

Environmental scan of policy levers for equity-integrated environmental public health practice in BC



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Executive Summary

This report summarizes the findings of a pan-Canadian environmental scan that was undertaken to examine environmental public health (EPH) policy levers through an equity lens. The project entailed:

- a high-level environmental scan of public health legislation and downstream policy instruments to identify those that explicitly mention the social determinants of health or health equity/inequity
- a more detailed examination of key instruments, accompanied by key informant interviews, to determine how and where they have been used

The aim of the project is to clarify the mandate for an equity-integrated EPH practice. It builds on the findings of consultations with EPH practitioners in British Columbia (BC) and across Canada in 2015 about how to integrate equity into their work at the regional or local level. This work is part of a 3-year project at the BC Centre for Disease Control (BCCDC) called *Through an Equity Lens: a new look at environmental health*. *Through an Equity Lens* is funded by the Provincial Health Services Authority (PHSA) as a Population and Public Health Prevention Project.

The key insights that emerged from this environmental scan are:

- **Policy Instruments:** There is considerable variation across the country in whether, and the degree to which, equity is referenced in the public health legislation and subordinate regulations. Because the legislation and regulations tend to be more prescriptive than outcomes-based (i.e., they limit opportunities for EHOs to exercise discretionary power), they are often perceived as a barrier to incorporating equity in environmental health practice.
- **Policy Drivers:** There is considerable variation across the country in the degree to which equity is embedded into the culture of organizations with responsibility for delivering public health services. In organizations where equity is identified as a core value or is listed as a strategic priority, the corresponding outcomes and indicators tend to be focused on the delivery of health care services, as opposed to public health service delivery. Where equity outcomes or indicators are focused on public health, they tend to be primarily in other sectors (e.g., public health nurses or health promoters).
- **Barriers:** Many facets of environmental health are constrained by the policy instruments that govern not only what services are delivered, but also how they are delivered. Barriers include, for example, the “one-off” nature of inspections, the need for regulatory compliance, and the relatively limited discretion that inspectors have to measure and enforce compliance. Public and environmental health is traditionally organized by content or service area, creating silos that can lead to duplication of effort and present barriers to cross-cutting initiatives like equity.

- **Facilitators:** The biggest facilitators to embedding equity within an organization or within a particular initiative are: health equity champions at the managerial and/or executive level, the sharing of knowledge, collaboration and partnerships between units across an organization or with external agencies. Flexibility in the policy instruments governing practice, which gives inspectors the opportunity to exercise discretionary power, is also a key facilitator.

The report concludes with a summary of the gaps and opportunities and a series of recommendations designed to facilitate the integration of equity into environmental health practice (see Summary). Recommendations are organized according to the three areas influencing environmental health practice: (1) governing instruments (e.g., legislation and regulations), (2) policy drivers (e.g., Ministry goals and targets), and (3) efforts to embed equity organizationally or into particular service areas.

Introduction and Background

About this Report

This report summarizes the findings of a pan-Canadian environmental scan that was undertaken to examine environmental public health (EPH) policy levers through an equity lens. The aim of the project is to clarify the mandate for an equity-integrated EPH practice. The project entailed: (1) a high-level environmental scan of public health legislation and downstream policy instruments to identify those that explicitly mention the social determinants of health or health equity/inequity; and (2) a more detailed examination of key instruments, accompanied by key informant interviews, to determine how and where they have been used.

This work is part of a 3-year project at the BC Centre for Disease Control (BCCDC) Environmental Health Services called *Through an Equity Lens: A new look at environmental health*.¹ Environmental Health at BCCDC serves as a resource for environmental health policy, practice, and research within the province.

This project builds on the findings of consultations with EPH practitioners in British Columbia (BC) and across Canada in 2015, which aimed to support environmental health officers (EHOs) to effectively integrate equity into their work at the regional or local level.² Following a 2014 pilot study in BC and Nova Scotia, BCCDC held additional focus groups in each of BC's health authorities in 2015. These were supplemented by additional consultations done in partnership with the National Collaborating Centre for Environmental Health (NCCEH) and the National Collaborating Centre for Determinants of Health (NCCDH). Together, these consultations explored what kind of supports might assist EHOs to incorporate health equity considerations into regulatory practice.

Purpose of the Project

The purpose of this project was to clarify the mandate for an equity-integrated environmental public health (EPH) practice. To achieve the project's objectives: a high-level pan-Canadian environmental scan of public health legislation and downstream policy instruments was first undertaken to identify those that explicitly mention health equity or that implicitly refer to the social determinants of health. The scan was subsequently followed by a more detailed examination of the instruments identified to determine the degree to which they have been practically applied in their respective jurisdictions. For example, did a particular policy goal lead to the development of a framework or to the formation of an equity position or group within a health protection unit? And, if so, what was the path or process that led from one to the other? Information was collected primarily from online sources, but was supplemented by key informant interviews wherever possible (Appendix A).

Health Equity Defined

The *social determinants of health (SDH)* are the social, political, geographic, and economic conditions in which people live, learn, work, and play that impact health. These conditions change over time and across the life span, impacting the health of all people (individuals, groups, and communities) in different ways. *Health equity* exists when everyone has a fair opportunity to reach their full health potential and is not disadvantaged by social, economic, environmental conditions, and circumstances. It is a lens that is being increasingly applied across a range of health systems and policies in Canada and elsewhere. *Health inequities* are differences in health status associated with social disadvantages that are modifiable and considered unfair. Health inequities arise when variation in the distribution of the SDH leads to people having differential exposure to health risks and vulnerability to conditions that compromise health and well-being. *Disparities*, sometimes used interchangeably with health inequalities, are measureable differences in health between individuals, groups, or communities.³

Health Equity and the Practice of Environmental Health

Environmental public health professionals include environmental health officers (EHOs),^a public health inspectors (PHIs), and medical health officers (MHOs). They are the frontline practitioners who deal with a cross-section of the population through their regulatory and educational activities. Although the role of environmental health practitioners in addressing inequities may not be obvious, inequities impact environmental health in many ways. For example, inequities can lead to differences in environmental exposures, as well as vulnerabilities to and outcomes from those exposures. Inequities can also create barriers that impact people's ability to follow health advice or to comply with public health regulations. The manner in which environmental health practitioners interact with individuals who have SDH-related barriers could potentially minimize or amplify the negative impacts of those barriers. By understanding and targeting specific inequities that may pose barriers to meeting public health regulations, environmental health practitioners may be able to improve compliance with health regulations, facilitate sustained behaviour change, adapt guidelines to better identify and address these inequities, and advocate for legislative or regulatory change, where warranted.⁴

Environmental Health “Policy Levers”

The term “policy levers” is often used to refer to the range of tools that government and its agencies have at their disposal to direct, manage, and shape change in public services.^{5,6} Included in this toolkit are: governing or enabling legislation (laws); subordinate legislation such as regulations, orders, directives, bylaws, and proclamations; and, anything that provides cues to action by those who manage and deliver

^a EHO is the term used in British Columbia. All have the Certificate in Public Health Inspection, or CPHI(C), designation. In other jurisdictions, they may be referred to as PHIs or EHOs.

public services (e.g., a government's over-arching goals and strategies, as articulated by targets or outcome measures in a service, business, or resource plan). The government or agency may use an individual lever or a combination of levers to achieve a particular public policy outcome.

For the purposes of this project, environmental health policy levers were divided into two categories: governing instruments and policy drivers.

- **Governing instruments** are those policy levers that only the government can make (legislation and subordinate legislation) and that are enforceable. In the context of environmental health, this includes the *Public Health Act* and any regulations made pursuant to it. Policy instruments are either prescriptive or outcomes- (i.e., performance-) based. Prescriptive instruments are inflexible—they set out the standard that must be met, as well as the method by which it must be met. In contrast, outcomes- or performance-based instruments are more flexible. They set out the standard that must be met, but allow the individual(s) or organization(s) being regulated to choose how they will meet the standard. Compliance with both prescriptive and outcomes-based instruments is enforced through mandated inspections and statutory reporting requirements. However, outcomes-based instruments allow EHOs to exercise their discretionary powers.
- **Policy drivers** are those policy levers that provide cues to action (e.g., government goals, strategic plans, frameworks, protocols). Policy drivers are not enforceable by law and tend to be outcomes- or performance-based (for example, they set out the government's targets and any associated performance measures or indicators of success, but don't direct the manner in which the targets are achieved). In the context of environmental health, policy drivers include any plans and strategies put forward by government departments with responsibility for public health, as well as any public health frameworks, standards, or protocols developed by government or public health agencies.

Environmental Scan Methodology

Scoping Exercise

The scope of the scan was delineated by the following terms: "environmental health practice" and "policy instruments" (or "policy levers"). For the purposes of this project:

- **EPH practice:**
 - refers to environmental health or health protection departments operating at the provincial, territorial, or regional level
 - includes the work of environmental health officers (EHOs), public health inspectors (PHIs), or medical health officers (MHOs)

- encompasses oversight of drinking water, recreational water, housing, health hazards, air quality, soil quality, food premises, personal services, and the built environment as they relate to public health
- **EPH policy instruments or levers include:**
 - governing or enabling public health legislation and any regulations made pursuant to the *Acts*
 - overarching goals and objectives of government ministries with responsibility and oversight of public health in Canada
 - business, resource, strategic, and/or service plans of government ministries and agencies with responsibility and oversight of public health (and more specifically environmental health)
 - public health frameworks, protocols, and standards developed or implemented at the provincial and/or regional level
 - documents created by entities responsible for environmental health at the provincial and/or regional level, including policies, guidelines, and standards

Policy Instrument Search

Policy instruments were identified and retrieved using: searches of official government websites; searches of legal information⁷ and environmental health legislation⁸ websites and public health portals, and a review of references or citations from selected documents published on equity and public health practice. Promising sites were bookmarked and any relevant documents were downloaded (when available in a downloadable format).

Within each jurisdiction, the starting point for the search was the official website of the ministry or department with provincial responsibility for or oversight of public health (typically, this was the Ministry of Health). Using the hyperlinks and search engines located within the official government website, any relevant documents were downloaded and webpages pertaining to public health were downloaded and/or bookmarked. For example, in British Columbia, this cascading search included the following websites: the Ministry of Health Service Plan,⁹ the Office of the Provincial Health Officer,¹⁰ aboriginal health,¹¹ laws related to health in BC,¹² the Queen's Printer,¹³ BC's health authorities¹⁴ (which, in turn, cascaded into a series of links and webpages about individual health authorities, such as Fraser Health¹⁵).

Internet searches were supplemented by a review of the reference lists of selected documents and articles to pick out any leads on other relevant policy levers. Examples include documents published on the NCCDH website: "Advancing provincial and territorial public health capacity for health equity: Proceedings"¹⁶ and "Alberta Health Services: Establishing a province-wide social determinants of health and health equity approach".¹⁷



Policy Instrument Scan

Every piece of public health legislation in Canada, as well as the regulations made pursuant to the *Acts* that fell under the environmental health service areas identified above, were carefully read to identify any reference (explicit or implied) to the social determinants of health or health equity/inequity. To ensure that any and all references to equity were captured, glossaries of health equity terminology were first consulted to ensure a thorough understanding of the definitions and to create a conceptual map of terms (Appendix B).^{3,18,19} To be consistent with the approach taken by the NCCDH, the terms were organized into the following four categories: health status, root causes, populations, and interventions.

Where a potential reference to equity was identified, the language of the relevant section was extracted verbatim and recorded (Appendix C, Tables C1 – C18). Each reference was first considered in light of the definitions of SDH and then categorized on the basis of the terms in the conceptual map. The specific reference was then highlighted in yellow and a notation was made of which of the four broad categories it fell into, along with the specific equity term that applied.

Key Informant Interviews

To gain insight on how these policy instruments may have influenced practice or how they were being practically applied, interviews were conducted with selected key informants. The objective of these interviews was to elucidate how these instruments had been operationalized. For example, what role did a particular policy instrument play in the development of a particular health equity tool or program? The interview format was semi-structured (Appendix A). Key informants were first given some context on the objectives of the environmental scan and then were asked to tell the story of their program or initiative. As the 30–60 minute interview unfolded, informants were prompted with questions about the history of their program (how did it happen, who was involved, what were their roles), the outcome of the process (where is it at now), and any challenges they faced.

Environmental Scan Data

Summary of Findings by Type of Policy Instrument

Detailed *cross-jurisdictional* summary tables were created for each type of policy instrument considered in the scan (Appendix C). Individual tables were created for:

- public health legislation (Table C1)
- regulations made pursuant to the public health acts (Tables C2–C9)

- over-arching government goals, as articulated on Ministry websites and in Ministry service, business or resource plans (Table C10)
- regional health authority goals, as articulated in business, service, or strategic plans (Tables C11–C14)
- provincial public health frameworks (Tables C15–C16)
- provincial public health protocols or standards (Tables C17–C18)

Governing Policy Instruments

Table 1, below, presents an overview of the findings of the scan of public health legislation and regulations in Canada.

Table 1: Summary of Governing Policy Instruments

✓ High-level reference to equity ✗ No reference to equity E Equity embedded in instrument		Reference to Equity in Public Health Governing Instruments Across Canada													
		Province or Territory													
No regulation in force (Note 3)		BC	AB	SK	MN	ON	QC	NL	NB	NS	PEI	YK	NWT	NU	
Governing Instrument	<i>Public Health Act</i>	✓	✗	✗	✓	✗	E	✗	✓	✗	✓	✗	✗	✓	
	Regulations made pursuant to <i>Public Health Act</i>														
	Food Premises	✓	✓	✓	✗	✓		✗	✗	✗	✓	✗	✓	✗	
	Communicable Diseases	✗	✓	✓	✗	✗	✓		✗	✗	✗	✗	✓	✗	
	Health Hazards	✗		✓	✗					✗					
	Recreational Water	✗	✗	✗	✗	✓		✓			✗	✓	✓	✓	
	Sewage & Sanitation												✓	✓	
	Housing		✗		✓										
Personal Services	✗	✗	✗	✗	✗	✗	✗	✗	✗		✗	✗	✗	✗	
Drinking Water/Water Supply															

Notes:

1. High-level reference to equity means that the policy instrument used some of the terminology in the health equity glossaries, but the reference was broad in nature. An example of a high-level reference is "to protect health and well-being".
2. Equity embedded in instrument means that equity is explicitly referenced throughout and that an equity lens has been applied to all aspects of the legislative instrument.
3. No regulation in force means that no regulation exists under this title, either because a specific regulation has not been made pursuant to the Public Health Act (e.g., housing in British Columbia) or because requirements are included in another regulation (e.g., drinking water requirements in Saskatchewan are covered under the Health Hazards Regulation).

As Table 1 (and the detailed tables in Appendix C) illustrate, there is considerable variation in the *governing policy* instruments across jurisdictions with regards to references to equity:

- Quebec is the only province in Canada that has deeply embedded equity throughout its *Public Health Act*.²⁰

- The *Public Health Acts* in British Columbia,²¹ Manitoba,²² New Brunswick,²³ Prince Edward Island,²⁴ and Nunavut²⁵ include high-level reference to equity.
- No mention of equity is made in the *Public Health Acts* of Alberta,²⁶ Saskatchewan,²⁷ Ontario,²⁸ Newfoundland and Labrador,²⁹ Nova Scotia,³⁰ the Yukon,³¹ and Northwest Territories.³²
- There are references to equity in some of the regulations made pursuant to the *Public Health Acts*, although again there is considerable variation.
- High-level reference to equity is made in regulations governing: food premises (British Columbia, Alberta, Saskatchewan, Ontario, Prince Edward Island, and the Northwest Territories)³³⁻³⁸; communicable diseases (Alberta, Saskatchewan, Quebec, and the Northwest Territories)³⁹⁻⁴³; health hazards (Saskatchewan)⁴⁴; recreational water (Ontario, Newfoundland and Labrador, Yukon, Northwest Territories, and Nunavut)⁴⁵⁻⁴⁹; sewage and sanitation (Northwest Territories and Nunavut)⁵⁰⁻⁵⁴; and housing (Manitoba)⁵⁵.
- No reference is made to equity in the regulations governing personal services,^{30,44,56-66} drinking water and water supply.^{44,67-69}

Policy Driving Instruments

Similar variation is seen in the *policy driving* instruments (i.e., the instruments that are generally cues for action by those who manage or deliver programs).

- High-level reference to equity appears in many provinces' overarching goals and objectives, as well as their provincial plans and strategies (typically in relation to the "well-being" of the population).
- Some provinces (e.g., British Columbia, Alberta, Saskatchewan, Ontario, Newfoundland and Labrador, New Brunswick, Prince Edward Island, and the Yukon) make reference to one or more of the social determinants of health (the most common reference is to indigeneity).
- Quebec is the only province with equity explicitly embedded into the mission of the Ministry of Health and Social Services.
- Some provinces have clearly applied an equity lens in the identification of their strategic goals, priorities, outcome measures, and indicators. However, in these cases equity is almost always referenced in regards to the delivery of health care services as opposed to public health programs.
- In some provinces, equity has been identified as a "priority public health outcome," but in all these cases, no corresponding measures or indicators have been identified.
- In the public health frameworks, protocols, and standards considered, equity is a foundational and cross-cutting issue that relates to every aspect of public health delivery and practice.
- This cross-cutting approach has been (or is being) adopted by several organizations across the country (for example, the Winnipeg Regional Health Authority) to operationalize equity in environmental health practice. (See pages 35–39 for additional information on these programs.)

Table 2 provides an example of how equity references appear in provincial Ministry of Health service/business plans across Canada and illustrate the variation in health equity terms used.



Table 2: Example of the Variation in Health Equity References in Ministry of Health Service Plans

<input type="checkbox"/> Explicit reference		Specific Equity Terms Referenced in Ministry of Health Business/Service Plans													
I Implied reference (Note 1)		Province or Territory													
No explicit or implicit reference		BC	AB	SK	MN	ON	QC	NL	NB	NS	PEI	YK	NWT	NU	
Equity Terms	Health Status														
	Health equity														
	Health inequity								<input type="checkbox"/>						
	Health inequality														
	Health disparity			<input type="checkbox"/>											
	Wellness		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Well-being	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Root Causes														
	Risk factors												<input type="checkbox"/>		
	Risk conditions														
	Advantage/disadvantage											I			
	Socioeconomic/economic							<input type="checkbox"/>							
	Environment	<input type="checkbox"/>								<input type="checkbox"/>			<input type="checkbox"/>		
	Social determinants														
	- Gender														
	- Race/ethnicity														
	- Indigeneity	<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>				
	- Disability									<input type="checkbox"/>					
	- Security (income/food/housing)						I								
	- Social safety net							<input type="checkbox"/>							
	- Social inclusion/exclusion									I			<input type="checkbox"/>		
	- Assets/deficits														
	Populations														
	Marginalized														
	Vulnerable/Hard to serve												<input type="checkbox"/>		
	At risk														
	Low income						<input type="checkbox"/>								
	Diverse										<input type="checkbox"/>				
	Special needs											<input type="checkbox"/>			
	Interventions														
	Leveling up														
	Closing the gap			<input type="checkbox"/>											
Upstream/downstream															
Targeting within universalism															
Universal delivery															
Asset/strength based approach															

Notes:

1. Implied reference to equity means that the policy driver did not explicitly use a term listed in the glossaries, but it used terminology that could be interpreted as a synonym for equity. For example, the Ontario service plan states "The province will further promote healthy behaviours by: making it easier for children in low-income families to get dental care through a single integrated program." The reference to low-income families was flagged as an implicit reference to the social determinant of income security and vulnerable or at-risk populations.

Summary of Findings by Jurisdiction

The section presents summary tables that were created to indicate which particular policy instrument *within* a jurisdiction made reference to equity. These summaries show the connections between the various categories of policy instruments and highlight where an upstream policy instrument (or priorities and imperatives at the political level) may have led to equity being incorporated in downstream policy instruments or practice.

British Columbia

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	Sections 3(1) and 61 of the <i>Public Health Act</i> make high-level reference to equity. Section 3(1) sets out the discretionary authority of the minister to require public bodies to make a public health plan. Section 61 mandates what the minister must do in regards to the health of British Columbians and to advising government on those actions of government that may impact on public health. ²¹
Regulation	Section 1(1) of the <i>Food Premises Regulation</i> makes an implicit reference to food security and vulnerable populations in its definition of “food bank.” Section 2 then provides an exemption to food banks for compliance with the <i>Regulation</i> . ³⁸

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Policy Drivers at the Provincial Level	
Overarching Objectives & Priorities	No reference to equity is made in the Ministry’s overarching goal: “to deliver accessible and responsive health care services guided by the needs of patients, while achieving the best value for the health care dollar.”
Strategic/Service Plans	Goals 1 and 2 of the <i>Ministry of Health Service Plan 2015/16 – 2017/18</i> make high-level reference to incorporating equity into the Ministry’s strategic objectives and priorities . Goal 1 (“Support the health and well-being of British Columbians”) explicitly references health status (well-being) and implicitly references root causes (environments). Goal 2 (“Deliver a system of responsive and effective health care services across British Columbia”) explicitly addresses root causes (social determinants of health, specifically indigeneity). ⁹



Policy Driver	Reference to Equity
<p>Frameworks</p>	<p>Equity is embedded in “<i>Promote, Protect, Prevent: Our Health Begins Here, BC’s Guiding Framework for Public Health</i>”.⁷⁰ Explicit reference is made in the overarching goals, as well as specific strategic goals and outcomes, to: health status (wellness, well-being, health equity, health inequity), root causes (risk factors, risk conditions, environment, disadvantage, indigeneity, rural/remote), populations (vulnerable, at risk, disadvantaged), and interventions (closing the gap, targeting within universalism).</p>
<p>Programs & Initiatives</p>	<p>HealthyFamilies BC is a provincial strategy, housed within the Ministry of Health, aimed at improving the health and well-being of British Columbians at every stage of life. Guided by BC’s <i>Guiding Framework for Public Health</i>⁷⁰ and the <i>Healthy Families Policy Framework</i>,⁷¹ HealthyFamilies BC acts as a resource, as well as provides leadership and direction on health promotion activities. It is not responsible for implementation. The regional health authorities have the responsibility for implementing health promotion plans and programs and for evaluating their effectiveness. As part of its Healthy Communities initiative, HealthyFamilies BC has partnered with employers, schools, and local governments to work on plans that will help British Columbians to live healthier lifestyles. Pages 33–35 of this report discuss how the Northern Health Authority has incorporated equity into environmental health practice through the Healthy Communities program.</p>
<p>Policy Drivers at the Provincial Level – Provincial Health Services Authority</p>	
<p>Overarching Objectives & Priorities</p>	<p>No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of the PHSA, as articulated by its vision and mission statements. “<u>Vision</u>: Province-wide solutions. Better health. <u>Mission</u>: To improve the health of the population by: delivering quality health services; coordinating and setting standards for selected province-wide specialized services; leading system-wide improvements and creating province-wide partnerships; implementing populations and public health initiatives; advancing research and practically applying it to improve patient care, decision-making and planning; creating a learning culture by promoting the development of health care professionals through a commitment to excellence in education and training.” A high-level reference to equity is made in one of the PHSA’s guiding values: “We strive to provide value from the patient’s perspective which means timely and equitable access to specialty and province-wide services and better health outcomes for all citizens of BC.”</p>



Policy Driver	Reference to Equity
Strategic/Service Plans	The PHSA developed its <i>2015/16 – 2017/18 Service Plan</i> to align with the Ministry of Health’s three goals for the BC healthcare system: “support the health and wellbeing of British Columbians; deliver a system of responsive and effective health care services across British Columbia; and ensure value for money”. ⁷² Reference to equity appears throughout the service plan, in the objectives and strategies identified to achieve the goals, as well as in the rationale for their proposed approach. Reference is made to: health status (well-being), root causes (socioeconomic, social determinants – indigeneity), populations (vulnerable, at risk, high risk, remote/rural, hard to reach, marginalized, geographically remote), and interventions (targeting within universalism, downstream).
Frameworks	No frameworks were identified for review.
Programs & Initiatives	No PHSA programs and initiatives were selected for review.
Policy Drivers at the Provincial Level – First Nations Health Authority (FNHA)	
Overarching Objectives & Priorities	Equity is embedded into the role of the FNHA: “The First Nations Health Authority aims to reform the way health care is delivered to BC First Nations to close these gaps and improve health and wellbeing. We work with the province and First Nations to address service gaps through new partnerships, closer collaboration, and health systems innovation.”
Strategic/Service Plans	The First Nations Perspective on Health and Wellness underpins the strategic goals, strategies, objectives, and key deliverables set out in <i>Looking Forward</i> , the FNHA’s <i>2015/2016 FNHA Summary Service Plan</i> . ⁷³ The First Nations Perspective on Health and Wellness is a holistic vision of health and wellness that incorporates the social determinants of health . It is visually depicted by five concentric circles that represent the interconnectedness of the individual (the inner circle); the balance between the mental, emotional, spiritual, and physical (the second circle); the overarching values that support and uphold wellness: respect, wisdom, responsibility, and relationships (the third circle); the people that surround us and the places from which we come: nations, family, community, and land (the fourth circle); and, the social, cultural, economic and environmental determinants of health and well-being (the fifth and outer circle).
Frameworks	No frameworks were selected for review.
Programs & Initiatives	No FNHA programs and initiatives were selected for review.
Policy Drivers at the Regional Level – Fraser Health (FH)	
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of FH, as articulated by its vision and mission statements. “ <u>Vision</u> : Better health. Best in health care. <u>Mission/Purpose</u> : To improve the health of the population and the quality of life of the people we serve.”

Policy Driver	Reference to Equity
Strategic/Service Plans	In its <i>2014/15 – 2016/17 Strategic and Operational Plan</i> , ⁷⁴ FH makes implicit reference to equity in two of its ten strategic priority areas : public health measures (strategic priority 3) and patient centeredness (strategic priority 6). Reference is made to roots causes (social determinants: diversity) and populations (vulnerable, diverse).
Frameworks	No frameworks were identified for review.
Programs & Initiatives	FH’s approach to embedding equity within the organization is discussed on pages 32–33 of this report.
Policy Drivers at the Regional Level – Interior Health (IH)	
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of IH, as articulated by its vision and mission statements. <u>Vision</u> : To set new standards of excellence in the delivery of health services in the Province of British Columbia. <u>Mission</u> : Promote healthy lifestyles and provide needed health services in a timely, caring, and efficient manner, to the highest professional and quality standards.”
Strategic/Service Plans	IH’s <i>2015/16 – 2017/18 Service Plan</i> aligns with the Ministry of Health’s three goals for the BC healthcare system: “support the health and wellbeing of British Columbians; deliver a system of responsive and effective health care services across British Columbia; and ensure value for money”. ⁷⁵ Explicit reference to equity is made in Goal 1 (health status: wellness) and in the strategies/objectives identified to achieve Goal 1 (health status: wellness, inequity; root causes: environment, social determinants - indigeneity). Implicit reference is made in Goal 2 (populations: vulnerable, at risk).
Frameworks	No frameworks were identified for review.
Programs & Initiatives	No IH programs and initiatives were selected for review.
Policy Drivers at the Regional Level – Island Health (VIHA)	
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of VIHA, as articulated by its vision and mission statements. <u>Vision</u> : Excellent health and care for everyone, everywhere, every time. <u>Mission/Purpose</u> : To provide superior health care through innovation, teaching and research, and a commitment to quality and safety—creating healthier, stronger communities and a better quality of life for those we touch.”

Policy Driver	Reference to Equity
Strategic/Service Plans	The strategic goals and priorities outlined in VIHA's 2015/16 – 2017/18 Service Plan align with the Ministry of Health's three goals for the BC healthcare system: "support the health and wellbeing of British Columbians; deliver a system of responsive and effective health care services across British Columbia; and ensure value for money". ⁷⁶ Reference to equity appears throughout the service plan , in the objectives and strategies identified to achieve the goals, as well as in the rationale for their proposed approach. Reference is made to: health status (well-being, wellness, inequity, disparity), root causes (risk factors, social determinants – indigeneity), and populations (vulnerable, at risk).
Frameworks	No frameworks were identified for review.
Programs & Initiatives	No VIHA programs and initiatives were selected for review.
Policy Drivers at the Regional Level – Northern Health (NH)	
Overarching Objectives & Priorities	One reference to equity (populations: rural) is found in the overarching goals of NH, as articulated by its vision and mission statements. " <u>Vision</u> : Northern Health leads the way in promoting health and providing health services for Northern and rural populations. <u>Mission</u> : Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners."
Strategic/Service Plans	NH applied an equity lens in the development of its 2015/16 – 2017/18 Service Plan . ⁷⁷ In planning for the services it will provide, NH applied an equity lens to the environmental factors that frame its strategic context: rural/remote populations, socio-economic, variations in health status, aboriginal peoples and communities . Explicit reference is made to: health status (well-being), root causes (social determinants – indigeneity), and populations (rural/remote, vulnerable, at risk) .
Frameworks	No frameworks were identified for review.
Programs & Initiatives	The NH's approach to embedding equity into environmental health practice, and how it relates to its Healthy Communities Strategy in particular, is discussed on pages 33–35 of this report.
Policy Drivers at the Regional Level – Vancouver Coastal Health (VCH)	
Overarching Objectives & Priorities	A high-level reference to equity (health status: wellness) is found in the overarching goals of VCH, as articulated by its vision and mission statements. " <u>Vision</u> : We will be leaders in promoting wellness and ensuring care by focusing on quality and innovation. <u>Mission</u> : We are committed to supporting healthy lives in healthy communities with our partners through care, education and research."



Policy Driver	Reference to Equity
Strategic/Service Plans	The strategic goals and priorities outlined in VCH's <i>2015/16 – 2017/18 Service Plan</i> align with the Ministry of Health's three goals for the BC healthcare system: "support the health and wellbeing of British Columbians; deliver a system of responsive and effective health care services across British Columbia; and ensure value for money". ⁷⁸ A number of references to equity appear throughout the service plan. Reference is made to: health status (well-being, health inequity, health disparity), root causes (risk factors, indigeneity, disability), and populations (rural/remote, vulnerable, at risk, marginalized).
Frameworks	No frameworks were identified for review.
Programs & Initiatives	No VCH programs and initiatives were selected for review.

Alberta

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	No reference to equity is made in the <i>Public Health Act</i> . ²⁶
Regulation	<ul style="list-style-type: none"> Section 1(1)(q) of the <i>Food Regulation</i> makes an implicit reference to food security and vulnerable populations in its definition of "food bank." Section 1(1)(ss) makes an implicit reference to vulnerable populations in its definition of "social care facility." Section 2 then clarifies the application of the <i>Regulation</i> to social care facilities, by granting an exemption from compliance for those facilities providing care to fewer than 10 people.³⁵ Section 1(m.1) of the <i>Communicable Diseases Regulation</i> makes explicit reference to marginalized populations and implicit reference to income security in its definition of "institution." Section 1(s) makes implicit reference to the social safety net in its definition of "public place." Schedule 4 to the <i>Regulation</i> references vulnerable and at-risk populations when prescribing actions to be taken by medical officer of health in regards to controlling the spread of specific communicable diseases (diphtheria, enteric infections, hepatitis B, pertussis, and typhoid or paratyphoid).³⁹

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of Alberta Health, as articulated by its vision and mission statements. " <u>Vision</u> : Healthy Albertans in a healthy Alberta. <u>Mission</u> : to ensure that Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams."

Strategic/Service Plans	Desired Outcomes 1 (“Improved health outcomes for all Albertans”) and 2 (“The well-being of Albertans is supported through population health initiatives”) of the Ministry of Health’s <i>Business Plan 2015–18</i> make high-level reference to achieving equity in outcomes . Health status (well-being, wellness) is explicitly referenced in priority initiatives aimed at achieving both desired outcomes. Priority Initiative 2.6 implicitly addresses indigeneity as a social determinant of health (“Develop initiatives with Aboriginal partners and the federal government to improve health services”). ⁷⁹
Frameworks	Equity is embedded in both Alberta’s “Strategic Approach to Health and Wellness”⁸⁰ and “Social Policy Framework”. ⁸¹ These frameworks make explicit reference in the overarching goals, as well as in the specific strategic goals and outcomes, to: health status (wellness, equity, inequality), root causes (risk factors, risk conditions, socioeconomic, environment, disadvantage, indigeneity, social inclusion, income/food/housing security, social safety net), and populations (vulnerable, at risk).
Programs & Initiatives	No provincial programs and initiatives were selected for review.

Saskatchewan

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	No reference to equity is made in the <i>Public Health Act</i> . ²⁷
Regulation	<ul style="list-style-type: none"> • Section 2(1) of <i>The Food Safety Regulations</i> makes explicit reference to vulnerable populations and implicit reference to food insecurity in its definition of “food banks.” Section 5(2) subsequently exempts “food banks” from the licensing requirements of the <i>Regulations</i>.³⁶ • Sections 14(2) and 15(2) of <i>The Disease Control Regulations</i> makes implicit reference to root causes (risk factors) and explicit reference to gender and race/ethnicity. These sections set out information required in reports of communicable diseases from physicians and clinic nurses and from anonymous test sites.⁴¹ • The social determinants of health (social safety net) and vulnerable populations are implicitly identified in Section 3(1) of <i>The Health Hazard Regulations</i>. This section sets out that the requirements and duties of operators of public water supplies apply to facilities defined by Section 3(1).⁴⁴



Reference to equity in policy drivers

Policy Driver	Reference to Equity
Policy Drivers at the Provincial Level	
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of the Ministry of Health, as articulated by its vision and mission statements. " <u>Vision</u> : Healthy People, Healthy Communities. <u>Mission</u> : The Saskatchewan health care system works together with you to achieve your best possible care, experience and health."
Strategic/Service Plans	The Ministry of Health and Health System explicitly addresses equity in its <i>Plan for 2015–16</i> . ⁸² The Ministry has set a goal, which was identified in support of the <i>Saskatchewan Plan for Growth</i> , to improve population health through health promotion, protection and disease prevention, and collaborating with communities and different government organizations to close the health disparity gap. ⁸³ A number of key actions have been identified to achieve this goal, but none relate to environmental health practice.
Frameworks	The Saskatchewan Disability Framework (" <i>People Before Systems: Transforming the Experience of Disability in Saskatchewan</i> ") includes explicit reference to equity . ⁸⁴ Its overarching goals, specific strategies and outcomes refer to: root causes (risk conditions and social determinants such as race/ethnicity, disability, indigeneity and social inclusion), and interventions (closing the gap).
Programs & Initiatives	No programs and initiatives were identified at the provincial level that explicitly relate to environmental health practice.
Policy Drivers at the Regional Level – Saskatoon Health Region	
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of the Health Region, as articulated by its vision and mission statements. " <u>Vision</u> : Healthiest People, Healthiest Communities, Exceptional Service. <u>Mission</u> : We improve health through excellence and innovation in service, education and research, building on the strengths of our people and partnerships."
Strategic/Service Plans	Equity is embedded in the Health Region's 2013-2015 Strategic and Operational Plan . ⁸⁵ In its purpose statement, the Region identifies six ways to enhance the health and well-being of the population. One is by achieving health equity, another is by addressing health inequities. Health equity is also a cross-cutting element of the values and principles that guide the Region's plan. While the plan outlines specific strategies, outcomes, and indicators to achieve its purpose, all are focused on the delivery of health care services (as opposed to public health programs).



Policy Driver	Reference to Equity
Programs & Initiatives	<p>Formed in early 2008, the Saskatoon Health Region Public Health Observatory (PHO) brought together the Population Health Surveillance department, Public Health Services, and the Population Health Research Unit of the Office of the Chief Medical Health Officer. Its surveillance, research, and knowledge transfer activities inform policy, support decision-making and influence practice efforts to improve health and address health disparities within the Saskatoon Health Region. The PHO, which applies an equity lens to all of its work, has undertaken some evaluation work in Environmental Health (primarily in restaurants) and is working with regional partners to develop a health equity position statement that will inform future work across Public Health and the Health Region as a whole. The key informant acknowledged that, in light of legislation governing public health practice, taking an equity approach can be challenging. The PHO has drafted a policy/procedure for home visits that allows the Region to continue to provide service to higher risk clients while ensuring they are doing so in a safe way for their staff (which includes EH practitioners).</p>

Manitoba

Reference to equity in governing instruments

Instrument	Reference to Equity
Legislation	<p>Sections 2 and 4 of <i>The Public Health Act</i> make high-level reference to health status (well-being). These sections set out the purpose of the <i>Act</i> and the minister’s authority under the <i>Act</i>.²²</p>
Regulation	<p>Implicit reference to the social determinants of health is made in Section 1 (Definitions), Section 6 (Size Requirements), Section 14 (Requirements for a multiple family dwelling, lodging house or rooming house), and Section 16 (Requirements to operate an apartment house, lodging house or rooming house) of the <i>Dwellings and Buildings Regulation</i>.⁸⁶</p>

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Policy Drivers at the Provincial Level	
Overarching Objectives & Priorities	<p>One high-level reference to equity is found in the overarching goals of Manitoba Health, Healthy Living, and Seniors. “Vision: Healthy Manitobans through an appropriate balance of prevention and care. Mission: To meet the health needs of individuals, families and their communities by leading a sustainable, publicly administered health system that promotes well-being and provides the right care, in the right place, at the right time.”⁸⁷</p>



Policy Driver	Reference to Equity
Strategic/Service Plans	Equity is embedded into the Department’s <i>Resource Plan</i> . One of its six priorities explicitly addresses equity: to improve health status and reduce health disparities in the province (Priority 6). In addition, the objectives identified to achieve two of its six priorities (Priority 3: health system sustainability and Priority 5: improved service delivery) make high-level reference to health status (well-being) and root causes (risk conditions and indigeneity) .
Frameworks	The connection between equity and health is implicitly made in <i>All Aboard: Manitoba’s Poverty Reduction and Social Inclusion Strategy</i> . Equity is referenced in the strategic priorities and objectives outlined under each of the four pillars of the framework. Included are references to: root causes (risk conditions and social determinants such as gender, race/ethnicity, disability, indigeneity, income and housing security, social inclusion/exclusion), populations (vulnerable, at risk), and interventions (closing the gap). ⁸⁸
Programs & Initiatives	A number of programs and initiatives have been undertaken to support the poverty reduction strategy. None explicitly fall under the umbrella of environmental health practice, although opportunities may exist for transferable lessons.
Policy Drivers at the Regional Level – Case Study: Winnipeg Regional Health Authority (WRHA)	
Overarching Objectives & Priorities	Equity is embedded in the mission, vision, values, and strategic direction of the WRHA. In addition, the WRHA has issued a position statement articulating its health equity mission, and values. ⁸⁹
Strategic/Service Plans	Equity is a core element of the <i>Winnipeg Regional Health Authority Strategic Plan 2016 – 2021</i> . ²⁶ Addressing health inequities and improving health equity is explicitly articulated in both the strategic direction and the operational strategies of the organization. Equity is being operationalized through two approaches: a “pre-determinant” approach (e.g., a formalized committee with a structured mandate) and an emergent approach (e.g., seizing opportunities to bring equity forward as they arise).
Frameworks	<i>Health for All: Building Winnipeg’s Health Equity Action Plan</i> articulates a framework for understanding and addressing health equity and offers up key considerations for action in 12 cross-cutting areas. ⁹⁰
Programs & Initiatives	The WRHA has created three cross-cutting service areas to support the inclusion of equity/application of an equity lens into all programmatic areas . They are: Health Equity Promotion, Healthy Built Environment, and a newly created area, Healthy Public Policy.

Ontario

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	No reference to equity is made in the <i>Health Protection and Promotion Act</i> . ²⁸
Regulation	<ul style="list-style-type: none"> Section 40(3) of the <i>Food Premises Regulation</i> exempts an indigenous health, wellness and well-being centre from the requirements governing meat and meat products. Specifically, it allows the centre to serve uninspected wild game meat, provided certain conditions are met.³⁴ Section 2(vi) of the <i>Public Pools Regulation</i> explicitly references vulnerable populations in its classification of public pools. Sections 6, 17 and 19 then set out the obligations of the owner/operator and the requirements to protect public safety in the class of pools operated in conjunction with facilities serving these vulnerable populations. Equity is implied in the application of these requirements, but is not explicitly stated.⁴⁷

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Policy Drivers at the Provincial Level	
Overarching Objectives & Priorities	No overarching goals, as articulated by a vision or mission statement, were identified on the Ministry of Health and Long-Term Care's website.
Strategic/Service Plans	The Ministry's <i>2015–16 Plan</i> makes high-level reference to health status (well-being), social determinants of health (income security), and populations (low income) in regards to outcomes . ^a
Frameworks	Equity is explicitly referenced in Public Health Ontario's 2014–2019 Strategic Plan, " <i>Evidence, knowledge and action for a healthier Ontario</i> ". ⁹¹ Included are references to: health status (health inequality, health inequity), root causes (risk factors, risk conditions and social determinants of health), and populations (priority populations).
Standards & Protocols	The <i>Ontario Public Health Standards</i> (OPHS) were published in 2008 (revised in October, 2015) as guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the <i>Health Protection and Promotion Act</i> . ⁹² Equity is a cross-cutting issue that underpins the foundational principles of the Standards . The social determinants of health are explicitly mentioned in the principles of need and impact. High-level reference to equity appears in the goal of the foundational standard (health status: well-being). While the concept of equity underpins the Standards as a whole, there is no explicit mention of it in the Environmental Health Standards .
Programs & Initiatives	No provincial programs and initiatives were selected for review.

^a Available from: <http://www.health.gov.on.ca/en/common/ministry/publications/plans/ppar15/#1.1>



Policy Driver	Reference to Equity
Policy Drivers at the Regional Level – Case Study: Simcoe-Muskoka District Health Unit	
Overarching Objectives & Priorities	Reference to equity is implicit in the health unit’s vision and mission statements, and explicit in its values and strategic priorities. “ <u>Vision</u> : The people who live, work and play in Simcoe Muskoka lead healthy, fulfilling and productive lives. <u>Mission</u> : As champions of health for all, the Simcoe Muskoka District Health Unit works with individuals, families, agencies and communities to promote and protect health, and to prevent disease and injury.”
Strategic/Service Plans	The health unit articulates four strategic priority areas of focus, supported by nine strategic objectives to measure progress, in its <i>2016–2017 Strategic Plan</i> . ⁹³ The “Determinants of Health” is one of the four strategic priority areas of focus. Equity is explicit in the specific strategy identified: “address the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes.” It is also explicit in the two outcomes identified to support this strategy: “implement the agency action plan to meet the public health needs of individuals and families living in low income; assess populations at risk of health inequities and identify those that require an agency response.”
Programs & Initiatives	Communicable Diseases Exclusion Period (finding flexible solutions) (see pages 43–45).
Policy Drivers at the Regional Level – Case Study: Sudbury & District Health Unit	
Overarching Objectives & Priorities	While equity is not explicitly mentioned in its overarching vision and mission statements, the health unit has adopted a Health Equity Vision. “ <u>Vision</u> : Healthier communities for all. <u>Mission</u> : Working with our communities to promote and protect health and to prevent disease for everyone.” “ <u>Sudbury & District Health Unit Health Equity Vision – 2020</u> : The Sudbury & District Health Unit will work to improve the overall health and health equity of area citizens so that: <ul style="list-style-type: none"> • systemic and avoidable health disparities are steadily reduced and the gap in health between the best and worst off is narrowed; • all citizens have equal opportunities for good health and well-being; and • all citizens have equitable access to a full range of high quality public health programs and services.”
Strategic/Service Plans	While equity is not explicitly mentioned in the health unit’s overarching goals, it is embedded in the five strategic priorities outlined in its <i>Strategic Plan: 2013 to 2017</i> . ^a These five priorities reflect the essential concepts of public health practice (includes community engagement, relationships, evidence-informed practice, health equity, and public health workforce adaptability and flexibility) and make explicit reference to health equity and the social determinants of health. The <i>2013 to 2017 Performance Monitoring Plan</i> reports on the health unit’s progress towards achieving its strategic goals ⁹⁴ . Pages 40–42 and 46–48 discuss how equity has been embedded across the organization and provide an example of how equity has been operationalized into environmental health practice.
Programs & Initiatives	Accommodating people with disabilities in the Food Handler Training and Certification Program (see pages 46–48).

^a Available from: <https://www.sdhu.com/about/strategic-plan-2013-2017>



Policy Driver	Reference to Equity
Policy Drivers at the Regional Level – Case Study: York Region	
Overarching Objectives & Priorities	Equity is not explicitly mentioned in the region’s overarching goals. “ <i>Vision 2051: Creating strong, caring and safe communities.</i> ”
Strategic/Service Plans	The Region articulates four strategic priority areas of focus, supported by 16 strategic objectives to measure progress, in its <i>2015 to 2019 Strategic Plan: From Vision to Results</i> . ⁹⁵ Achieving health equity (health status: well-being) forms the basis of one of the strategic priority areas. One of the strategic objectives identified to support this focus area is “protecting public health.” One of the key performance measures relates to the practice of environmental health: maintain percentage of samples that meet Ontario drinking water standard. Neither the strategic objectives nor the performance measures explicitly mention health equity, although it is implicit in another strategic objective and its associated performance measure (affordable housing and social services for vulnerable populations).
Programs & Initiatives	Accommodating people with disabilities in the Food Handler Training and Certification Program (see pages 46–48).

Quebec

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	<ul style="list-style-type: none"> Two pieces of public health legislation have been promulgated in Quebec: the <i>Public Health Act</i>²⁰ and <i>An Act Respecting Health Services and Social Services</i>. Explicit reference to equity is made throughout the <i>Public Health Act</i>. The purpose of the Act references health status and root causes, such as the social determinants of health, socioeconomic status, and risk factors. Chapter II of the Act sets out the requirements related to a national public health program (see below), as well as regional and local public health action plans. This Chapter explicitly references health status, root causes, and populations in relation to the elements required in these programs/plans and the minister’s obligations under the Act. Similar explicit references to equity are found in Chapters IV (Ongoing Surveillance), V (Collection of Information and Registries), VI (Health Promotion and Prevention), IX (Compulsory Treatment and Prophylactic Measures for Certain Contagious Diseases or Infections), and XI (Powers of Public Health Authorities and the Government in the Event of a Threat to the Health of the Population). <i>An Act Respecting Health Services and Social Services</i> sets out requirements for health services and social services plans, and establishes an organizational structure of human, material, and financial resources designed to achieve the Act’s objectives. Equity is firmly embedded in the Act through explicit reference to root causes (risk factors, social determinants) and interventions (closing the gap).

Regulation	Division I of <i>A Regulation under the Public Health Act (c. S-2.2, r.1)</i> lists criteria that the Minister of Health and Social Services must observe when drawing up a list of intoxications, infections and diseases pursuant to Sections 79 and 83 of the <i>Public Health Act</i> . References to equity in this Regulation address root causes (risk factors, environment). ⁴⁰
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Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	The mission statement of the Ministère de la Santé et des Services Sociaux makes high-level reference to health status (well-being) and root causes (economic and social safety net) . " <u>Mission</u> : to maintain and improve the health and well-being of people in Québec by making a range of integrated and quality health and social services accessible to all in order to contribute to the social and economic development of Québec."
Strategic/Service Plans	<ul style="list-style-type: none"> • Equity has been a strategic priority of the Québec government for over a decade. In 2003, the government adopted and committed to implementing the <i>Québec Public Health Program 2003 – 2012</i>, which set out a comprehensive action plan (objectives, activities, strategies, measures and indicators by core areas of public health practice) to address the physical and social determinants of health.⁹⁶ • Some of the activities and strategies identified to incorporate equity into environmental health practice included: harmonizing practices related to epidemiological investigations (of drinking water contamination, water-borne diseases, environmental poisonings, and indoor air quality); preventing and raising awareness about asthma, skin cancers, seasonal allergies, and problems linked with air quality; assessing the consequences of environmental projects; and, developing an emergency environmental plan (that included activities related to nuclear, biological and chemical hazards as well as to the management of risks of industrial accidents). Intersectoral collaboration was identified as a key activity.^{96(pp.57-61)}
Frameworks	<i>The Public Health Act</i> and <i>Québec Public Health Program 2003 – 2012</i> set out Québec's over-arching public health framework.
Programs & Initiatives	No programs and initiatives were selected for review.



Newfoundland and Labrador

Reference to equity in governing instruments

Instrument	Reference to Equity
Legislation	No reference to equity was made in the <i>Health and Community Services Act</i> . ²⁹
Regulation	Section 4(1)(a)(vi) of the <i>Public Pools Regulation</i> explicitly references vulnerable populations in its classification of public pools . ⁴⁹ The remaining sections set out the manner in which these pools are to be constructed, equipped and operated to protect public safety. Equity is implied in the application of these requirements , but is not explicitly stated.

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	A high-level reference to health status (well-being) is found in the overarching goals of the Department of Health and Community Services, as articulated by its vision and mission statements. " <u>Vision</u> : individuals, families and communities achieving optimal health and well-being. <u>Mission</u> : to provide leadership to support an enhanced health care system that effectively serves the people of the province and helps them achieve optimal health and well-being."
Strategic/Service Plans	The Department of Health and Community Services makes high-level reference to health status (wellness) in its <i>Strategic Plan 2014–2017</i> . ⁹⁷ Indigeneity as a social determinant of health is identified as a strategic focus area.
Frameworks	Equity is explicitly referenced in <i>Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015-2025</i> . The actions identified to achieve Objective 1.3 ("Consider and address the social determinants of health when assessing the ability of an individual, family, or community to meet goals of care or improve health and well-being") reference: health status (well-being), root causes (social determinants of health), populations (vulnerable, at-risk, under-served), and interventions (universal access). The <i>Framework</i> sets out a model for integrating the social determinants of health into primary health care. Public health programming and practice are not considered in the model.
Programs & Initiatives	No programs or initiatives were selected for review.



New Brunswick

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	Explicit reference to health status (well-being) is made in Sections 57 and 58 of the <i>Public Health Act</i> . Section 57 sets out the discretionary authority of the Minister to protect the health and well-being of the population by any means and Section 58 gives the Minister discretionary authority to enter into agreements (subject to approval of the Lieutenant-in-Council). ²³
Regulation	No explicit or implicit reference to equity or the social determinants of health is found in the Regulations made pursuant to <i>The Public Health Act</i> .

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals, as articulated by the government's vision statement. " <u>Vision</u> : Moving New Brunswick Forward."
Strategic/Service Plans	All of the five key goals put forward in <i>Rebuilding Health Care Together – The Provincial Health Plan 2013–2018</i> explicitly reference equity. ⁹⁸ Goals 2 and 3 explicitly mention health status (well-being, wellness). In addition to wellness, Goal 5 addresses health equity. Goals 1, 2 and 4 address root causes, like environment and the social determinants of health (social exclusion). Strategic initiatives address health inequities and indigeneity as a social determinant of health.
Frameworks	<ul style="list-style-type: none"> <i>Above and Beyond Together</i>, the 2012–2015 Strategic Plan of the Office of the Chief Medical Officer of Health makes explicit reference to equity in its over-arching goals, specific strategies, and outcomes.⁹⁹ Included are references to: health status (health inequity), root causes (risk factors, risk conditions, environment, socioeconomic and social determinants of health, such as indigeneity), and populations (at risk, vulnerable). The link between poverty, social inclusion, and health is made in <i>Overcoming Poverty Together. The New Brunswick Economic and Social Inclusion Plan 2014–2019.</i>¹⁰⁰ Equity is explicitly referenced in its vision, values and guiding principles and is addressed by its strategic goals and objectives. Included are references to: health status, root causes (socioeconomic, economic, and social determinants of health, such as indigeneity, social inclusion, and income security), and populations (marginalized, vulnerable).
Programs & Initiatives	No programs and initiatives were identified at the provincial level that explicitly relate to environmental health practice.



Nova Scotia

Reference to equity in governing instruments

Instrument	Reference to Equity
Legislation	No reference to equity is made in the <i>Health Protection Act</i> . ³⁰
Regulation	No explicit or implicit reference to equity or the social determinants of health is found in the Regulations made pursuant to the <i>Health Protection Act</i> .

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	No explicit or implicit reference to equity or the social determinants of health is found in the overarching goals of the Department of Health and Wellness, as articulated by its vision and mission statements. <i>“Vision:</i> an innovative and sustainable health system for generations of healthy Nova Scotians. <i>Mission:</i> to provide leadership to the health system for the delivery of care and treatment, prevention of illness and injury, and promotion of health and healthy living.”
Strategic/Service Plans	Health System Goal #1 of the Department’s <i>Statement of Mandate 2015–2016</i> makes high-level reference to health status (wellness) and diverse populations . ¹⁰¹
Frameworks	No public health frameworks were identified.
Standards & Protocols	<ul style="list-style-type: none"> The <i>Nova Scotia Public Health Standards</i> establish the expectations for public health at the provincial and regional (District Health Authority) levels.¹⁰² Equity is a cross-cutting issue that underpins the standards. Reference to health equity, social justice, and the social determinants of health appears throughout (e.g., in the purpose statement, the guiding principles, and the foundational standard that underpins the <i>Standards</i> as a whole). Equity is explicitly identified as an integral aspect of environmental health practice in the requirements of the Environmental Health Standard (quoted verbatim, below): <ul style="list-style-type: none"> Public health conducts population health assessment and surveillance seeking understanding regarding environmental health issues identifying the existence and impact of inequalities/inequities and priority populations. Public health strategically conducts policy analysis and seeks policy change to improve environmental health: <ul style="list-style-type: none"> Identifies and addresses information gaps Considers the needs of priority populations Develops policies and positions that support an upstream approach to environmental health Considers and acts on unintended impacts of existing legislation and policies



	<ul style="list-style-type: none"> – Ensure relevant evidence/information is available to inform the development and modification of legislation – Supports equitable distribution of environmental health services.
Programs & Initiatives	No provincially delivered environmental health programs and initiatives were selected for review.

Prince Edward Island

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	Explicit reference to health status (well-being) and root causes (social determinants—disability) is made in Section 3(1) of the <i>Public Health Act</i> . ²⁴ This section sets out the discretionary authority of the Minister to protect the health and well-being of the population by any means.
Regulation	Sections 1 of <i>Food Premises Regulations</i> make explicit reference to vulnerable populations and to food insecurity in its definition of “food banks” . ³³ Section 2(1) subsequently exempts “food banks” from the requirements of the <i>Regulations</i> . Section 26(4) gives the Director discretion to authorize the use of uninspected wild game for food bank donations.

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Policy Drivers at the Provincial Level	
Overarching Objectives & Priorities	A high-level reference to health status (well-being) is found in the overarching goals of the Department of Health and Wellness, as articulated by its vision and mission statements. <u>Vision</u> : Healthy Islanders, Healthy Communities now and into the future. <u>Mission</u> : Provide leadership, policy direction and programs that contribute to: high quality, accessible, affordable, accountable, and sustainable health services provided to Islanders; and health protection and promotion to improve the health and wellness of Islanders.”
Strategic/Service Plans	<ul style="list-style-type: none"> • Pillars 3 (Developing and Implementing a Comprehensive Wellness Strategy) and 4 (Working with the People of PEI) of the province’s <i>Health and Wellness Business Plan 2012/13 – 2013/14</i> make high-level reference to incorporating equity into strategic priorities and action items.¹⁰³ Reference is made to health status (wellness, well-being), root causes (barriers), and populations with special needs. • Pillar 4 (Health Promotion and Prevention) of <i>Healthy Islanders Healthy Communities</i>, the Department of Health and Wellness’ strategic plan for 2015–2018 explicitly references equity in the strategic priorities identified to achieve its goal of helping individuals improve their health through prevention and health promotion:



Policy Driver	Reference to Equity
	"collaborate with stakeholders to influence the social determinants of health..." ¹⁰⁴ No explicit reference to public health programming or practice is made.
Frameworks	No public health frameworks were identified.
Programs & Initiatives	No provincially delivered environmental health programs and initiatives were selected for review.

Yukon

Reference to equity in governing instruments

Governing Instrument	Reference to Equity
Legislation	No reference to equity was made in the <i>Public Health and Safety Act</i> . ³¹
Regulation	Section 1(1)(a)(vi) of the <i>Public Pools Regulation</i> explicitly references vulnerable populations in its classification of public pools ⁴⁵ The remaining sections set out the manner in which these pools are to be constructed, equipped and operated to protect public safety. Equity is implied in the application of these requirements, but is not explicitly stated.

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	High level reference to health status (wellness, well-being) is made in the overarching goals of Health and Social Services, as articulated by its vision and mission statements. " <u>Vision</u> : Healthy Communities - wellness for all. <u>Mission</u> : to promote, protect, and enhance the well-being of Yukon people through a continuum of quality, accessible, and appropriate health and social services."
Strategic/Service Plans	Health and Social Services makes high-level reference to equity in the strategic goals and outcomes outlined in its <i>Strategic Plan 2014–2019 Healthy Communities—Wellness for All</i> . ¹⁰⁵ Strategic Goal 1 (Optimal physical and mental well-being) addresses health status (well-being) and root causes (risk factors, environment). Strategic Goal 2 (Safety and well-being for vulnerable/"hard-to-serve" populations and those with complex conditions) addresses health status (well-being), root causes (social inclusion), and vulnerable populations.
Frameworks	No public health frameworks were identified at the territorial level.
Programs & Initiatives	No programs and initiatives were identified at the territorial level that explicitly relate to environmental health practice.



Northwest Territories

Reference to equity in governing instruments

Instrument	Reference to Equity
Legislation	No reference to equity was made in the <i>Public Health Act</i> . ³²
Regulation	<ul style="list-style-type: none"> Section 2 of the <i>Food Establishment Safety Regulations</i> makes reference to the social safety net in setting out the establishments to which the <i>Regulations</i> apply.³⁷ Section 12(2) of the <i>Reportable Disease Control Regulations</i> makes implicit reference to at-risk populations in regards to the powers of investigation delegated to the Chief Public Health Officer.¹⁰⁶ Schedule D of the <i>Public Pool Regulations</i> make implicit reference to vulnerable populations (i.e., the elderly, children, and pregnant women) in relation to the duty of the owner/operator to post signs to protect public safety.⁴⁸

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	The mission statement of Health and Social Services makes high-level reference to health status (well-being) . " <u>Mission</u> : is to Promote, protect, and provide for the health and well-being of the people of the NWT."
Strategic/Service Plans	No strategic or service plan for Health and Social Services was found on its website.
Frameworks	No public health frameworks were identified at the territorial level.
Programs & Initiatives	No programs and initiatives were identified at the territorial level that explicitly relate to environmental health practice.

Nunavut

Reference to equity in governing instruments

Instrument	Reference to Equity
Legislation	Section 25 of the <i>Public Health Act</i> sets out the discretionary authority of the Commissioner to make regulations in regards to provisions under the <i>Act</i> . The section makes explicit reference to vulnerable populations . ¹⁰⁷
Regulation	Schedule D of the <i>Public Pool Regulations</i> make implicit reference to vulnerable populations (i.e., the elderly, children, and pregnant women) in relation to the duty of the owner/operator to post signs to protect public safety. ⁴⁶

Reference to equity in policy drivers

Policy Driver	Reference to Equity
Overarching Objectives & Priorities	High level reference to health status (well-being) is present in both the Department of Health's vision and mission statements. " <u>Vision</u> : We envision the well-being of all Nunavummiut, with individuals leading productive lives in self-reliant and healthy communities throughout the territory. <u>Mission</u> : To promote, protect and enhance the health and well-being of all Nunavummiut, incorporating Inuit Qaujimagatuqangit at all levels of service delivery and design." The mission statement makes explicit reference to using an equity lens in service delivery and design (<i>Inuit Qaujimagatuqangit is defined as the foundation upon which social/emotional, spiritual, cognitive, and physical wellbeing is built</i>). ¹⁰⁸
Strategic/Service Plans	No strategic or service plan was found on the Ministry website.
Frameworks	No public health frameworks were identified for review.
Programs & Initiatives	No programs and initiatives were identified for review.

Examples: operationalizing equity into environmental health practice

Across the country, there are two principal ways that equity has been operationalized into environmental health practice: by embedding it into organizational culture and by incorporating it into specific initiatives within environmental health service areas. The four case studies of organizational culture described in the following section were undertaken at the regional health authority level. These examples are not focused specifically on the delivery of environmental health services; rather they are aimed at changing practice *across* the organization as a whole. The next three case studies of service area initiatives (pages 43–48) were undertaken in specific environmental health units *within* particular regional health authorities or local health units. Generally, the impetus for these initiatives was the passion and/or action of individuals who recognized a gap and created an instrument to address it.

Case Studies: How Equity has been Embedded into Organizational Culture

British Columbia: Fraser Health

Fraser Health (FH) is one of seven health authorities (one provincial, five regional, and one First Nations) in British Columbia. At present, there is only high-level reference to equity in FH's 2014/15–2016/17 *Strategic*

and Operational Plan.⁷⁴ Strategies and measures are identified to improve outcomes for vulnerable populations and ensure that these strategies are culturally sensitive. However, FH may soon adopt a formal policy on health equity, diversity, and incorporating equity into planning and service delivery (at the time of writing this report, the policy was in the draft stage). This policy would apply not only to acute care settings but also to the delivery of public health programming.

Historical context:

Like many other bodies with a public health mandate, FH's historical approach to the delivery of environmental health services was rooted in regulatory-based compliance. Gradually, with the shift to health promotion and chronic disease prevention, the way services are delivered is beginning to change, although this is happening in a more *ad hoc* way than as the result of a formal change in policy or practice. Some examples include:

- finding solutions to the challenges that many immigrants face in understanding and complying with the food safety requirements (adapting materials into other languages, applying a cultural awareness lens, coming up with culturally acceptable solutions); and
- taking a bigger picture, upstream approach to help facilitate solutions to environmental health issues related to housing (EHOs may be able to facilitate a solution, even though they don't have the regulatory "hammer").

Organizational awareness of health equity is combined with a focus on diversity, and has evolved into broader diversity/equity awareness. The key informant's own personal epiphany about the intersection of health and equity was influenced by the work of Trevor Hancock^a and a column header in BC Public Health Core Programs documents entitled "Equity Lens." The lack of explanation about what equity meant or instruction on how to apply the lens triggered conversations with the medical health officer support team. These conversations evolved into a health equity working group that produced an assessment toolkit and a pilot project, which got people involved from the acute care side. Participation in the committee is fairly broad, largely voluntary (not mandated), and has no budget per se.

Current status and activities:

The health equity committee now has an executive champion in the Chief Medical Health Officer, who sits at the VP table. A policy proposal to embed equity organizationally is being brought forward (although the date to do so had not been set at the time of writing this report). The policy includes measures and indicators and they hope that by having a formal policy adopted, equity will get mandatory consideration in program planning and service delivery. They are about halfway through rolling out training for population health staff about a health equity impact assessment tool for population and public health. At FH, health equity impact assessments (HEIAs) have never been done using a formal framework. Rather, they were being done in an *ad hoc* way (for example, for vulnerable populations). The expectation is that this tool will be used

^a See <http://www.uvic.ca/hsd/publichealthsocialpolicy/faculty-staff/faculty/profiles/hancocktrevor.php>

for program planning purposes, not at the line level. More program examples may be available by 2017, after the training is completed.

Critical success factors:

Executive champions are key to the success of an effort to embed equity into an organization and its culture. Having the Chief Medical Health Officer (who sits as a VP on the executive team) as an executive champion means that they have support in bringing the policy proposal forward and support for undertaking training programs like the HEIA training (the Chief Medical Health Officer directed that it be done).

Principal challenges:

The biggest challenge organizationally has been **competing priorities**. A **lack of resources** to support the equity initiative has also been challenging. While the process at FH has been fluid and dynamic, it has also been somewhat fragile because it requires that people have the commitment and willingness to do work off the side of their desk. In environmental health practice, the **lack of good data systems to identify specific vulnerable populations** presents another challenge. Anecdotal evidence is available at the line level (for example, people with literacy issues), but that kind of evidence doesn't meet an "auditable" standard. The "tunnel vision" approach of regulatory-based compliance also presents barriers.

British Columbia: Northern Health Authority

Northern Health (NH) is one of seven health authorities (one provincial, five regional, and one First Nations) in British Columbia. The health authorities work with the provincial government to provide "high quality, appropriate and timely health services to British Columbians." In the development of its *2015/16 – 2017/18 Service Plan*,⁷⁷ NH applied an equity lens to the environmental factors that frame its strategic context: rural/remote populations, socio-economic, variations in health status, aboriginal peoples and communities. NH has also been very proactive at incorporating equity into environmental health practice.

Historical context:

NH began taking a close look at the inequitable distribution of health outcomes in the North approximately 4 to 5 years ago. They found distinct differences between towns across the North—in some cases, differences in outcomes as high as 80%. As a consequence, they pulled together the senior public health leadership to think about how best to serve vulnerable populations. This initially led to the creation of a healthy communities strategy, which led to the creation of one or two committees at the local level. The work of these committees was originally done "off the side of their desks," but the process has since evolved into an entire resourced department.

In 2012, NH released a position paper on the environment as a context for health.¹⁰⁹ It acknowledged the role of social, economic and personal development in health and outlined how these can be determined by

the settings where people live, work, learn and play. Building on the comprehensive framework presented in the Ottawa Charter for Health Promotion,^a NH proposed an integrated setting approach that placed healthy settings in the broader context of a safe and healthy environment and that encouraged the health sector to look upstream and find new ways to learn and work collaboratively to promote a healthy society. One area where this holistic approach has been applied is housing. Historically, where a housing-related hazard was identified, Environmental Health would support the Ministry in their efforts to take children away or to condemn a house. Now, NH works with a range of partners, like poverty and mental health/addictions advocates, to find and facilitate a solution.

Up until about five or six years ago, the **delivery of environmental health services at NH was inspection oriented**. A change in senior leadership shifted the approach away from inspections and enforcement to community relationship-building. Environmental health officers were given training in coaching and facilitation and were directed to think as far upstream as they could in order to find and facilitate solutions. As a consequence, no tickets have been given in the region for the past five years. A research team at the University of Northern British Columbia (UNBC) recently interviewed every facility owner across the region. They found that owners were no longer thinking of EHOs as “enforcement only”—rather, they considered them as partners, supporters, and facilitators.

Current status & activities:

The philosophy that underpins the NH’s approach to public health is that neither public health officials nor the community have all the answers. To make changes in population health, the answers have to come locally and the most successful interventions are built around empowerment. NH now has 21 Healthy Community (HC) committees (up from one or two at the start). These committees have 10 members, on average, and are co-chaired by the mayor and the senior ranking Northern Health leader in each community. Facilitated visioning sessions with representatives from community organizations (with an interest in community well-being) assist the committees to identify targets and to zero in on upstream risk factors. For example, after “youth and hopelessness” emerged from the HC’s visioning session in Terrace, a subcommittee was struck to address the issue. In the first year, the Terrace committee focussed on listening rather than doing. They successfully secured grant funding, set up a youth advisory council, and developed a survey, which was administered by youth to several hundred youths. The survey findings were “shocking,” identifying feelings of extreme hopelessness in the community’s youth. The HC committee is drilling down into the survey findings to determine what can be done in the community and what can be done to support youth. A youth conference, modelled along the lines of ECOFest in Waterloo Ontario, was held in April, 2016 to further engage youth stakeholders about the survey results and identify ways to reduce risk factors that contribute to poorer health status among northern youth.

One component of NH’s **upstream approach to the delivery of environmental health services** has been that EHOs are supported, as part of their work plan, to join a community group. EHOs share what they are

^a See: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

learning in a weekly huddle and they meet with their supervisor one-on-one once a month. Community leadership is one of the measurable work plan indicators and is reported on quarterly.

Noting that approximately 80% of inspections are done in food premises, the key informant identified an inequity in the traditional inspection/enforcement model: it is the rich, not the poor, who eat out. Because there are disparate health outcomes in every single community across the North, “when you go upstream, you can see what’s causing it.” While he believes that inspections still have a place in public health practice, he thinks they should be used for following up on complaints or for facilities with a poor history.

Critical success factors:

Critical success factors for incorporating equity into environmental health practice include: executive support and **championship at the senior leadership level**; recognition that the most powerful interventions come from empowerment (i.e., public health doesn’t have all the answers); **strong community relationships**; a willingness for environmental health practitioners to “do what they can” to address the inequitable distribution of health outcomes (i.e., the willingness to be “black sheep”); and effective strategies to engage the community in **solving problems collaboratively**.

Principal challenges:

A traditional focus on inspections and enforcement can be a major challenge to incorporating equity into environmental health practice. However, support for “upstream” work is seen as one way to support a shift in focus toward the social determinants of health.

Manitoba: Winnipeg Regional Health Authority

In Manitoba, the delivery of environmental health services is under the jurisdiction of the province. Public health inspectors are employed by the province, but work at the regional level.^a The Environmental Health Branch of Manitoba Health provides environmental health services and programs (such as food premises inspections and investigation of complaints), in coordination with the regional health authorities. Although the development and monitoring of provincial public health legislation, standards, policy, and service delivery is a provincial responsibility, regional health authorities can work collaboratively to influence upstream policy levers through partnerships and intergovernmental liaisons. The Winnipeg Regional Health Authority (WRHA) illustrates how equity can be embedded organizationally and how upstream policy levers (like legislation and standards) can be influenced by bringing a health equity lens to policy dialogues.^b

As highlighted in the Summary of Findings by Jurisdiction, the WRHA has not only explicitly embedded equity into its mission, vision, values, and strategic direction, but it has also endorsed a position statement

^a Provincially, environmental health is a branch of the Public Health Division, which is a unit of Manitoba Health, Healthy Living and Seniors. Regionally, environmental health is a service area falling under population and public health.

^b The National Collaborating Centre for Determinants of Health highlighted Winnipeg’s experience in making the case for health equity (<http://nccdh.ca/resources/entry/casestudy-MB>).

on health equity.⁸⁹ The Board of Directors' position statement, which was released in December 2012, sets out the WRHA's vision, mission, and values in regards to health equity, as well as their commitment to changing health equity outcomes through an increased health equity focus in the services provided, the way planning and operations is conducted, in the provision of knowledge and decision-making support to others, and in real partnerships and committed relationships outside the health care sector.

Health Equity Vision, Mission, Mandate: (quoted verbatim)

- **Health Equity Vision:** "Health for all." Everyone reaches their full health potential without barriers due to socially determined and modifiable circumstances.
- **Health Equity Mission:** To coordinate and provide equitable health services that promote optimum health and well-being for everyone, recognizing that achieving the provision of universal health care requires proportionally more effort and resources to reach out to those in most need; to portray and call attention to the impact of social disadvantage on health; to facilitate sustainable contributions and collaborations from many sectors; and, to close the health equity gap in a generation.
- **Health Equity Values ("principles"):** Availability; Accessibility; Affordability; Appropriateness; Accountability; Comprehensiveness; Equity; Participation; Social Justice; Sustainability; Universality

Historical context:

Consideration of health equity at WRHA began in 2007–2008. The impetus was an external policy driver, namely the anticipated release of a fall 2008 report by the Canadian Institute of Health Information¹¹⁰ in collaboration with the Urban Public Health Network of which WRHA medical officers of health (MOHs) were part. That report's data were presented to WRHA's senior management team, including the CEO, to highlight gaps and inequities in Winnipeg's health outcomes (compared to the Canadian average) to engage interest and generate action.

The MOHs' presentation led to the creation of a regional equity committee in January 2009, which was re-started in late 2010 after being on hold during the pandemic response in 2009. Their work to raise the profile of health equity eventually led to the release of *Health for All: Building Winnipeg's Health Equity Action Plan*.⁹⁰ The aim of this plan, which articulated a framework for understanding and addressing health equity, was to start collaborative conversations about equity by offering up key considerations for action in 12 crosscutting areas. After the report was approved (in June 2013), a series of briefing notes were created to communicate its findings. Around this time, the regional equity committee evolved into the Health for All Coordinating Committee (HACC) and new Working Groups. The purpose of HACC is to promote sustained health equity action and influence opportunities to address unjust and preventable health gaps within the WRHA. In January 2014, resources within the Population and Public Health program at the WRHA were realigned to create a permanent health equity position, dedicated to embedding equity within and across the organization. Before this point, the initiative had no dedicated staff time and people involved in the initiative contributed their time over and above their regular working duties.

The WRHA's approach to equity has evolved organically over the last 8 years (i.e., it has not come about as the result of top-down directives) and its operationalization has happened in two ways: through a structured "pre-determinant" approach (e.g., a formal committee with a structured mandate) and an emergent approach (e.g., individuals seizing opportunities as they arise to bring equity forward and into the discussion).

Current status:

The Population and Public Health Program at the WRHA currently falls under the umbrella of Community Health Services. Like many other organizations with a mandate to deliver public health programs, its work is organized into content or service areas as well as strategic approaches such as health equity, healthy public policy, and communication. At present, the Population and Public Health Program's (PPHP) website lists 16 service areas. The intent is for all service areas to include a crosscutting emphasis on health equity. For example, the Healthy Built Environment Service area specifically includes a focus on equity in their planning documents.

In early 2016, a healthy public policy position was created and a Healthy Public Policy Collaboration Group was structured in the PPHP.^a Its role will be to support healthy public policy action, with an equity focus, across the PPHP and to build capacity of all areas to strengthen their public policy work.

To support the HACC and the WRHA's commitment to health equity, minimal resources (human and financial) have been dedicated to promoting equity across the region. This resourcing came about as a consequence of a full-time equivalent position being protected during periods of organizational realignment. The PPHP is recognized as the sponsoring program for the HACC. Excluding its three vice president (VP) sponsors, the HACC currently has over 30 members, with representation from WRHA leadership; from sites, programs and sectors across the WRHA. It reports through the three VP co-sponsors to a senior management committee and/or the Chief Executive Officer directly.

Current activities:

Equity efforts have recently been focussed in three key areas: accreditation,^b public consultation on strategic and transparent (re)allocation of resources, and patient flow improvement. Current areas include outreach to and engagement with all sites and programs, staff learning and capacity building, and inserting equity considerations in operational plan development relative to the regional strategic plan.

^a HPP is not a service area but a strategic approach. It appears on an extranet location <http://www.wrha.mb.ca/extranet/publichealth/priorities-policy.php>

^b The WRHA is accredited by Accreditation Canada (<https://accreditation.ca/>), a not-for-profit, independent organization accredited by the International Society for Quality in Health Care. It provides health-care organizations with an external peer review process to assess and improve the services they provide to their patients and clients based on standards of excellence.

Accreditation: In early 2016, the WRHA underwent a review by Accreditation Canada for the Accreditation Population Health and Wellness Standard.^a The priority populations the WRHA selected were populations that are socially or economically disadvantaged, especially those at risk for or experiencing homelessness.

Strategic Resourcing Public Consultation: Equity is embedded in the WRHA's *2016–2021 Strategic Plan*.²⁶ One of the operational strategies identified is the creation of a transparent resource (re)allocation methodology that includes a health equity lens. To give the Board an opportunity to hear a broad range of perspectives, the WRHA undertook a public consultation using existing structures to identify health equity related recommendations, including resource allocation options.^b Input from this consultation was compiled into a report and presented to the WRHA Board in April 2016.^c

Patient Flow: Improving patient flow is one of three overarching strategic goals in the *2016–2021 Strategic Plan*.²⁶ Achieving this goal will involve the identification of strategies, collaborations and other approaches that will demonstrate an impact on improving health equity and the consequential use of the health care system. The equity team worked with partners at the university level over a one-year period to develop an equity-informed model of patient flow. Following a series of presentations at senior levels of the organization, the model is being used to inform further exploration into the health equity dimensions of patient flow.

Going forward, there is ongoing outreach, engagement and dialogue with leaders and potential champions across the organization. A half-day workshop has been piloted with managers of programs and sites to engage with them about health equity and to start a discussion about what could be done differently to remove barriers to health and other relevant services. A “part two” to that workshop is under development. A review of equity prompts in the WRHA briefing note process is underway^d and tools (with a series of prompting questions) are being created for clinicians and staff across the organization (<http://www.wrha.mb.ca/about/healthequity/tools.php>). The WRHA was also one of the major sponsors of the 2016 Pathways to Health Equity Conference^e in Winnipeg.

Critical success factors:

Support and buy-in at the executive level has been key to the successful embedding of equity within the organization and in creating culture change. Three senior vice presidents (Vice President, Population and Aboriginal Health; Vice President and Chief Operating Officer; Senior Vice President Clinical Services and

^a These standards are applied to a priority population, or multiple priority populations, identified by the organization. Priority populations can be condition-specific (e.g. mental health or cancer), or age-specific (e.g. children and youth or seniors). An organization may select its priority population(s) based on priorities set out by the provincial or territorial government, or the organization's own strategic plan and priorities. Available from: <https://accreditation.ca/population-health-and-wellness>.

^b The process entails consultation with six Local Health Involvement Groups over two meetings (Jan to April 2016) and single meetings/consultations with: the Ethics Public Engagement Group (November 2015), the Aboriginal Health and Human Resources (AHHR) Committee of the Board (February 2016), the Francophone community consultation (February 2016), the Regional Ethics Council (December 2015).

^c The report “The ethics of equity and sustainability” can be downloaded from <http://www.wrha.mb.ca/about/engagement/lhiq/reports.php>.

^d By the inclusion of two questions: What inequalities or inequities exist related to this issue? (Present data or describe the gaps related to social disadvantage.) How will the recommended action affect equity? (Describe how the recommended actions will decrease gaps in health for those most disadvantaged.)

^e Available from: <https://www.equity2016.ca/>

Chief Medical Officer) co-sponsor the HACC and share responsibility for chairing the committee. Leadership on the issue of health equity and being a health equity champion is one criterion for membership on the committee.

Another success factor is the **strategic approach that was taken from the beginning to engage the organization's leadership and the organization as a whole in the health equity discussion**. Elements of that approach include: using indicators to benchmark Winnipeg's health outcomes against the rest of the country and create a call to action; positioning the *Health for All* action plan as a conversation starter and highlighting where there was room for action in the health sector, rather than issuing a series of recommendations; inserting health equity considerations into policy discussions and bringing equity out to service areas to help them build capacity, rather than merely telling them what to do; and, seeding championship for equity across the organization by strategically identifying where leadership exists and considering how they can bring a health equity focus to where they have influence. Underlying this approach is the message that health equity is a lens that can be used by all, that everyone has something within the scope of their individual influence.

Principal challenges:

Securing dedicated staff time was the biggest challenge. For much of its history, members of various equity committees were doing this work "off the side of their desks." Over 100 people have been involved in the committees since the beginning and at least 80 people were involved in shaping the *Health for All* report. Shortly after the release of the report in 2013, a proposal for new resources (2.5 full-time equivalents) was unsuccessful and the initiative was less active while re-strategizing until January 2014, when existing resources were realigned to create a position dedicated to health equity promotion. The transition in the structure of the equity committee (with increasing senior VP involvement) created critical mass to embed equity in the organization. **Three key challenges to embedding equity in environmental health practice are that the services delivered are rooted in legislation-based activities, they tend to be organized in silos by content or service area, and environmental health services are not delivered by the WRHA.**

Ontario: Sudbury & District Health Unit (SDHU)

The Sudbury & District Health Unit is one of 36 local public health agencies in Ontario. Health equity is embedded throughout the organization, from frontline staff to the Medical Officer of Health (MOH) and Board of Health.

Historical context:

At the SDHU, formal work in the area of health equity dates back to approximately 2000 and supportive internal structures and processes have been created over time. The MOH secured the SDHU's Board of Health (BOH) support in preparing a Board motion on the SDOH position statement in 2005, which led the SDHU to make equity an organizational core value and a strategic priority. In March 2006, the SDHU published a discussion paper entitled "A Framework to Integrate Social and Economic Determinants of

Health into the Ontario Public Health Mandate”.¹¹¹ This was followed by the publication of “Social Inequities in Health and Ontario Public Health”,¹¹² a background document prepared for a meeting in January 2007 between the Ministries of Health Promotion, Health and Long-Term Care and Children and Youth Services and the SDHU, Northwestern Health Unit, and Simcoe Muskoka District Health Unit.

Between 2008 and 2010, the SDHU’s MOH and two senior health unit colleagues were fellows in the Canadian Health Services Research Foundation’s EXTRA (Executive Training for Research Application) Program, researching evidence-informed local public health practices to reduce social inequities in health. The Director of Resources, Research, Evaluation and Development led a team of committed planners to develop the Ontario Public Health Standards (OPHS) Planning Path,^a which has the social determinants of health at the center of the process and incorporates equity-based planning tools (such as the Priority Populations Primer and an assessment tracking form that documents equity considerations). In 2010, SDHU program teams developed 3-year program logic models that explicitly identified equity-related activities. Health equity has increasingly become integrated throughout SDHU practice as evidenced through budgetary decision-making, including the re-orientation of existing public health unit (PHU) services to reduce social inequities in health.

The SDHU undertook an internal visioning process in the spring of 2010 to engage staff across the organization in the development of a shared vision for reducing social inequities in health. A description of the process and the resultant vision was published in a report entitled “Social Inequities in Health and the Sudbury & District Health Unit – Building Our Path for the Next 10 Years”.¹¹³ Key milestones and actions to guide the SDHU’s work were subsequently identified in a 10-year action plan, which was published in January 2011.¹¹⁴ Later that year, the MOH’s involvement in the Ontario Medical Association’s Physician Leadership Development Program led to the idea to create a short dynamic video that could communicate the complexity of the SDOH using simple language and narrative. The SDHU’s 5-minute video, *Let’s Start a Conversation About Health...and Not Talk About Health Care at All*, used a broad view of health to highlight that health is about much more than access to medical care, that everyone has different opportunities for health, and those opportunities are largely influenced by their social and economic conditions.^b

Current status and activities:

Two formal structures are responsible for overseeing and implementing equity initiatives at the SDHU: a health equity steering committee (HESC) and the health equity knowledge exchange resource team (HEKERT). The HESC was established in approximately 2010 with members from middle and upper management from across the organization and chaired by the MOH. This committee drives the health equity focus organizationally. It meets a minimum of four times per year. The HEKERT is an interdisciplinary team led by one manager (specialist in health equity) and has representation from teams and divisions across the agency. Disciplines represented on the team include public health nursing, public health inspection, and

^aThe OPHS Planning Path has since been replaced with the Evidence-Informed Planning Cycle. Available from: <https://www.sdhu.com/resources/research-statistics/evidence-informed-public-health-practice/planningcycle>

^bAvailable from: <https://www.sdhu.com/health-topics-programs/health-equity/health-equity-resources>

health promotion. HEKERT team members dedicate 50% of their time to health equity work. The HEKERT management lead is 100% dedicated to leading the team and working on health equity issues at the SDHU. HEKERT meets every 2 weeks.

In addition to the formal structures described above, one of the key informants mentioned an informal committee made up of SDHU staff and representatives from agencies across the community that was created by a recently retired public health inspector (PHI) in the Environmental Health Division. The impetus for the creation of this committee was that PHI's feeling that public health was just one "piece of the pie" in helping people with complex issues such as hoarding and mental health. As a consequence, the PHI gathered together representatives from other agencies (e.g., emergency management services, community mental health, the police and fire departments, by-law enforcement, and the community health care coordination centre) to find ways to address the needs of vulnerable clients through intersectoral collaboration.

The SDHU is about mid-way through the implementation of its 10-year action plan. The language of health equity is embedded throughout the health unit's strategic priorities and an equity lens is applied to all of the health unit's activities, including the delivery of environmental health services. For example, every meeting held in the health unit ends with the question, "What health equity examples can we bring forward to highlight the work?" In the area of environmental health, the SDHU recently adapted its food handler training program to accommodate people with disabilities (see pages 46–48).

Resources are allocated in the budgeting process to support health equity initiatives. For example, there is a separate line item in the budget for the health equity specialist, and teams and divisions across the agency absorb the cost of staff-time within their budgets. In addition, in 2011 the Ontario Ministry of Health and Long-Term Care initiated funding for 2.0 full-time equivalent (FTE) public health nurse positions in each PHU. This welcome funding has allowed each PHU in Ontario, including the SDHU, to increase their capacity for work addressing the social determinants of health. The 5-minute video *Let's Start a Conversation About Health...* continues to draw attention, with 40 requests for permission to adapt it for local purposes, from Ontario and Canada, as well as several international requests.

Critical success factors:

Executive championship has been one of the key factors in the successful embedding of health equity at the SDHU. There is "an amazing MOH at the helm," who is passionate about addressing the social determinants of health. Under her tenure and with support of the SDHU's Board of Health, **health equity has been embraced as a core value** and has been embedded throughout the organization, from the front line to the executive level. **Supportive managers** who are willing to have staff work half-time, as well as the **presence of over-arching structures** within the SDHU, have been critical to the success of the HEKERT. Other important factors contributing to the SDHU's success are: compassionate and receptive staff who embraced the vision and organizational changes, an engaged and caring community, **partnerships** with

external organizations (e.g., non-governmental organizations, poverty groups, etc.), and **consistent messaging from the top down**.

In regards to the question of how to embed equity into environmental health practice, one key informant noted that the provincial government is about to change five key pieces of environmental health legislation. At present, there are no plans to incorporate health equity. However, she noted that because the Ontario Public Health Standards (OPHS) dictate the scope of their work, if the Environmental Health Standard was changed to incorporate equity, then “everything else would fall into place.” She also noted that because health units across Ontario are required to sign an accountability agreement with the provincial health ministry, embedding equity into the OPHS would require health units to meet annual targets.

Principal challenges:

Organizationally, the **amount of staff training initially required** was one of the biggest challenges in making health equity a focus across the organization as some did not see equity in their mandate. **An insufficient amount of time** to do the work and stay on top of what is going on was also identified as a challenge. Two of the challenges to embedding equity in environmental health practice that were identified:

- The manner in which public health previously operated (i.e., in silos) limited inspectors’ ability to facilitate solutions.
- There are 36 health units across Ontario. Although they offer similar services, “everyone does everything differently.”

Case Studies: How Equity has been Incorporated into Specific EH Service Areas

The case studies below present examples of how equity has been incorporated into traditional service areas, such as food safety. These examples highlight the tools (e.g., the health equity impact assessment (HEIA) instrument) and the strategies (e.g., collaborating with other individuals or teams who are championing health equity in their organization, adapting training/processes/tools for inclusivity) that are being used to apply an equity lens to environmental health practice. A brief snapshot of the specific initiative is provided, along with information on how (and/or why) it was undertaken, the current status and outcomes, how it connects to policy instruments and/or policy drivers, any challenges faced, and the key factors influencing success.

Ontario: Simcoe Muskoka District Health Unit

Information for this case study came from interviews conducted with key informants for another BCCDC project on the facilitators and barriers to an equity-integrated environmental health practice.¹¹⁵

Environmental Health service area: Communicable Disease

Title of the equity initiative: Communicable Disease Exclusion Periods

Snapshot of the initiative: Service industry workers are often low-income, part-time workers. Many don't have paid sick leave or drug plans to cover the cost of required medications. When an infectious disease required that they stay home from work, their response was often, "I have to work to pay rent and put food on the table."

How the initiative was undertaken:

The manager of the Communicable Diseases Team used the HEIA process to review the impact of exclusion periods on low-income populations. Rather than running each reportable disease through the HEIA, she chose to run the issue of "exclusion" through the HEIA. Any disease that has an exclusion from work requirement was put through the HEIA. All the benefits of exclusion periods and the benefits to employers from exclusion (e.g., preventing the spread of disease to other employees, customers, etc.) were listed. From this, mitigation and implementation strategies were developed. Potential solutions and strategies that were identified included: policy change, advocacy, partnerships, referrals, as well as the possibility that some people could qualify for medication funding. Although there was an implication for staff time, developing new policies (or changing existing ones) came at minimal cost; and, other than the medication line item, budget implications were also small. A small working group was formed and met regularly to develop the strategy. The initiative took a full year and is ongoing in its implementation.

Current status/outcomes:

While the strategy was being developed, the team knew they had latitude to address individuals' situations on a case by case basis. The approach is now more formalized.

- The Communicable Diseases Team began supporting clients negotiating with their employers so that employees with lower-risk diseases could work out of contact with the public, or to continue to receive the same wages and make up for lost shifts when they were well again.
- Affordability and accessibility of the medications people require to return to work are also an issue (e.g., medications are not accessible if workers can't afford a taxi to get to the pharmacy). To address these issues, the health unit created a priority population budget line to pay for medications for those who couldn't afford them. The cost of getting the prescription filled and transporting medication to the worker at home is also covered. A means test is not required.
- The Team also looks at how duties could be modified to accommodate an early return to work. For example, when someone is diagnosed with pertussis and are interacting with vulnerable populations, they need to be on antibiotics for 5 days before they can return to their duties. In a recent situation, someone working in a high-risk situation could not afford to take 5 days off. The Team found another place for her to work within the organization, outside of public contact. She did office work, in a quiet area, removed from the public.

Connection to policy instruments and/or drivers:

This initiative flows from the strategic direction of the Simcoe-Muskoka District Health Unit, which clearly articulates equal opportunity for health as an organizational value and has identified the low-income group as a priority population. There is an organizational expectation that all new initiatives will be looked at through an equity lens (What are the impacts? What are the mitigation strategies?). Much of programming at the health unit deals with the social determinants of health and the populations most affected by them. Throughout the organization, all managers have been trained in how to use health equity tools.

Critical success factors:

Forging connections and building trust is critical to being able to support the individuals involved. A key success factor in this initiative has been finding more flexible solutions to allow people to keep work, such as alternate work duties away from the public, rather than simply enforcing the act and saying that the person cannot work.

Principal challenges:

The utilitarian approach to public health protection programs and being bound to work within the confines of the legislation are the principal challenges to incorporating equity in this area of practice. For some diseases (e.g., hepatitis A, *E. coli* O157, measles), regardless of the person's situation, public health investigators cannot permit them to work while infectious to others. Public health staff try to work with employers, but have no jurisdiction to require that employers keep people employed or pay their salaries. They can try to influence, but an employer can ultimately terminate an employee (this is particularly an issue with part-time employees) if the illness takes a long time to resolve.

Ontario: Regional Municipality of York

Information for this case study came from the Region's webpage about food handler certification and was supplemented with data from interviews conducted with key informants for another BCCDC project on the facilitators and barriers to an equity-integrated environmental health practice.¹¹⁵

Environmental Health service area: Food Safety (Training and Certification)

Title of the equity initiative: Food Handler Certification for Individuals with Intellectual Disabilities

Snapshot of the initiative:

The YorkSafe Food Handler Certification program is offered in three ways: 1-day workshop, self-study, and online learning modules. The one-day workshop is lecture based and includes the 1-hour exam. To accommodate people with intellectual disabilities, the course was broken down into smaller time segments, using oral and pictorial formats rather than the current approach.

How the initiative was undertaken:

The idea for this initiative emerged when York Region's Health Protection Division was approached by an external community partner about ways to help people with intellectual disabilities. Using the Health Equity Impact Assessment (HEIA) Tool, public health inspectors and nurses from the Health Equity Program worked collaboratively to identify the changes required to meet the needs of this population.

Current status/outcomes:

Revising and developing the course has taken a considerable amount of staff time. Materials are currently being adapted and it is anticipated that the pilot will be implemented in summer 2016.

Connection to policy instruments and/or drivers:

York Regional Council recently approved a bylaw requiring all high and moderate-risk food premises in the Region to have a certified food handler on site during operations. The bylaw, which is being phased in over a 3-year period (starting January 2016), will require that current and valid food handler certification be held by at least one owner/operator and at least one food handler in the food premises. In addition, at least one certified food handler must be present on site at all times during operations, to supervise the processing, preparation, storage, handling, display, distribution, transportation, sale, service, or offering of food for sale.

Critical success factors:

Critical success factors to integrating health equity into everyday environmental public health practice include:

- **organizational and managerial support** of efforts to accommodate different needs
- a **Health Equity Champions Network** (of which the Health Protection Division's manager is a member)
- **collaboration** with health equity nurses
- support of **health educators** on staff (who are particularly helpful with figuring out how to deliver information in plain language, with promoting the equity aspects of a program, with helping design the project and applying health promotion theories.)
- **training** provided by the Health Equity committee (on how to use HEIA tool, health equity literacy, how to find information about vulnerable populations (data sources, people to draw from), etc.)

Principal challenges:

The principal challenge to integrating health equity into everyday environmental public health practice is the **compliance-based nature of the work** (i.e., the need to achieve compliance with the regulations, inflexible timelines) and that **inspections are one-off, ad hoc visits**. In the food safety service area, this challenge is compounded by the diversity of the population (i.e., varied cultural backgrounds, language, literacy, education level, and socioeconomic status). To address these challenges, inspectors are coming up with their own *ad hoc*, individual solutions (e.g., using staff members/family members as translators, using translated

education materials, prioritizing compliance timelines for changes that need to be made). Critical to the success of these solutions is connecting and gaining the trust of the operators.

Ontario: Sudbury & District Health Unit (SDHU)

Information for this case study came from the October 2015 *Strategic Priority Narratives Report*⁹⁴ and was supplemented with data from interviews conducted with key informants for this report and another BCCDC project on the facilitators and barriers to an equity-integrated environmental health practice.¹¹⁵

Environmental Health service area: Food Safety (Training and Certification)

Title of the Health Equity Initiative: Food Handler Training and Certification Program

Snapshot of the initiative:

At the Sudbury & District Health Unit (SDHU), a survey of Food Handler Training learners revealed that many were students, workers, or volunteers living in low socio-economic conditions. In fact, for 40%, the highest level of education they attended was high school, and 39% reported living below the Ontario low-income cut-off. The delivery of the Food Handler Training and Certification Program was evaluated to identify improvement opportunities, particularly around changes that would improve equity and accessibility. Based on the results, the delivery of the program was transformed. Changes included working to build active learning into the course, assisting PHIs to accommodate learners with disabilities, and reducing fees for individuals in need.

Significantly, a *Guide to Accommodating People with Disabilities* was developed with the goal of supporting instructors to be aware of and accommodate differences in participant's physical or learning abilities. The *Guide* offers instructors the tools needed to ensure that participant's dignity and independence are respected while providing equitable opportunities for all people to benefit from SDHU services. Specific elements include: the Health Unit's duty to accommodate, tangible examples on how to identify a person in need of accommodation, and a list of types of disabilities with suggestions for accommodation as well as guidance to staff when interacting with individuals with varying abilities. This initiative directly aligns with one of the strategic priorities identified in the *2013–2017 Strategic Plan*: to champion and lead equitable opportunities for health.^a

How the initiative was undertaken:

An evaluation of the Food Handler Training and Certification Program was conducted in 2014, led by the Health Promoter in the Environmental Health Division. The evaluation included one-on-one interviews with the PHIs who provide the training, managers, and support staff for the program, as well as surveys distributed to learners at the course.

^aThe strategic plan is available as a webpage at: <https://www.sdhu.com/about/strategic-plan-2013-2017>

Current status/outcomes:

The *Guide to Accommodating People with Disabilities* was implemented in 2015. Although the *Guide* focusses on food handler training, its content is applicable to all training programs. The *Guide* is now being used across the Health Unit and offers guidance to all frontline staff on how to provide service to people with varying abilities. The Food Handler Training and Certification Program is offered a minimum of twice per month, incorporating interactive learning in its delivery and reduced or waived fees for those in need. Reduced fees are offered to seniors and students; fees are often waived for those that could benefit from pre-employment training, and for low-income workers and volunteers at not-for-profit agencies, particularly those handling food for vulnerable populations (ill, elderly, and babies/young children).

Connection to policy instruments and/or drivers:

In 2013, the Ontario Ministry of Health and Long-Term Care issued new provincial guidelines on Food Handler Training. The new guidelines set out requirements for consideration of accessibility in the delivery of the program with respect to culture, gender, and ability. The evaluation and program transformation was further driven by SDHU's Strategic Priorities, which commit to strengthening evidence-informed practice, and championing equitable opportunities for health. In addition, the *Guide to Accommodating People with Disabilities* was well-timed to align with increased awareness and implementation of accessibility standards for public service organizations under the Accessibility for Ontarians with Disabilities Act.

Critical success factors:

Key factors influencing the success of this initiative were: equity is already embedded throughout the organization so getting support and buy-in for the initiative was not difficult, evidence-informed practice is imbedded in the organization, and key staff have the capacity to plan and implement program evaluations. Also, trust existed between the evaluation lead (Health Promoter), staff, and management, making interviews with PHIs and others fruitful and enabling the findings of the evaluation to be actioned.

Principal challenges:

Challenges remain in the public health model where "there are 36 health units and everyone does everything differently." Best practices and wins are not consistently shared, and before changes are made to programs, stakeholders frequently ask "What is everyone else doing?" At the level of Food Handler Training and Certification Program delivery, challenges include PHIs that are not comfortable with public speaking, which can affect the experience and possibly the outcome for the learner. Also, PHIs have varying levels of comfort identifying and addressing participants of differing abilities in the class.

Summary – Key Findings, Gaps & Opportunities, Recommendations

Key Findings

The key insights that emerged from this environmental scan are the following:

Governing Policy Instruments: These are policy levers that only the government can make and that are enforceable. There is considerable variation across the country in whether or not, and the degree to which, equity is referenced in public health legislation and subordinate regulations. Where the legislation and the regulations tend to be more prescriptive than outcomes-based (and because these instruments don't explicitly authorize the application of an equity lens), they limit opportunities for EHOs to exercise discretionary power. As a consequence, they are often perceived as a barrier to incorporating equity in environmental health practice. This perception was flagged by several of the key informants (e.g., Fraser Health, Northern Health, Simcoe-Muskoka). The Simcoe-Muskoka case study (pages 43–45) illustrates how a governing instrument (i.e., the food safety regulations) can limit an inspector's ability to facilitate a solution for a worker with a foodborne illness. In this situation, an inspector cannot permit the worker to work, but has no jurisdiction to require that employers keep people employed or pay their salaries while the illness resolves.

Policy Drivers: These are policy levers that provide cues to action (such as government goals, strategic plans, frameworks, protocols). There is considerable variation across the country in the degree to which equity is referenced in these policy drivers.

- Where equity is embedded into the culture of the organization, an equity lens is applied to all strategic and operational activities and this is reflected in all of the policy drivers. Two case studies highlight how effectively equity can be incorporated once it becomes part of the organizational culture: the Winnipeg Regional Health Authority (see pages 35–39) and the Sudbury and District Health Unit (see pages 40–42). Sudbury's new food handler training program is an example of how internal drivers (i.e., corporate culture) and external drivers (i.e., Ontario's new provincial guidelines on food handler training) can leverage action on equity in environmental health practice (see pages 46–48).
- In organizations where equity is identified as a core value or is listed as a strategic priority (but is not embedded in the culture), an equity lens may be applied when identifying outcomes and indicators. However, this lens is, without exception, applied only to the delivery of health care services (i.e., equity does not appear to be a factor considered in determining the outcomes or indicators of success in public health service delivery).

Given that these types of policy levers tend to be outcomes-based, they will likely facilitate the implementation of an equity lens better (and more rapidly) than changing the regulatory framework will.

Barriers: Many facets of environmental health are constrained by the policy instruments that govern what services are delivered and how they are delivered. These include:

- the “one-off” nature of inspections
- the need for compliance
- the relatively little discretion that inspectors have to measure and enforce compliance
- the traditional way in which public and environmental health is organized (i.e., by content or service area, which creates silos that can create duplication of effort as well as present barriers to taking an upstream approach and implementing cross-cutting initiatives such as equity)

Critical Success Factors: The biggest facilitators to embedding equity within an organization or within a particular initiative are:

- recognition by key decision-makers of the value of taking an upstream approach to the delivery of public health services
- health equity champions at the managerial and/or executive level
- knowledge sharing, collaboration and partnerships between units within an organization or with external organizations (i.e., other agencies with a responsibility for delivering public health services, non-governmental and advocacy organizations)
- flexibility in the policy instruments governing practice (i.e., an outcomes-based regulatory framework, as opposed to a prescriptive approach). This kind of flexibility, combined with supportive management/leadership, would allow inspectors the opportunity to exercise discretionary power and to facilitate creative solutions to help those most affected by health inequities. The impact of having such flexibility is highlighted by the Northern Health (see pages 33–35) and Simcoe-Muskoka Health District case studies (see pages 43–45). In both case studies, inspectors were empowered by key decision makers to focus on relationship building and to think upstream in order to find and facilitate solutions.

Gaps & Opportunities

The principal gaps identified in this scan are the following:

Policy Levers: In every jurisdiction except Quebec, there is limited, or non-existent, connection between the various levels of governing instruments or between the governing instruments and the policy drivers intended to cue action for equity and public health. For example:

- There may be no reference to equity in the over-arching public health legislation, but multiple references (implicit or explicit) in the subordinate regulations that are made pursuant to the legislation.
- The converse is also true. In some cases, equity is referenced in the over-arching legislation, but not in the subordinate regulations.
- The public health policy drivers, which one would presume should derive some of their direction from the enabling legislation, tend to be driven by political imperatives (e.g., government goals or targets), which may or may not have equity incorporated as a core value or strategic priority.

Equity Focus on Health Care: In the strategic/service plans where equity appeared in the over-arching goals (i.e., in the vision or the mission statements, or as a core value) or where it was explicitly identified as a strategic priority, the corresponding outcomes and performance measures were, without exception, focussed on the delivery of health care services, as opposed to the delivery of public health programming.

The opportunities identified by this scan include:

- **Creating Consistent Policy Levers:** Tables 1 and 2, as well as the detailed tables included in Appendix C, illustrate how variable public health governing instruments and policy drivers are in regards to the incorporation of equity. The Summary of Findings by Jurisdiction synthesizes this information to highlight the relationship between governing instruments and policy drivers for each jurisdiction. The findings of this project highlight not only where the gaps exist, but also identify opportunities for incorporating equity and creating consistency across and within jurisdictions. This information could be used as a starting point to leverage change in the governing instruments as well as to embed equity in the policy drivers at all levels.
- **Expanding Equity Focus Beyond Health Care:** Organizations that have included equity as an over-arching goal or as a core value have already shown a commitment to applying the equity lens to their planning processes. However, the findings of this project suggest that equity in health outcomes tends to be focussed only on those outcomes related to the usage and delivery of health services. There may be an opportunity to use this discrepancy to leverage change to expand the equity lens to include public health outcomes in the strategic planning process. The experience of Public Health Protection at BC's Northern Health Authority (see pages 33–35) may serve as a useful model and starting point.
- **Strategic Resourcing:** A lack of dedicated resources was identified by multiple key informants as being one of the biggest challenges to embedding equity organizationally and into environmental health practice, specifically. The approaches taken in Winnipeg (pages 35–39) and Sudbury (pages 40–42) to strategically (re)allocate resources (e.g., protecting positions during times of organizational realignment, broad consultation about resource reallocation) may be transferable to other organizations.

Recommendations

Based on the findings of this scan and the case studies presented, the following recommendations could facilitate the integration of equity into environmental health practice.

Governing instruments:

- Resolve inconsistencies between references to equity in the overarching public health legislation and any subordinate regulations made pursuant to the legislation.
- Work with the responsible authorities to embed equity in all governing instruments. Quebec's public health legislation could be used as a model.
- Explore opportunities to revise regulatory requirements from a prescriptive model to a performance- or outcomes-based model, thereby allowing EHOs more opportunity to exercise discretion. This will require additional training, time, and resources to equip EHOs to do so consistently and effectively. Public Health Protection at Northern Health may be a valuable resource in this regard.
- In the absence of legislative or regulatory change (or until such change is promulgated), explore opportunities to find flexible solutions that still meet the intent of the governing instruments. Public Health Protection at Northern Health and the Simcoe-Muskoka Health District may be a valuable resource in this regard.
- Create new tools that conform to the spirit of the legislation but still allow for EHOs to apply an equity lens. One option is to incorporate elements of the HEIA tool into inspection forms and checklists. The Health Equity Impact Assessment (HEIA) Tool and Workbook created by the Ontario Ministry of Health and Long-Term Care may be a valuable resource in this regard.¹¹⁶

Policy drivers:

- Encourage organizations with responsibility for public health to embed equity in their over-arching goals and strategic priorities (if they have not already done so). The Winnipeg Regional Health Authority's Health Equity Position Statement could be used as a model. The Sudbury and District Health Unit and the Simcoe-Muskoka Health Unit could also provide valuable insights.
- Encourage organizations to apply the equity lens beyond the delivery of health care services to include outcomes and performance measures explicitly related to public health—and specifically environmental health—programming. Public Health Protection at Northern Health may be a valuable resource in this regard. In addition, two documents recently published by the Government of Quebec (on policy interventions to reduce social inequalities in health, and a strategy for monitoring social inequalities in health) could also be very useful.^{117,118}
- Look for links between existing programs and health equity goals (e.g., healthy built environment, Healthy Communities).

Embedding equity organizationally and/or into areas of practice:

- Use health equity language to benchmark organizational performance and to engage interest at the decision-making level. The approach taken by the Winnipeg Regional Health Authority may provide useful insights and a starting point.
- Find and engage health equity champions at the managerial and/or executive level. This will not only promote uptake across the organization, but may also facilitate opportunities for strategic reallocation of resources. Transferable lessons may be gleaned from the experience of the Winnipeg Regional Health Authority, the Sudbury and District Health Unit, and Northern Health.
- Find and take advantage of opportunities to strategically realign resources (e.g., protecting positions during periods of realignment). The approach taken by both the Winnipeg Regional Health Authority and the Sudbury and District Health Unit may provide valuable insights.
- Find or create opportunities for the sharing of knowledge, collaboration, and partnerships between units within an organization, with other organizations in the jurisdiction responsible for the delivery of public health services, and with external agencies (like non-governmental organizations and advocacy groups).
- Share information (such as the findings of this report), tools, and resources across health authorities to capitalize on strengths and to minimize duplication of effort.
- Focus on building capacity at the organizational and individual level (i.e., training on equity and on the use and adaptation of tools like the HEIA).
- Celebrate health equity champions and those who pioneered its integration into practice.

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Appendices: available for individual downloads:

[Appendix A: Key Informant Interview Guide](#)

[Appendix B: Equity Lens Applied in Environmental Scan](#)

Appendix C: Findings of the Environmental Scan

[Table C-1: Pan-Canadian Scan of Public Health Legislation](#)

[Table C-2: Pan-Canadian Scan of Public Health Regulations: Communicable Diseases](#)

[Table C-3: Pan-Canadian Scan of Public Health Regulations: Drinking Water Or Water Supply](#)

[Table C-4: Pan-Canadian Scan of Public Health Regulations: Food Premises](#)

[Table C-5: Pan-Canadian Scan of Public Health Regulations: Health Hazards](#)

[Table C-6: Pan-Canadian Scan of Public Health Regulations: Housing](#)

[Table C-7: Pan-Canadian Scan of Public Health Regulations: Personal Services](#)

[Table C-8: Pan-Canadian Scan of Public Health Regulations: Recreational Water](#)

[Table C-9: Pan-Canadian Scan of Public Health Regulations: Sewage and Sanitation](#)

[Table C-10: Pan-Canadian Scan of Ministry of Health Service Plans/Strategic Priorities](#)

[Table C-11: British Columbia Health Authority Service Plans: Overarching Goals](#)

[Table C-12: BC Health Authority Service Plans: Strategic Goals, Objectives, Outcomes](#)

[Table C-13: Selected Canadian Health Authorities' Service Plans: Overarching Goals](#)

[Table C-14: Selected Canadian Health Authorities' Service Plans: Strategic Goals, Objectives, Outcomes](#)

[Table C-15: Selected Public Health Frameworks: Overarching Goals](#)

[Table C-16: Selected Public Health Frameworks: Strategic Goals, Objectives/Strategies, Outcomes/Measures](#)

[Table C-17: Selected Public Health Standards: Foundation \(Purpose/Guiding Principles\)](#)

[Table C-18: Selected Public Health Standards: Goals, Outcomes, and Requirements](#)

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