:

- Sustainable community engagement is supported and promoted by encouraging local communities to get involved in all stages of public health planning, implementation, and evaluation;
- Relationships are built on trust, commitment, leadership, and capacity across local communities, recognizing that relationship building is a continuous process that takes time;
- Decision-making groups include members of local communities who reflect the diversity of those communities; and
- The results of community engagement are reported back to the local communities concerned, as well as other partners.[13,15]

For guidance on required approaches to engaging First Nations and Indigenous communities, refer to the *Relationship with Indigenous Communities Guideline*, *2018* (or as current).

6.2.2 Designing Strategies to Improve the Health of the Entire Population while Decreasing Health Inequities

In operationalizing the requirement to design strategies to improve the health of the entire population while decreasing health inequities, boards of health shall:

- Apply the concept of proportionate universalism within all processes for planning, implementation, and evaluation. **Proportionate universalism** is an approach that can be used to address the **health gap** and **health gradient** by making health actions or interventions available to the whole population, but with a scale, intensity, and delivery that is proportionate to the level of need and disadvantage in specific populations. It balances **targeted** and **universal** population health perspectives and recognizes that programs, services, and policies must include a range of responses that address varying needs, assets, and the social determinants of health.[16,17] While some programs are universal (e.g., immunization), there will be groups within the general population that require additional resources and targeted actions to fully realize the intended health benefit.
- Employ the most appropriate tools, processes, and resources for health equity assessment within the local context, such as health impact assessments (HIA), equity focused health impact assessments (EFHIA), health equity impact assessments (HEIA), situational assessments, and health equity audits (HEA).

6.3 Engaging in Multi-Sectoral Collaboration

Requirement #3 of the *Health Equity Standard* requires boards of health to engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities. As many factors and upstream interventions for addressing health equity and the social determinants of health lie outside the purview of the public health sector, it is particularly important that stakeholders and partners across multiple sectors be engaged to contribute to effective local strategies that decrease health inequities.

In operationalizing this requirement, and in alignment with the *Effective Public Health Practice Standard,* boards of health shall engage relevant partners in the health and non-health sectors. The board of health shall also consider effective stakeholder engagement strategies such as:

- Establishing and participating in collaborative partnerships and coalitions which address public health issues and social determinants with:
    - Key health sector partners, including but not limited to: LHIN(s), hospital administrators, long-term care facility administrators, community health centre administrators; and
    - Non-health sector partners, including but not limited to: community planning organizations, school boards, social housing authorities, labour organizations, grassroots and civic organizations, children and youth services, and local chambers of commerce.

- Establishing relationships with schools of public health and/or other related academic programs to promote collaborative research projects and knowledge exchange activities that advance the evidence and knowledge base for health equity; and
- Monitoring and evaluating these partnerships to determine their effectiveness and identify and address gaps.

Additional partner-specific considerations for addressing health equity are articulated in the relevant protocols and guidelines, such as the *Board of Health and Local Health Integration Network Engagement Guideline, 2018* (or as current) and the *Relationship with Indigenous Communities Guideline, 2018* (or as current).

6.4 Health Equity Analysis, Policy Development, and Advancing Healthy Public Policies

Requirement #4 of the *Health Equity Standard* requires boards of health to lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities.

In operationalizing this requirement, and in alignment with the *Effective Public Health Practice Standard,* boards of health shall engage in various forms of research, knowledge exchange, and communication modalities regarding factors that determine the health of the local population, including consideration of the following actions:

- Gathering and disseminating data;
- Developing health reports and policy statements that address social determinants of health and health inequities experienced by local priority populations;
- Providing the health and health equity context to the analysis of local issues;
- Participating in partnerships/coalitions organized to advance specific policy issues to decrease health inequities;
- Identifying organizational and community-level enablers and barriers to policy change; and
- Assessing and/or supporting the use of assessments and tools to evaluate the health impact of all policies with a health equity approach.

Additional guidance to support public health practice in advancing healthy public policies may be found in Public Health Ontario's "At a Glance: The Eight Steps to Developing a Healthy Public Policy," or the World Health Organization's "Health in All Policies: Helsinki Statement; Framework for Country Action."[18,19]

Glossary

Anti-colonialism/decolonization refers to a movement or approach that seeks to disrupt, dismantle, and unlearn colonialist structures and processes in support of Indigenous sovereignty and self-determination, which has been cited as the most important determinant of health among Indigenous peoples.[20,21]

Anti-oppressive practice refers to the strategies, theories, actions, and practices that seek to recognize the systems of privilege and oppression that exist in society, to actively mitigate their effects, and to equalize power imbalances over time.[9] This requires individuals and institutions to acknowledge and accept responsibility for their role in perpetuating oppression, whether intentionally or unconsciously.

Anti-racism is an active approach to identifying, challenging, and changing the systems, behaviours, and values that uphold racism at all levels of society. It "is intended to promote an equitable society in which people do not face discrimination on the basis of their actual or perceived race, however defined".[21]

Bias refers to ingrained ideas, prejudices, stereotypes, and assumptions that we are often unaware. These ideas influence our perceptions, expectations, judgments, and behaviours. All people have biases which are developed through socialization and personal experience.

Colonialism refers to "a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolutionary level that the colonized." "While neo-colonialism detrimentally influences the health of contemporary Indigenous peoples, historic, successively traumatic events continue to affect generations through what has been referred to as 'historic or cultural trauma'". Colonialism impacts the health of Indigenous peoples by producing social, political, and economic inequalities that 'trickle down' through the construction of unfavourable intermediate and proximal determinants.[20-23]

Community refers to "a group of people who have common characteristics or interests. Communities can be defined by: geographic location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage."[24]

Community assets "include not only buildings and facilities but also people, with their skills, knowledge, social networks, and relationships."[24]

Community engagement "is a process, not a program. It is the participation of members of a community in assessing, planning, implementing, and evaluating solutions to problems that affect them. As such, community engagement involves interpersonal trust, communication, and collaboration. Such engagement, or participation, should focus on, and result from, the needs, expectations, and desires of a community's members."[25]

Comprehensive health promotion approach applies diverse strategies and methods in an integrated manner—one of the preconditions for health promotion to be effective. Health promotion addresses the key action areas identified in the Ottawa Charter in an integrated and coherent way.

Cultural safety refers to "an environment which is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need." Cultural safety is conceptualized on a continuum that begins with unsafe practises, moving to cultural competence, and culminating in culturally safe practices that account for the role and consequence of power in relationships between providers and communities, and in which the needs and voices of communities take a prominent role.[11,12 ,26]

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.[3]

Health gap refers to the difference between those who are most and least healthy in a society.[27]

Health gradient refers to the consistent pattern formed by the health gap at every step of the socioeconomic spectrum, where those with higher status are healthier than those below them.[27]

Health inequity is a sub-set of health inequality and refers to differences in health associated with social disadvantages that are modifiable, and considered unfair.[3]

Intersectionality recognizes that individuals and communities must be related to as complex and heterogeneous, rather than one dimensional.[21] It acknowledges that identities and forms of oppression intersect to produce unique and often unpredictable experiences, as one form of oppression can be shaped by and influence another.[28] Additionally, one individual or community's experiences of privilege and oppression can shift over time and in different contexts.

Oppression refers to institutionalized power that is historically formed over time. It allows certain groups to assume a dominant or privileged position over other groups and identities, either knowingly or unconsciously, and this dominance is maintained and continued at individual/interpersonal, cultural, and structural/institutional levels.[9,29,30]

Population health is the health of the population, measured by health status indicators. Population health is influenced by physical, biological, behavioural, social, cultural, economic, and other factors. The term is also used to refer to the prevailing health level of the population, or a specified subset of the population, or the level to which the population aspires. Population health describes the state of health, and public health is the range of practices, procedures, methods, institutions, and disciplines required to achieve it. The term also is used to describe the academic disciplines involved in studies of determinants and dynamics of health status of the population.[31]

Priority populations are those that are experiencing and/or at increased risk of poor health outcomes due to the burden of disease and/or factors for disease; the determinants

of health, including the social determinants of health; and/or the intersection between them. They are identified by using local, provincial, and/or federal data sources; emerging trends and local context; community assessments; surveillance; and epidemiological and other research studies.

Privilege refers to unearned power that gives members of a dominant group economic, social, and political advantages.[29,30]

Program of public health interventions includes the suite of programs, services, and other interventions undertaken by a board of health to fulfill the requirements and contribute to achieving the goals and program outcomes outlined in the Standards.

Proportionate universalism is an approach that balances targeted and universal population health perspectives. This approach makes health actions or interventions available to the whole population, but with a scale, intensity and delivery that is proportionate to the level of need and disadvantage in particular populations.

Racialization refers to the social processes that construct racial categories as "real, different and unequal in ways that matter to economic, political and social life".[32] Racialization is often based on perceived differences in anatomical, cultural, ethnic, genetic, geographical, historical, linguistic, religious, and/or social characteristics and affiliations.

Racism refers to a set of individual, cultural, and institutional beliefs and practices that seeks to construct social differences between groups of people in order to subordinate and oppress one group for the benefit of another.[33-35]

Resiliency refers to the ability of an individual or community to effectively manage or cope with adversity or stress in ways that are not only effective, but increase their ability to respond to future adversity and enable them to thrive.[36]

Risk and protective factors are variables that can be present at the individual, interpersonal, community, and societal levels and that impact mental health and resiliency.[37] **Protective Factors** are determinants that affect health in a positive way. They help with maintaining good health, and can assist in effective management of health conditions.[38] **Risk Factors** are determinants that affect health in a negative way. They can increase the likelihood of developing chronic diseases, or hinder in the management of existing conditions.[38]

Social determinants of health are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.[39]

Targeted approaches use selection criteria, such as income, neighbourhood, health, or employment status, to target eligibility and access to programs and services to priority sub-groups within the broader population.[27]

Universal approaches are programs and services that are available to the whole population.[27]

Well-being refers to “the presence of the highest possible quality of life in its full breadth of expression focused on but not necessarily exclusive to: good living standards, robust health, a sustainable environment, vital communities, an educated populace, balanced time use, high levels of democratic participation, and access to and participation in leisure and culture.”[40]

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