Exploring Action on the Social Determinants of Health in Canada's Health Regions

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The views expressed in this thesis, including but not limited to views relating to health policy, are those of the author. The Canadian Institute for Health Information remains neutral and objective in fulfilling its mandate and neither creates nor takes positions on policy.

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ACRONYMS AND INITIALISMS

CIHI	Canadian Institute for Health Information
CPHI	Canadian Population Health Initiative
ECD	Early Childhood Development
GST	Goods and Services Tax
HEIA	Health equity impact assessments
HIV	Human Immunodeficiency Virus
LHIN	Local Health Integration Network
NCCAH	National Collaborating Centre for Aboriginal Health
NCCDH	National Collaborating Centre for the Determinants of Health
OECD	Organization for Economic Cooperation and Development
PHAC	Public Health Agency of Canada
RHA	Regional Health Authority
SDOH	Social Determinants of Health
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION

There has been no follow-up in Canada to the 2008 release of a World Health Organization report calling for action to address inequities in health through action on the social determinants of health (SDOH). This report examines the state of action on the social determinants in Canada at the health region level, with a specific lens for health equity and structural interventions. Structural interventions are those which address health outcomes not on a case by case basis, but across larger populations. A database of 2200 interventions that address social determinants of health was created, coded, and analyzed to enable a discussion of recurring themes in current policy action on the social determinants. This information will describe the current state of action on the SDOH in order to identify potential gaps and enable policy learning by creating a sample of innovative interventions that address health equity.

METHODS

A literature review was conducted to identify and define the social determinants of health relevant in the current Canadian context and was used to develop a coding framework for the social determinants of health. A jurisdictional scan of all health region websites was conducted, and their A-Z programs and service lists were reviewed for any interventions that address a social determinant of health. In addition to addressing a social determinant of health, whether and how an intervention addressed equity was also considered, and whether and how the program was structural in nature. Several dimensions of addressing equity were considered, including addressing vulnerable populations and reducing barriers to service access. Building community capacity for action on the SDOH, collaborating with non-health sector governance structures, and other possibilities for enabling structural change to improve health equity were considered. Results were compiled into a Microsoft Access database, and the results exported to Microsoft Excel for analysis. The vision, mission, and values sections of health region websites were also consulted to collect information on how often equity was presented as a goal of health regions.

FINDINGS

- 25% of interventions in the sample address equity
- 16% of interventions are structural in nature
- 0.7% of interventions in the sample mention being evaluated or provide an evaluation, though 1% of interventions are identified as being groups responsible for evaluating interventions
- Most interventions relied on direct interventions between health care providers and clients, though informational instruments such as pamphlets and workshops were also

Social Determinants of Health Considered (most to least addressed in the sample)	**Total (n)**
Personal Health Practices & Coping Skills	940
Early Childhood Development	522
Social Support Networks	479
Health Services	235
Social Environment	200
Built Environment	130
Food Security	116
Culture	115
Gender & Sexuality	100
Natural Environment	62
Education & Literacy	61
Employment & Working Conditions	61
Governance	61
Income & Social Status	55

common. Interventions providing fiscal support for citizens, or working to create more formalized policies, such as through regulation, were less common.

- Equity is more apparent as a theme in health regions' vision, mission, and values statements than it is as a theme in the interventions offered by the health regions.
- Equity was most commonly addressed by targeting vulnerable groups and addressing barriers to accessing health region services.

Recommendation

Several options for follow-up work are presented, and the undertaking of a series of case studies on innovative interventions addressing identified gaps in services is recommended.

1.0 Introduction

1.1 Project Client, Problem, and Rationale

This is a project for the Canadian Population Health Initiative (CPHI), a division of the Canadian Institute for Health Information (CIHI). CPHI is mandated to build a better understanding of the factors that affect population health, and to contribute to policy development to improve the health of Canadians. This project will contribute to policy development by exploring what action on health equity looks like at the regional level.

Health inequities are unfair differences in health outcomes observed across different groups. Reducing inequities in health was identified as a challenge facing the Canadian health system since the 1980s (Health and Welfare Canada, 1986, ¶12) and it remains an important issue today, both in terms of providing Canadians with just and equitable access to health, and for improving the efficiency and sustainability of Canada's health system.

There are a number of structural inequalities in Canada that contribute to a disproportionate burden of health problems on some populations and place an economic burden on Canada's health system due to such things as avoidable hospitalizations and higher rates of chronic conditions. New research has identified social conditions as the root of many inequalities in health (Marmot, 2005, p. 1099). Research has proven the importance of the social determinants of health for determining health outcomes, but there is little understanding on what action on the social determinants should look like in different contexts. There has been some work on this internationally (WHO, 2010a), but there is a gap in exploring what action on the social determinants of health inequalities looks like in Canada. This research is aimed at addressing that gap by creating a resource able to highlight what actions are taking place and to describe what that action looks like.

1.2 Project Objectives

1. Conduct a literature review to develop a method for coding and analyzing equity and structural interventions.

2. Conduct a jurisdictional scan of interventions at the health region level[1] that serve to mitigate health inequities through action on the social determinants of health. Collect these interventions in a database that will allow for analysis of how the interventions address equity and structural change.

3. Conduct analyses of this database to identify interesting findings in overall trends

4. Present recommendations for potential next steps to follow up on interesting themes in the findings or how CPHI can best disseminate the findings to appropriate audiences.

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[1] Because health is a matter of provincial jurisdiction and Canada's provinces are home to diverse populations with different approaches to healthcare, not all provinces are organized into health regions. In provinces not organized into health regions, equivalent organizations (providing direct care and with a role to play in population health) will be considered. These include health authorities, Local Health Integration Networks, and other health services planning bodies.

1.3 DELIVERABLES

The primary deliverable of this project is this report, which presents some findings from a preliminary quantitative analysis of the data and is intended to highlight options for future, more in-depth research in the area. A secondary deliverable is the creation of a database of health region level policies in Canada that address the social determinants of health, and can be dissected to examine how the interventions address equity and how they create structural change.

1.4 BACKGROUND

On August 28, 2008, the WHO Commission on the Social Determinants of Health released its final report entitled *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. It called for action to achieve health equity around the globe and put forward recommendations: improve daily living conditions; tackle the inequitable distribution of power, money and resources; and measure and understand the problem and assess the impact of action. Many of the recommendations contained within the 2008 report were endorsed by world leaders attending the 2011 World Conference on Social Determinants of Health, including a Canadian delegation led by the Chief Public Health Officer, Dr. David Butler-Jones (WHO, 2011c). At the international level, Sir Michael Marmot undertook strategic review of health inequalities in England and released a follow up report entitled 'Fair Society, Healthy Lives' in February 2010. The Marmot review was tasked to identify the health inequalities most salient in England, examine the evidence most relevant for addressing these inequalities, and explore how that evidence could be translated into action (Marmot et al., 2010, p. 4).The Marmot review ultimately arrived at a number of recommendations, largely focused around strengthening efforts in early childhood development, enabling self-determination, creating fair employment, developing healthy community environments, and strengthening ill health prevention efforts.

No equivalent exploration has yet been undertaken in Canada, but a number of initiatives focusing on different dimensions of health equity have been underway since the release of the WHO SDOH report. For example: the Public Health Agency of Canada's (PHAC) Canadian Reference Group (CRG) is developing a network of experts to collaborate and share expertise on how to reduce health inequalities; the National Collaborating Centre for Aboriginal Health (NCCAH) is addressing the specific determinants of Aboriginal health; and in 2009, the Senate Committee on Social Affairs, Science and Technology conducted an investigation into the social determinants of health in Canada and put forward a number of recommendations. These efforts have identified problems, but have not explored pathways to health equity through health system level interventions. This is the knowledge gap that this report seeks to address. This is an important gap to address because regional health authorities are the organizations responsible for direct service delivery in most regions in Canada, but are often also charged with improving population health.

1.5 Organization of Report

Conceptual Framework

This section explains frameworks for capturing information about equity, structural interventions, and the type of interventions during a jurisdictional scan. The frameworks are derived largely from past work at CPHI.

Methodology

The methodology section explains how the literature review was conducted and how the jurisdictional scan was designed and carried out. This section also explains how the database was constructed and organized.

Literature Review

The literature review for this project is designed to examine which social determinants of health should be considered in the jurisdictional scan, and also to define health equity. The results of the literature review inform the methodology of the jurisdictional scan and to some extent the conceptualization of a framework for equity.

Findings

The findings section describes the results of the jurisdictional scan, providing general findings of overall themes such as equity and structural interventions, and then presenting an analysis of each determinant identified in the literature review stage.

Options

This section highlights some options for follow-up actions by CPHI to address interesting findings and connect this research to relevant audiences.

Recommendation

This section recommends one of the previously identified options.

2.0 Conceptual Framework

2.1 The Social Determinants of Health Lens

Addressing non-health-care factors that influence health is an important component of policy action to improve the overall health of Canadians, or the health of specific groups (Romanow, 2004, p. xvi). Some social determinants are universally important for human health, such as access to food and clean water, but other determinants vary in importance for different groups and in different places. A number of academics and public sector organizations have created lists of the social determinants (see Frankish, 2007; PHAC, 2003) and there is often variation between lists of social determinants, but the underlying theme of the importance of factors beyond individual biology and behaviour are clear.

2.2 Structural Interventions and the Conditions of Daily Living

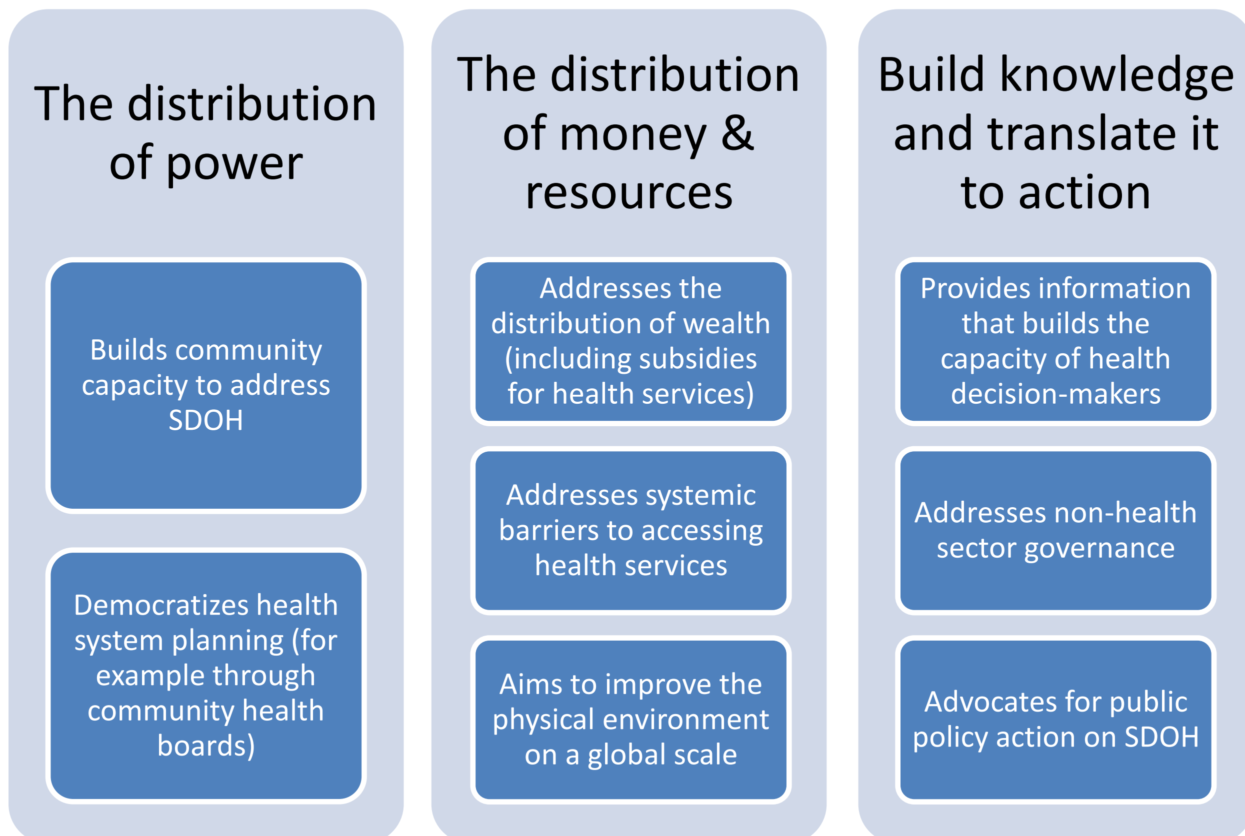
Public health interventions can address health risks at an individual level, or they can work at a structural level in an attempt to change health outcomes not on a case by case basis, but across the system as a whole. This requires consideration of not individual patients, but of interventions

targeted at entire populations (Rose, 1985, p.431-432). For example, a structural intervention could focus on reducing the price of healthy foods or taxing unhealthy foods to induce more people to choose healthy foods over less expensive fast foods which tend to be high in fat and sugars (Blankenship et al., 2006, p.59-60). This is different from an intervention targeted at individuals which may try to influence their personal food choices through individual or group education, for example.

The aim of structural interventions is to address the factors that influence health risks. In keeping with the themes of *Closing the Gap in a Generation,* for the purposes of this investigation, interventions targeted at the social determinants of health will be considered as addressing either the conditions of daily life, "the circumstances in which people are born, grow, live, work, and age", or "the structural drivers of those conditions of daily life", namely the inequitable distribution of power, money, and resources (WHO, 2008, p. 43).

The WHO recommends a principle of action to "measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health" (WHO, 2008, p. 43). Fostering evidence-based decision making and building the evidence necessary for designing effective interventions can also be considered as an important part of enabling structural change, as understanding the extent of disparities in health, their causes, and their costs, can be understood as a driver of policy action on the social determinants. Figure 1 depicts the different dimensions of structural interventions considered in this research, and how they relate to the recommendations of the 2008 WHO report, *Closing the Gap in a Generation.*

FIGURE 1 - DIMENSIONS OF STRUCTURAL INTERVENTIONS



The framework for structural interventions used in this analysis differs from others in that it includes those policies aiming to mitigate the effects of climate change or adapt to a warmer world as structural interventions This is because of the unique nature of climate change in the differential impacts that it is projected to have on different groups both within and between countries (see Morello-Frosch et al., 2009), and the global diffusion of the effects of mitigation strategies. Please see Appendix C for a specific breakdown of the coding of structural interventions.

2.3 Equity

Health equity as a concept for this investigation was informed by past work done at CPHI to develop a coding framework for health equity during a jurisdictional scan of Canadian interventions aimed at the urban physical environment. This framework was refined through the literature review for this work, and was used to formulate the detailed coding sheet found in Appendix C. The literature reviewed for defining equity included academic literature focused on defining equity in health, and grey literature focused on examining how equity could be addressed through policy interventions. Interventions were coded as having one or more equity component. Those components were:

- Addressing macro level determinants such as poverty
- Addressing barriers to accessing health services
- Addressing vulnerable groups
- Explicitly stating an intention to mitigate disparities or reduce health inequities

Please see Appendix C for specific barriers and vulnerable groups.

2.4 Intervention Type

Interventions were coded based on the type of policy instrument used. This typology was developed by CPHI based on the work of Pal (2006), and distinguishes between informational, procedural, regulatory, and fiscal interventions (CPHI, 2012, p. 7). A fifth type of intervention, direct interventions, was added to the typology for this research in order to capture services that operate on a case by case basis through the provision of a specific service from a health authority staff to a patient or other client.

- Informational interventions include classes, the distribution of pamphlets, websites, and other material, one on one question and answer sessions, and other means of distributing information from health experts to the public. Informational interventions typically are motivated by a desire to alter health behaviours by incentivizing healthy behaviours and discouraging unhealthy behaviours. Informational interventions tend to be relatively weak compared to other instruments as tools to mitigate health inequalities (Macintyre, 2007, p. 10).

- Procedural interventions are typically organization-level processes, frameworks, and policies that are not imposed by government. Procedural interventions can include workforce training, new hiring practices, new ways of operating or delivering services, or other organizational changes.

- Regulatory interventions are policy instruments put into place by legislation or regulation. Health authorities typically do not regulate, but can apply for bylaws on their premises such as a ban on smoking, and do sometimes play an enforcement role in regulations established by government.

- Fiscal interventions include providing subsidies, grants, bursaries, establishing funds to finance certain activities, and other ways of using money directly to either influence behaviour, mitigate barriers, or address a determinant of health (CPHI, 2012, p. 14). All instruments typically are fiscal in some way (health authority staff must be paid and typically consume resources while working even on informational interventions), but only those interventions where the fiscal element is the central instrument of the policy will be considered as fiscal for this research.

- Direct interventions are those that involve a care provider working directly with a client, such as a counselor or psychiatrist being connected directly to a patient, or a case worker assisting a patient. Direct interventions are a way to capture those interventions which are primarily focused on providing health services in a traditional relationship of a doctor and patient or administrator and client. Many direct interventions also use other policy instruments; most often informational.

3.0 METHODOLOGY

A literature review was conducted to inform the coding framework for a jurisdictional scan of healthcare delivery organizations in Canada. Literature was obtained from the CIHI library, JSTOR and similar online journal archives, as well as specific works known by CPHI staff to be relevant for different determinants. An initial search was carried out for "health equity" or "inequity in health", and a snowball method was employed using the references of identified literature. A grey literature scan of key sources for population health in Canada was also conducted, including agencies such as PHAC. The literature review and consultation with CPHI staff informed the coding criteria for social determinants of health and health equity, found in Appendix C. Appendix C details the different aspects of health equity identified, the different aspects of structural interventions, and the nature of interventions coded for different social determinants of health and intervention types.

The bulk of the research for this project was a jurisdictional scan of all health regions or equivalent organizations that are responsible for coordinating or delivering primary care services in Canada. These organizations were identified by a search of provincial and territorial government lists of health authorities and organizations operating in their jurisdictions. This scan identified a total of 92 such health authorities in Canada. Three of those organizations were excluded because their websites were undergoing maintenance at the time of the scan and did not have services listed by the cutoff date of November 20th, 2011. The regions excluded on this basis were the Outaouais region in Quebec, and both the Horizon and Vitalité networks of New Brunswick whose websites were not complete following a recent amalgamation of health regions in the province. One health region, Fort Smith in the Northwest Territories, did not have a website and is therefore also excluded from the sample. This left a sample of 89 health regions that were analyzed.

A search of those 89 health regions' websites was conducted. When available, A to Z program and service listings were examined to review interventions. When A to Z listings were not available, all interventions listed on the websites under program, policy, or service headings were examined instead. There were four health regions whose websites did not contain any information on the services offered: the Nunavik region in Quebec, the Churchill Regional Health Authority in Manitoba, and the Athabasca Health Authority and Northern Medical Services from Saskatchewan. All interventions listed on the other 85 health regions websites were considered for inclusion in a database. Please see Appendix A for a detailed description of the sample.

To be included in the database, the program or service had to address at least one social determinant of health as identified by the literature review and also had to contain enough information to be coded for type of intervention and for addressing daily living conditions or structural conditions. Please see Appendix B for a coding sheet and Appendix C for methodological details of the coding for social determinants, type, structural interventions, and equity. Coding criteria were informed by the literature review, in consultation with supervisors and analysts at CPHI, and by CPHI's past work involving coding for type and equity.

This research process resulted in the construction of a Microsoft Access database of 2200 records that met these criteria. For each intervention, the database contains information on the name of the intervention, the social determinants of health addressed, the type of intervention, the jurisdiction and the health region in which the intervention takes place, whether the intervention addresses structural conditions or the conditions of daily living, and it also contains a link to a description of the intervention. In addition, the database also contains information on how the intervention addresses equity and whether the program has been evaluated. This Microsoft Access database was exported into Microsoft Excel in order to conduct quantitative analyses of the data.

In addition to the construction of the database, an analysis of each health authority's vision, mission, and values statements was also analyzed to examine whether or not the health authority addressed equity in its goals. When health authorities did not have vision, mission, or values sections, their strategic directions were examined instead. This information was stored in a separate Microsoft Excel spreadsheet.

After the construction of this database, the database was printed and reviewed to ensure data quality. During the data cleaning process, all entries were reviewed to ensure that those coded as structural or equity-oriented met the inclusion criteria and were coded correctly. Approximately 15 entries were removed during this process.

4.0 Literature Review

This literature review is a compilation of grey and academic literature exploring the concept of health equity. The purpose of this literature review on health equity is to define criteria for policies that mitigate health inequities to be identified during the jurisdictional scan. This literature review will also identify the social determinants of health (SDOH) that are considered to be important for the health of Canadians and explain some of the ways in which the social determinants can affect health equity. This review of the SDOH will enable an analysis of which determinants of health are being addressed in Canada at the health region level.

4.1 Health Equality and Health Equity

Health equity and social justice have been identified as important components of health at least since the *Ottawa Charter* in 1986. The population health literature often refers to differences in health outcomes as health inequalities or health inequities. A health inequality is a difference in health outcomes between two or more groups; for example, seniors are more likely to be diagnosed with a chronic condition than children. In that way, a health inequality is a statement of fact that simply indicates a difference. Health inequities are a subset of health inequalities that are deemed to be unfair (NCCDH, 2010, p. 7). A health inequity can be identified only when health status is compared across factors that reflect social advantage, such as wealth, education, or ethnic group (Braveman, 2003, p. 182).

Health inequities are typically a result of "preventable, avoidable, systemic conditions and policies" (Hofrichter, 2006, p.22). Health inequities have also been defined as unnecessary health inequalities (Braveman & Gruskin, 2003, p. 254). Generally, it is most useful to consider those inequities that are avoidable "by reasonable action" (WHO, 2008, p. viii). Reasonable action is an important concept for the World Health Organization (WHO) to use at the international level because of the difference in expectations for investment in health promotion programs among low, middle, and high-income countries. In Canada, reasonable action can be interpreted as a policy action that is feasible given the current national and international economic context and justified by the ever expanding evidence base surrounding the social determinants of health.

The literature surrounding health equity does not define who is able to make distinctions between which inequalities in health are equitable and which are not, so the classification of health inequities is to a large extent subjective and dependent on a society's or an individual's expectations and understanding of social justice. However, beyond making distinctions between acceptable and unacceptable health inequalities, health equity can also be understood as the "fairness of opportunity to achieve and maintain good health" (Maryon-Davis, 2007, p. 522). The same issue of subjective assessment of equity is equally true for assumptions about which opportunities for health must be available to all as for which differences in health outcomes are unfair.

Health inequities can be addressed in a number of ways, including by income support measures, by reducing price barriers, by making services more accessible, and by prioritizing services for disadvantaged groups (Macintyre, 2007, p. 6). Structural interventions, fiscal interventions, and regulatory interventions tend to be more effective policy instruments for mitigating health inequalities than information-based campaigns (Macintyre, 2007, p. 10). Working across systems and building an evidence base that measures health outcomes stratified by social groups is also an important element of long-term efforts to reduce inequalities (Macintyre, 2007, p.6; NCCDH, 2010, p. 21).

4.2 Determinants of the Health of Canadians

This review is intended to identify those social determinants specifically discussed in the literature as currently significant in the Canadian context in order to bring more clarity to the social determinants of health approach described in the conceptual framework section. It takes what the Public Health Agency of Canada (PHAC) has identified as "key determinants" as a starting point and considers what the literature suggests might also be important determinants of the health of Canadians in order to allow consideration of which social determinants are being

addressed by policies at the health region level. The PHAC's 2003 list of determinants will therefore be a key source for this review. Frankish et al. (2007) takes the non-medical determinants of health from the PHAC list and goes into more depth, and so will be considered in conjunction with the PHAC key determinants. The overlap between these two lists presents a starting point, from which additional determinants were added or expanded based on literature review findings. The PHAC key determinant list includes the non-medical determinants of health discussed by Frankish et al., but also includes health services. Health services is a medical determinant of health, but also a social determinant (Mikkonen & Raphael, 2010, p.38). In this research, interventions addressing the social determinant of health services relate to access to health services. This process generated the following list[2] of determinants that will be considered in the jurisdictional scan:

- Built environment
- Culture
- Early childhood development
- Education and literacy
- Employment and working conditions
- Food security
- Gender and sexuality
- Governance
- Health services
- Income and social status
- The natural environment
- Personal health practices and coping skills
- Social environment
- Social support networks

This list is fairly similar to the PHAC list commonly used, but with a few noted differences. Sexuality was included along with gender in order to more appropriately capture the health impacts of the social construction of sexual roles and identities along with gender roles. These often fit closely together, but some issues such as differential exposure to the risks associated with eating disorders or elective cosmetic surgery can be better described as related to the construction of sexuality and ideal body images for men and women.

The physical environment for this scan has been separated into the built environment and the natural environment. The natural environment is concerned with large scale problems occurring outside of people's homes. Issues such as contaminated water and food sources, natural disasters, global warming, pollution, air quality, and the sustainability of ecosystems could be considered as a part of how the natural environment affects human health. The built environment can be understood as the micro environment in which people live, including issues such as the quality, quantity, affordability, and accessibility of housing, the availability of bike routes and pathways to be active in the community, the availability of green space, and the design of communities.

The Public Health Agency of Canada and some other sources consider food security as a component of income (PHAC, 2003). However, personal purchasing power is only one

[2] in alphabetical order, to avoid indicating or presuming a priority order

determinant of food security. Accessibility of affordable healthy foods, public knowledge, and the consistent availability of healthy foods are also determinants of food security. Food should also be culturally acceptable (Vancouver Island Health Authority, 2010, ¶1). Efforts to target food security therefore go beyond the scope of addressing households' incomes, and food security has thus been included as a separate determinant.

The last major deviation from the PHAC list is the inclusion of governance. Governance affects health in at least three ways in Canada: through direct legislation and policies for social protection, through intersectoral collaboration and horizontal communication to consider the health impact of policies in non-health sectors, and as a vehicle for self-determination and community actualization. Governance also captures interventions aimed at improving the decision-making capacity of the health and non-health sector and engaging communities in their health planning.

5.0 Findings

The findings of the jurisdictional scan will first be presented in terms of overall findings with regards to the general themes of equity, structural interventions, intervention type, and evaluation. Mini analyses for each social determinant of health identified in the literature review will then be presented.

5.1 Equity

As discussed in the conceptual framework section, interventions were considered as addressing equity when they explicitly stated an intention to address equity or reduce disparities, or when they addressed one of three other components:

- Addressing macro level factors that contribute to the existence of barriers and disparities (e.g. Poverty)
- Addressing barriers to health service access (cost, transport, etc.)
- Addressing vulnerable groups[3]

In addition to coding for which equity component is addressed, health authority websites (vision/mission/value statements or annual reports where those sections were not available) and interventions were also coded as implicitly or explicitly addressing equity.

An intervention explicitly recognizing equity as a goal would need to include a statement in its description of a desire to address health equity or to bridge a gap in health outcomes between populations, whereas a program implicitly addressing equity could have the same effect, but

[3] Vulnerable groups included were: Aboriginal groups, low-income groups, victims of abuse, frail elderly, homeless, refugees, and injection drug users. These groups were selected from a list of commonly occurring vulnerable groups in the literature. They were selected based on Frohlich & Potvin's definition of a vulnerable group as a group "at risk of risks" (2008, p.1). Other commonly cited vulnerable groups such as children, those with a physical disability or living with a mental illness were excluded because of the number of interventions addressing these groups, a wide variation within the groups, and limitations with the methodology. Specifically, it is not clear from the often limited information available on health authority websites about individual interventions which groups among the spectrum of those living with a mental illness or other condition are being addressed, and whether or not this has an impact on equity. Relatively few groups therefore are included under this framework in order to preserve clarity, though this list is by no means exhaustive of groups that could be reasonably identified as vulnerable or socially marginalized.

without stating an intent to address equity. As noted in Figure 3, approximately 42% of health regions included in the sample identified equity as a part of the organization's mission or vision, or as a value of the organization. This contrasts with only 25% of interventions identified (n=541) addressing equity, with only 1.73% explicitly addressing equity (n=38). This very low value for interventions explicitly addressing equity could be reflective of a limitation of this research in that health authorities do not often go into great detail about the goals of an intervention on the website. Interviews would likely be required to fully understand to what extent different interventions are expected to address health equity.

Among the interventions that address equity, addressing vulnerable groups and addressing barriers were the most common equity components. Only 0.68% of all interventions (n=15) addressed macro level factors such as poverty in an attempt to address the underlying conditions

FIGURE 2 – INTERVENTIONS WITH AN EQUITY COMPONENT

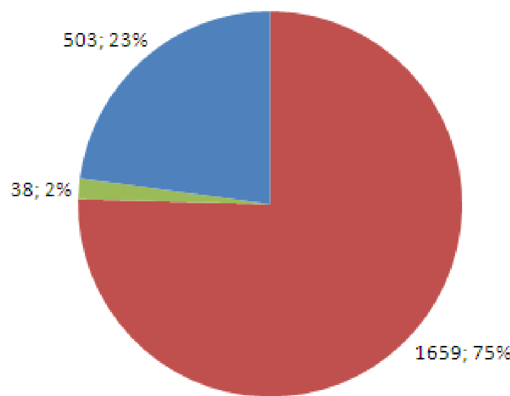
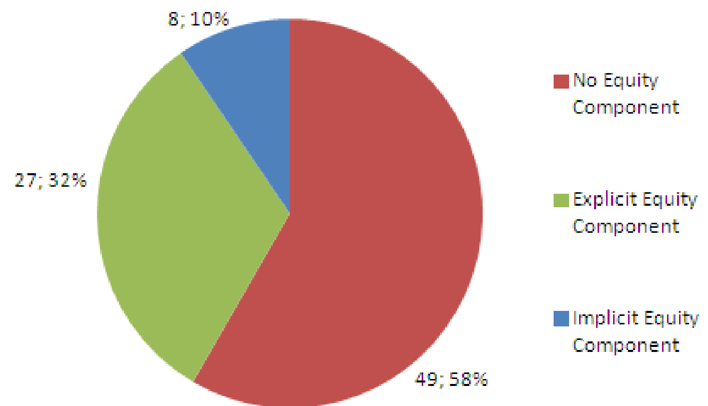
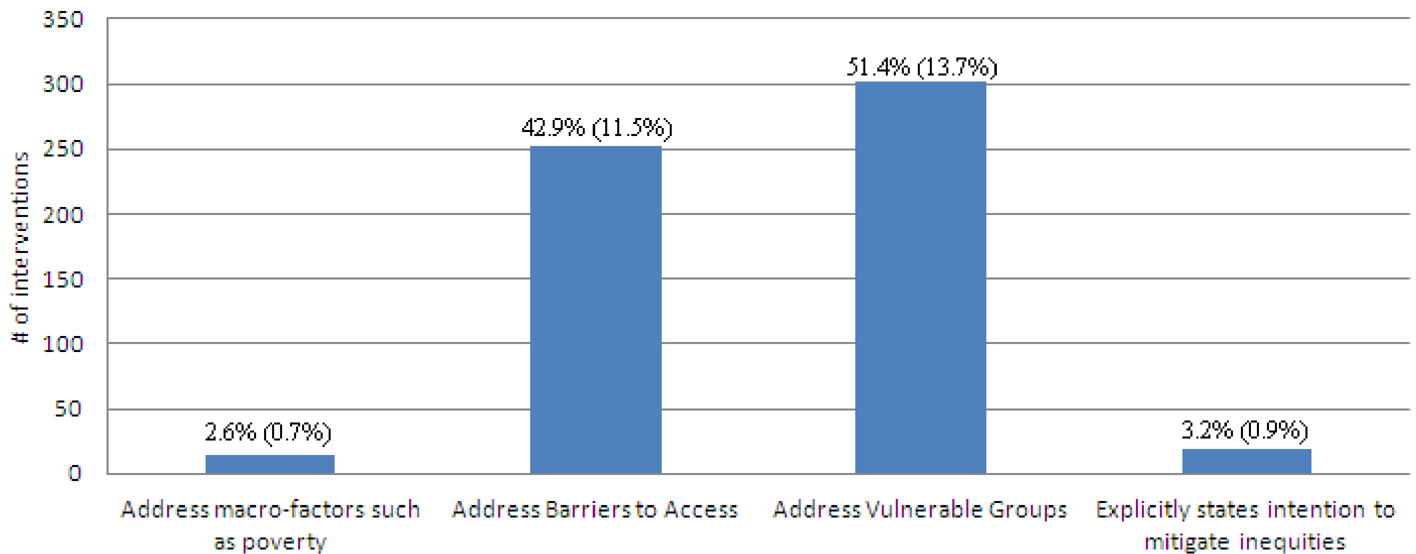


FIGURE 3 - HEALTH REGIONS STRIVING FOR EQUITY IN THEIR VISION/MISSION/VALUES STATEMENTS



that have an impact on health. Addressing poverty would have a long-term impact on health and mitigating health disparities, but short term solutions are more common in the form of providing subsidies for certain health services to mitigate barriers to service uptake.

FIGURE 4 – COMPONENTS OF EQUITY ADDRESSED

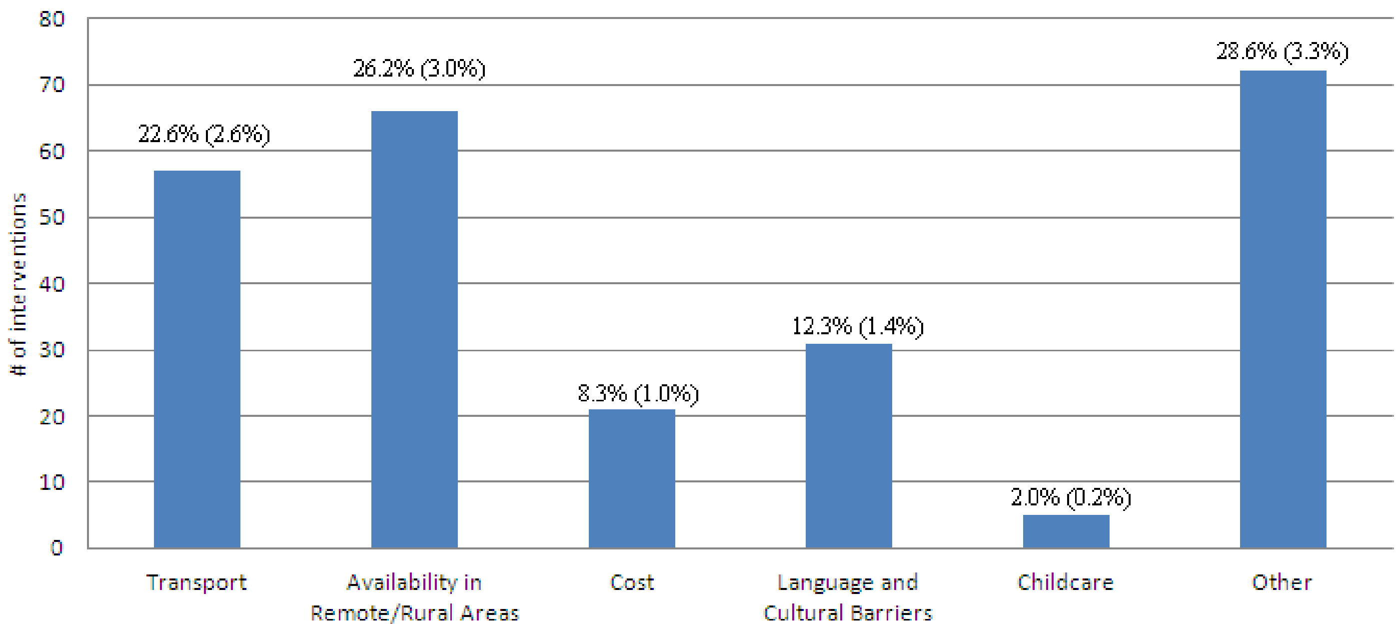


Note: X% refers to the percentage within these interventions, and (X%) refers to the percentage of total interventions

Barriers to Access

Barriers were addressed by 46.58% of equity-oriented interventions, or 11.45% of total interventions. Addressing barriers can be seen as a short term solution to address the differential access to services experienced by different groups as a result of history, the distribution of wealth, social attitudes, and other broad determinants that must be addressed by more long-term and widespread policy action from all levels of government, from individuals, businesses, and non-governmental organizations alike. The most populated category is "other", which in this research refers to interventions which express a desire to address barriers, but do not specify which barriers. These are often general statements about addressing barriers to social integration, or to full social participation. Many of these interventions tend to be mental health or addictions programs, or rehabilitation and occupational therapy programs targeting patients with a disability, suffering from social isolation, or newcomers to Canada. Figure 5 depicts the prevalence of interventions addressing different barriers.

FIGURE 5 – BARRIERS ADDRESSED



Note: X% refers to the percentage within these interventions, and (X%) refers to the percentage of total interventions

Availability in remote and rural areas is the next most common barrier addressed, and is being addressed by a number of different approaches. Telehealth initiatives are common in most jurisdictions and enable secondary and tertiary care in remote regions by video conferencing with specialists in larger hospitals, typically in urban areas. Nurse-led primary care clinics are also being used to increase access to primary care services in rural regions. Other interventions in this category include satellite and travelling clinics, such as mobile cancer screening initiatives and satellite dialysis clinics.

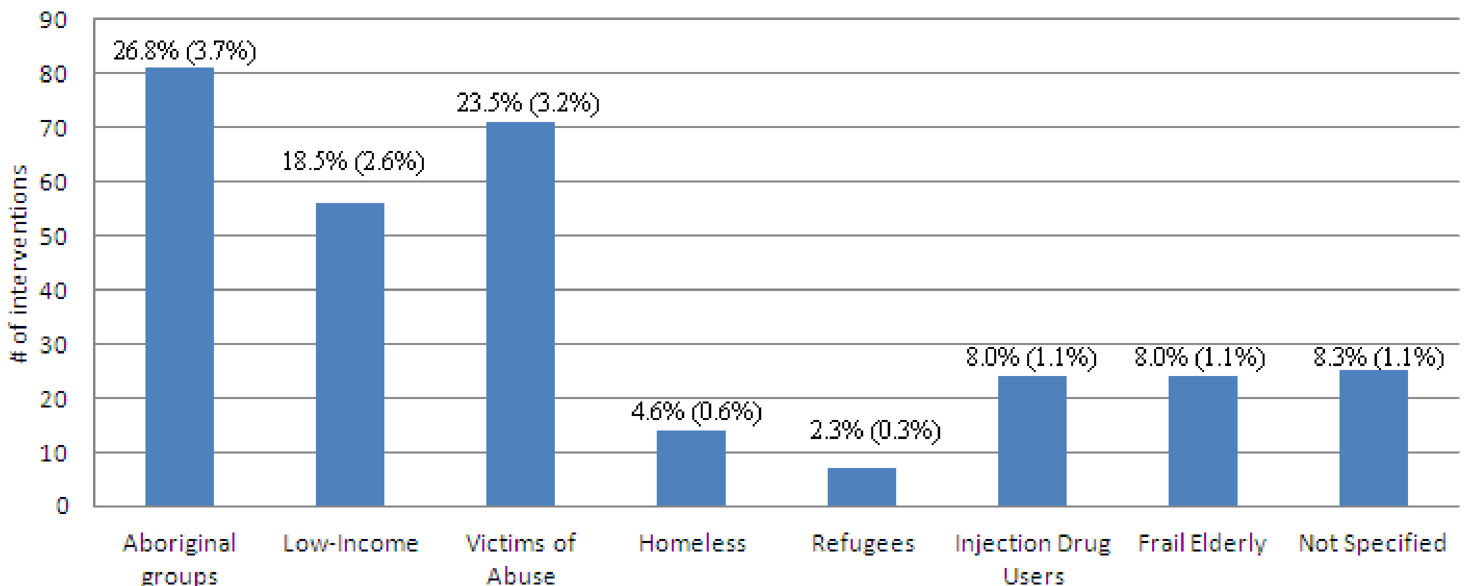
Transport barriers are addressed by providing bus tickets, by enlisting volunteers who bring patients to appointments, by providing subsidies for northern patients to travel for care, by dedicated buses for certain interventions such as adult day programs, and by administering programs such as meals on wheels. The cost barrier is often addressed by reimbursing patients for expenses incurred in travel, by subsidizing certain procedures and equipment for low-income groups, or by helping patients connect with sources of funding or tax incentives. Language and cultural barriers are addressed by providing translation and interpretation services for patients

and for printed informational material, by cultural competency training initiatives for health authority staff, and by specific initiatives such as all-nations healing rooms and providing access to elders in addition to chaplains in spiritual care services. Childcare is also provided for some services, especially for early childcare informational sessions and breastfeeding support targeted at new families.

VULNERABLE GROUPS

As noted earlier, relatively few groups were included as vulnerable groups in this research out of a much larger number of groups which have been identified as vulnerable in the literature. This is in part due to spectrums of patients with differing vulnerability in mental health services, addictions, and pediatric programs. Figure 6 depicts the distribution of interventions targeting specific populations.

FIGURE 6 – VULNERABLE GROUPS ADDRESSED



Note: X% refers to the percentage within these interventions and (X%) refers to the percentage of total interventions

The most commonly addressed vulnerable group in this sample was Aboriginal patients. They were addressed in consultation and engagement strategies, with Aboriginal Liaison Officers to assist Aboriginal patients in navigating the health system, by initiatives to make health services culturally relevant and to increase Aboriginal participation in the health authorities' workforces. Providing access to elders, facilities for ceremonies, and traditional foods were also relatively common initiatives in the North and in provinces with significant Aboriginal populations.

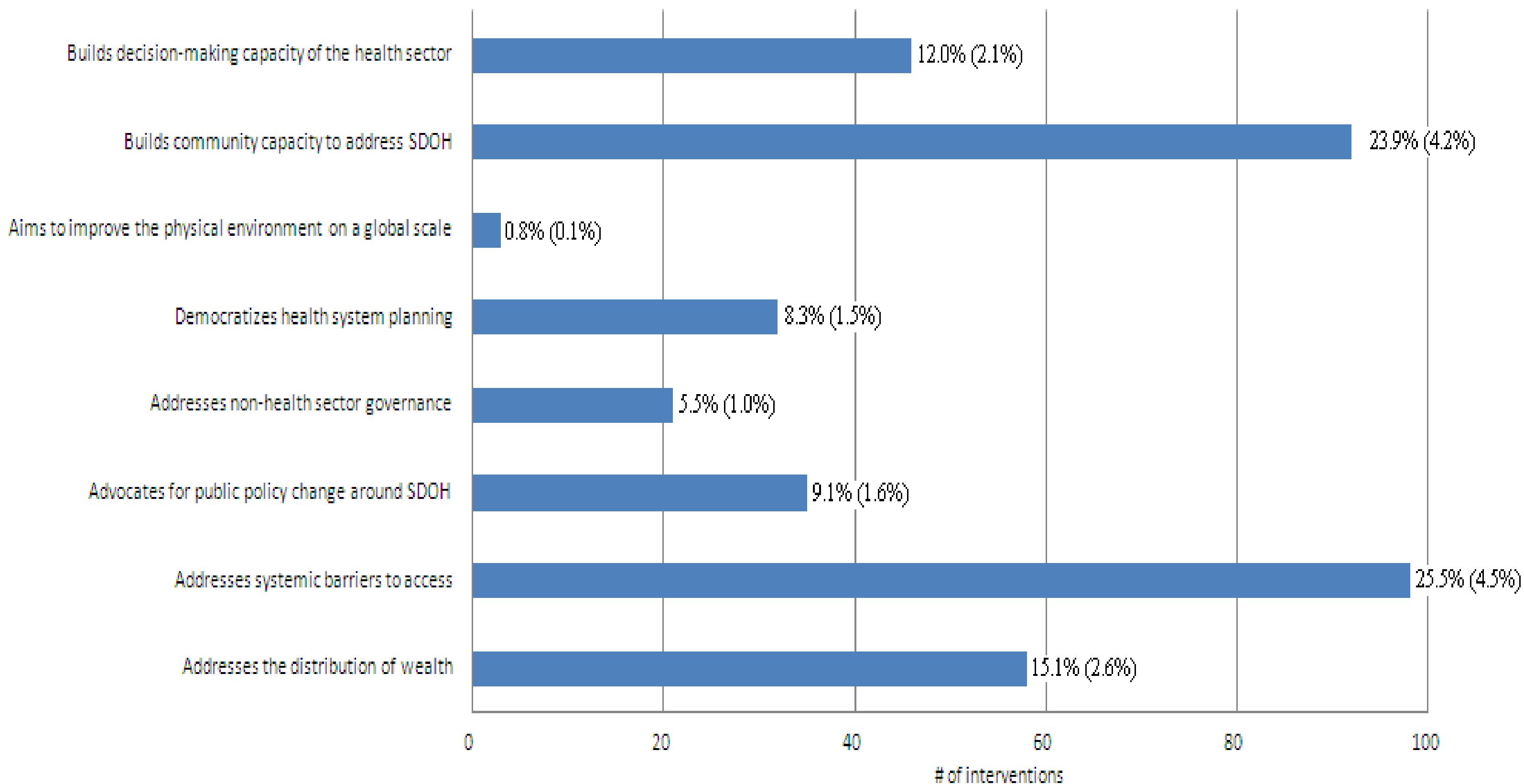
Victims of abuse were addressed by legal services for victims of sexual assault and for child abuse and elder abuse and neglect, by the provision of shelters, and alternatives to violence interventions for men in abusive relationships. Services for victims of sexual assault were also common. Low-income groups were addressed through subsidies and through interventions using public schools as a point of access, often for dental hygiene programs. Some health regions also offered housing at a price set at a percentage of income or provided social work resources to help connect low-income patients with financial assistance.

Injection drug users were often targeted by harm reduction initiatives such as needle exchange programs, methadone maintenance programs, and by mobile street health units geared to serving the homeless and difficult to reach populations. Frail elderly were often addressed through falls reduction initiatives, meals on wheels programs and adult day programs to combat social isolation and promote healthy nutrition and exercise. Homeless populations were most commonly addressed by specialized primary care facilities to reach out to homeless or difficult to access populations. A small number of interventions were geared specifically for refugees who arrive in Canada. Those services offer assistance in getting refugees connected with health services and other benefits of Canadian society, and help individuals to integrate into and participate fully in Canadian society. A number of initiatives described an intent to reach the "most vulnerable" or "most marginalized" without further specifying target populations.

5.2 Structural Interventions

As discussed in the conceptual framework section, a number of facets of structural interventions were considered in this research. A total of 344 structural interventions were identified of the 2200 in the sample (15.64%). The most commonly addressed aspect of structural change was addressing systemic barriers to access. Access in rural areas was addressed through telehealth and new primary care plans, and taking a client advocacy approach has facilitated navigation of complex health systems.

FIGURE 7 – BREADOWN OF STRUCTURAL INTERVENTIONS



Note: X% refers to the percentage of these interventions and (X%) refers to the percentage of total interventions

The second most common form of structural intervention was capacity building in the community. Community grants, training, advocacy, financial support, and community engagement were all employed in order to enable communities to better understand the social determinants and enable action to promote wellness at a community level.

A number of interventions addressed the distribution of wealth, most often by redistributing tax dollars to subsidize care for low-income health system users. Subsidies for living and home care were also provided in some jurisdictions, along with funding for low-income, unpaid caregivers. Few interventions were targeted at large-scale poverty reduction, and those that were tended to take an advocacy role or empower community actors to play an advocacy role.

Building the decision-making capacity of the health sector was incorporated into interventions by performing community needs assessments, using electronic health records to boost data collection and analysis capacity, presenting research findings to decision makers, evaluating public health interventions, and educating decision makers about the social determinants of health.

Advocacy for healthy public policy in a general way was most common among health promotion, public health, and population health groups. However, some primary care groups are involved in advocating for policy action on specific issues. For example, some community nutrition services advocate for policies to promote local and national food security.

The category of democratizing health system planning includes a number of different approaches to structural change. These initiatives seek feedback from the community and those groups affected by changes to health system in the planning phase of the policy cycle. These can be temporary, as in consultations for specific initiatives, or more permanent such as an engagement strategy for Aboriginal populations, or in the establishment of community health boards which serve as a permanent source of input into planning from community members.

Non-health sector governance is addressed by interventions that aim to connect research to policymakers. Initiatives in this sample approach this through speaker series and presentations, and by transferring knowledge about community needs related to the social determinants. Some interventions are general in nature and seek to transfer knowledge to governments and community planners to build towards a health-in-all-policies approach, but others are more specific. For example, some groups will collaborate with one related department, such as education, to bring policy changes to encourage healthy schools.

A small number of interventions also recognize the impact of the health region's operations on global warming, and seek to improve recycling and energy use in the region's many facilities to lessen the negative environmental impact of facilities' operations.

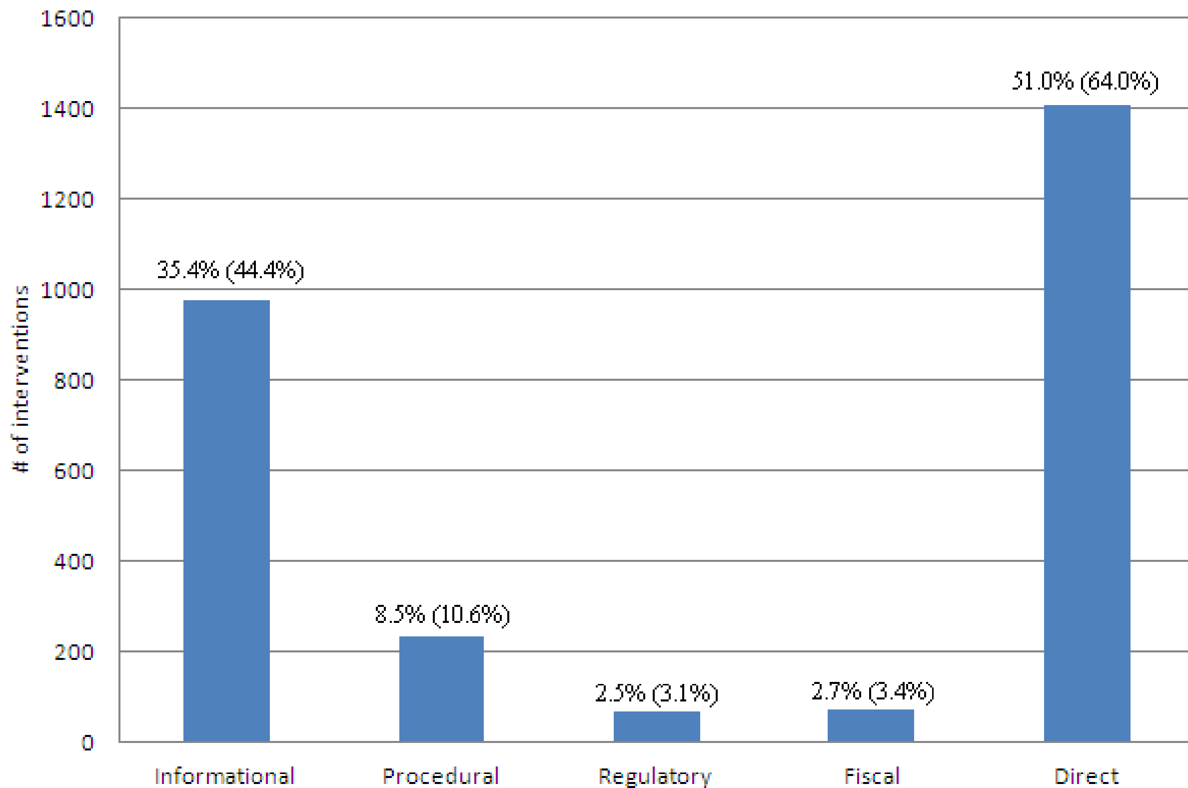
5.3 Intervention Type

Interventions identified in the jurisdictional scan were coded as being at least one type of intervention: informational, procedural, regulatory, fiscal, or direct. Most interventions (75.05%) were coded as only one type, while the remaining 549 interventions incorporated multiple policy instruments. Only 14 of those interventions incorporated more than two types, and none incorporated more than three. Figure 8 depicts how often interventions use certain kinds of

policy instruments. Many interventions use multiple instruments, so the percentage of total interventions will not add up to 100%.

Informational interventions often included websites, pamphlets, and instructional sessions. These were often attempts to encourage healthy lifestyle behaviours or information sessions on how to self-manage chronic conditions. Procedural interventions included in this database included workforce development strategies such as cultural competency training, engagement strategies for Aboriginal and other groups, or the implementation of evaluation processes and other data collection methods to assist in program planning and development.

FIGURE 8 – INTERVENTIONS BY TYPE



Note: X% refers to the percentage within these interventions and (X%) refers to the percentage of total interventions

Most of the regulatory interventions included in this database as a result of enforcement activities on the part of public health officials inspecting public areas such as restaurants and swimming pools. The fiscal interventions were often subsidies for certain procedures or equipment loans, or funding to mitigate barriers to participation in services, such as reimbursing the cost of travel. The direct services included clinics, counseling sessions, home-visits, and a variety of other services in which health services staff directly interacted with individual clients.

5.4 EVALUATION

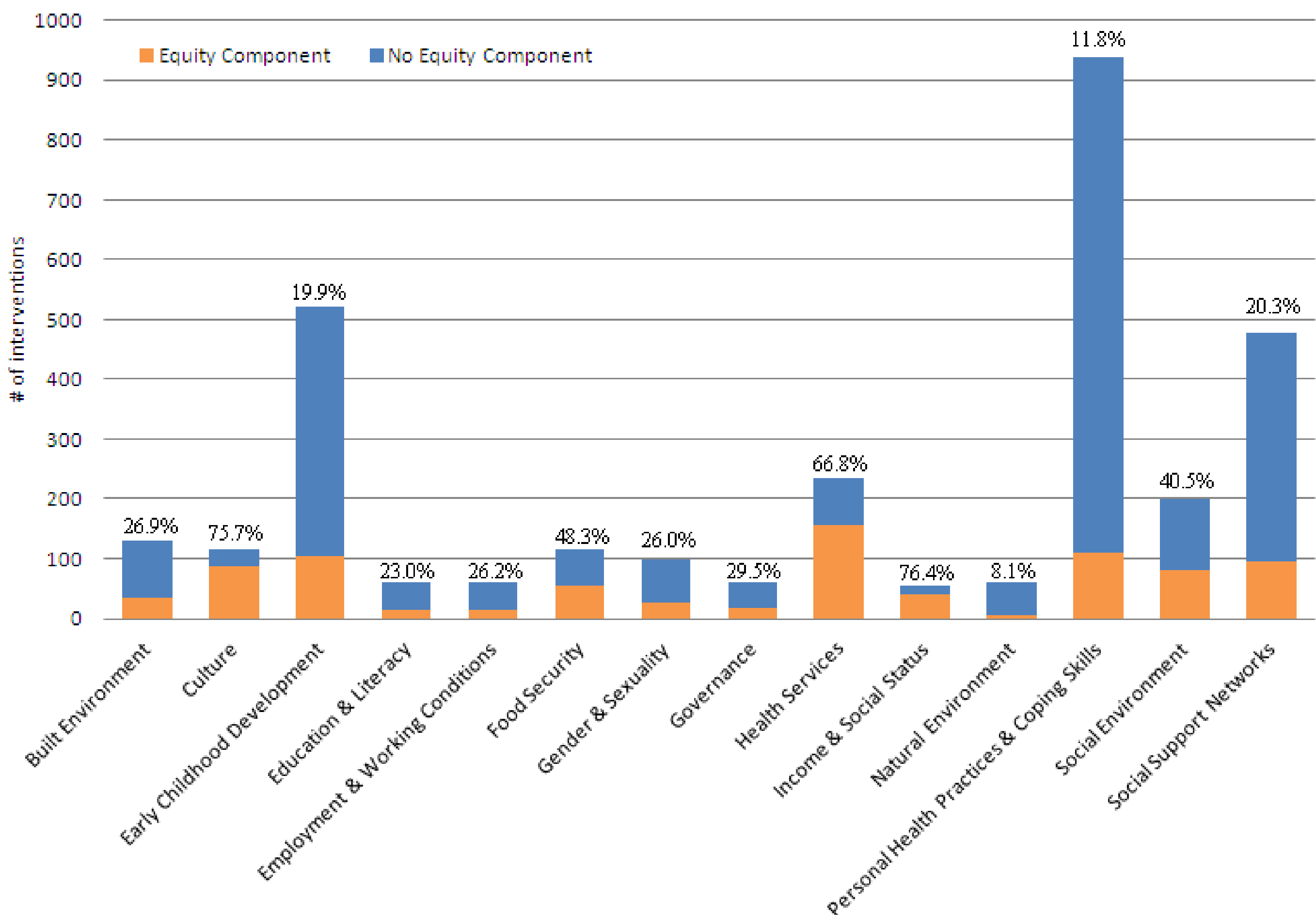
Only 15 of the interventions in the sample (0.68%) made mention of having been evaluated, with an additional six (0.27%) mentioning that evaluation is pending. This likely does not suggest that interventions at the health region level are not evaluated. More commonly, interventions were identified as evaluation bodies, responsible for evaluating interventions in certain areas (1.00%).

This suggests that interventions are being evaluated, but that the results of those evaluations are not made publicly available on health region websites. Another finding that might also suggest that evaluations are being done but are not shared is that those evaluations which are posted tend to be associated with more controversial programs such as methadone maintenance programs and a safe injection facility, programs which health authorities may feel require more evidence-based justification in the face of public opposition to harm reduction approaches. The methods for this research do not allow for further investigation of the extent to which alternative means of communicating evaluation results are used. However, if results of evaluations are not shared in other ways among health regions, that could be considered a barrier to the transfer of knowledge and would hinder policy learning between jurisdictions. This could lead either to the duplication of effort to evaluate similar interventions, or to the establishment and funding of interventions proven to be ineffective in other jurisdictions. The indicated mandates to evaluate public health interventions and simultaneous relative lack of published program evaluations could be considered as a direction for future research into how efficiencies in health system funding and operation could be found by sharing knowledge to build evidence for what works and encourage the adoption of good practices.

5.5 The Social Determinants of Health

In order to be included in the sample, interventions had to address at least one SDOH. Figure 9

FIGURE 9 – EQUITY BY SDOH ADDRESSED

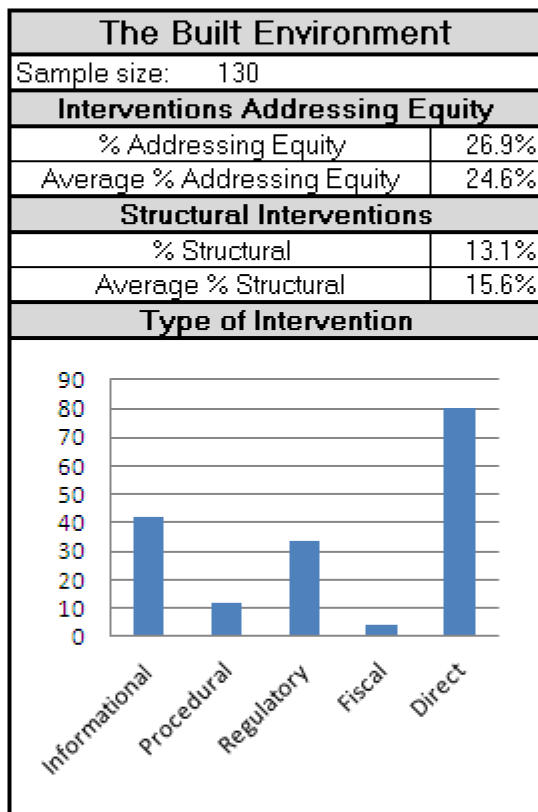


Note: X% refers to the percentage of interventions addressing equity in that category

indicates the proportion of interventions that address each SDOH identified in the literature review, and also the proportion of interventions within each SDOH that address equity. Sixty five percent of interventions address only one social determinant of health.

The following sections will provide a brief overview of policy and program actions at the health authority level to address each of the determinants of health considered in this review. The most commonly addressed determinant was personal health practices, with 940 interventions in the sample (42.7%). The least commonly addressed intervention was income and social status, with only 55 interventions (2.5%). However, the interventions addressing income were the most likely to include an equity component, and those addressing personal health practices were the least likely to do so. Culture and health services also had a high percentage of interventions addressing equity.

5.5.1 The Built Environment



The Built Environment	
Sample size: 130	
Interventions Addressing Equity	
% Addressing Equity	26.9%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	13.1%
Average % Structural	15.6%
Type of Intervention	

Main Activities

Interventions aimed at the built environment address a number of different environments. This category includes policies aimed at housing, both in advocating for expanded affordable housing and smaller scale interventions where home visit staff recommend changes to patients' homes to make them more accessible and safer in an effort to reduce falls or prevent other injuries. Some informational interventions in this category provide people with resources for how to check your own house for environmental hazards such as carbon monoxide or radon.

Some health authorities also directly provide housing. Western Health in Newfoundland, for example, provides a limited number of cottages to patients capable of independent living at a cost of 25-30% of their income (Western Health, 2011).

A number of interventions also assist users of the health system in transitioning into secure housing. These resources are often provided with mental health and addictions programming. Connecting patients with housing has been used as an indicator for the success of several methadone maintenance interventions evaluated in different provinces.

Other interventions target the broader community and encourage the adoption of walkable neighbourhoods and more green spaces that encourage active transport and healthy lifestyles. Some interventions also focus on synthesizing knowledge in this area and enabling community planners to consider the health impacts of community design. Harm reduction programs that offer needle exchange services in an effort to keep used needles off of streets are another example of community-level interventions aimed at fostering healthier built environments.

SUMMARY OF KEY ANALYSIS QUESTIONS

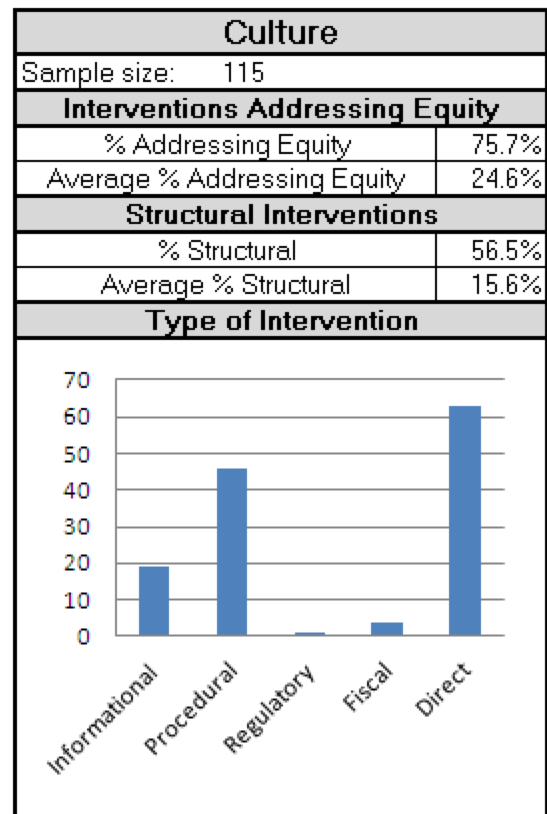
A far higher percentage of interventions aimed at the built environment are regulatory in nature than interventions aimed at most other determinants. This is due to public health inspection interventions which enforce regulations for housing and public spaces such as swimming pools and restaurants. Public health inspections and laboratory services also offer monitoring and inspection of drinking water sources to ensure that community water service infrastructure is adequate and producing healthy drinking water.

Many of the equity-oriented interventions in the built environment category are targeted at reducing barriers to accessing housing for low-income populations, or in redesigning the built environment to be safer for frail elderly populations. The structural interventions tend to be either redistributing wealth to subsidize housing, or in building community capacity to address housing and the built environment more generally.

5.5.2 CULTURE

MAIN ACTIVITIES

There is a focus on addressing cultural and language barriers to accessing health services. This is addressed in these interventions by providing interpreters for patients, by translating materials, and by making commitments to provide services in the language of the population. These include interventions in Quebec to make more services available in English, in BC to make more services available in Mandarin, and elsewhere in Canada making services available in French and other languages.



Culture	
Sample size: 115	
Interventions Addressing Equity	
% Addressing Equity	75.7%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	56.5%
Average % Structural	15.6%
Type of Intervention	

Some interventions in this category are articulations of general policy directions to integrate Aboriginal values and ideas about health into the health system or even more broadly into governance. In Nunavut, for example, there is a goal to integrate Qaujimajatuqangit, loosely translated as Inuit traditional knowledge, into all levels of policy. Other procedural interventions include policy goals of creating a diverse and representative workforce or board of directors, or for making services more accessible at an organizational rather than program level. Some procedural interventions are also focused on staff development, and provide cultural competency training for physicians and nurses who interact directly with diverse patients.

Many of the direct interventions are aimed at providing more culturally appropriate care. The provision of traditional Aboriginal foods in healthcare settings, for example, is common in British Columbia and the north. All nations healing rooms are also present in a number of hospitals, some of which are specially ventilated to allow for a variety of traditional healing ceremonies. Some spiritual care departments in hospitals also provide access to elders in addition

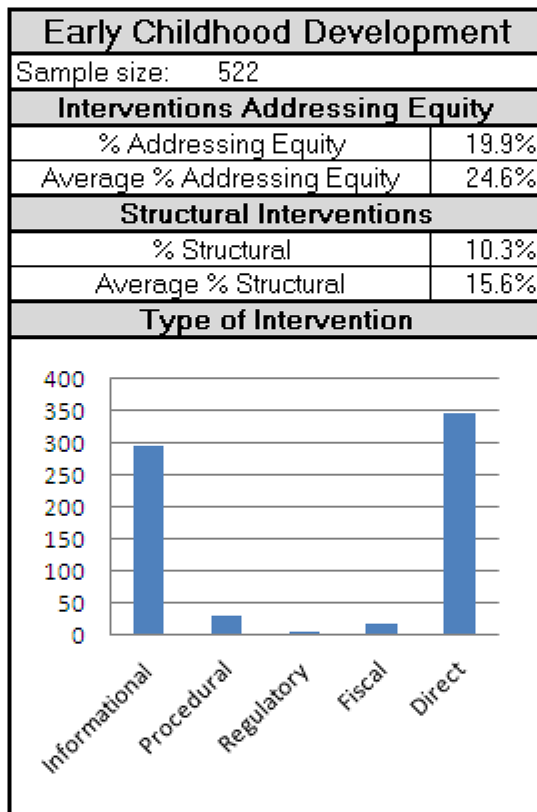
to the chaplains and other religious staff and volunteers commonly available in hospitals around the country. Aboriginal liaison officers also operate in a number of health regions, and improve access to the health system for Aboriginal patients by facilitating the navigation of a complex system.

SUMMARY OF KEY ANALYSIS QUESTIONS

Interventions aimed at the culture determinant have a strong equity focus. This is in part because they are often targeted at making services culturally relevant for Aboriginal populations, both by changing the nature of services and by increasing the representation of Aboriginal employees in the work force. The cultural interventions tend to be more procedural than actions on other determinants.

A significantly higher than average percentage of these interventions are structural in nature. The most common aspect of structural change addressed by these interventions is in making the system more accessible not only on a case by case basis as with the provision of interpreters for patients, but by requiring the availability of bilingual and culturally sensitive staff and adapting the workforce and organization to be representative of the cultural diversity of the patients they serve. A number of interventions also democratize health system planning by engaging Aboriginal communities in the planning process.

5.5.3 EARLY CHILDHOOD DEVELOPMENT



Early Childhood Development	
Sample size: 522	
Interventions Addressing Equity	
% Addressing Equity	19.9%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	10.3%
Average % Structural	15.6%
Type of Intervention	

MAIN ACTIVITIES

Early childhood development is one of the more commonly addressed determinants of health in this sample. Services addressing early childhood development tended to be either informational or direct. The informational interventions tended to be aimed at new parents on how to prepare for the change of becoming a parent, the importance of breastfeeding for healthy child development, and how to access community resources to assist new parents. These interventions also often addressed social support networks by linking new parents or specifically newly breastfeeding mothers. Many interventions have both an informational and a direct component, as with home visits by public health nurses who conduct screenings or basic health assessments with the child and also provide informational resources and answer questions from the parents. These home visits were very common, often occurred very quickly after new mothers were discharged from the hospital, and some also included a women's health component of assessing the mother's health and answering questions about common feelings experienced after giving birth and signs of postpartum depression. Many health regions also offer prenatal and postnatal parenting classes for new parents.

Many of the direct interventions are directed either through pediatric services or public health nurses, and include universal screening practices for vision and hearing as well as tooth decay. Mental and emotional functional assessments were also common services provided to parents with concerns about their child's development. Buddington the therapeutic clown, for example, acts shy and clueless in order to allow children to take a leadership role in reassuring and educating him. This allows healthcare staff to assess the child's understanding of what is going on, and allows the child to develop self-confidence and leadership skills (IWK Health Centre, 2009a).When early childhood screenings reveal abnormalities in development, there are many programs available to support parents with children suffering from Autism Spectrum Disorder, though there is significant variance in how long children can receive support from such interventions (anywhere from five to 18 years). Similar interventions are also in place to assist children at risk of Fetal Alcohol Spectrum Disorder and other developmental problems.

Some health authorities take an advocacy role in promoting the practice of breastfeeding, and supporting breastfeeding-friendly public places such as restaurants, or supported community groups with a similar aim.

Summary of Key Analysis Questions

Early childhood development interventions tend to be less engaged with structural changes than in other areas, in part because of the focus on the provision of information. Many of the structural interventions in this category are aimed at redistributing wealth to low-income mothers, in particular to support prenatal nutritional supplements. In Quebec, low-income mothers have access to OLO programs (oeufs, lait, et oranges) that supply pregnant women with food they need for a healthy pregnancy and to prepare for breastfeeding. Other interventions also offer milk coupons or vitamins for low-income, pregnant women.

This focus on low-income mothers is also the nature of much of the equity focus of these interventions. In addition to a focus on vulnerable populations, mostly low-income populations, some interventions also addressed barriers in accessing their services by providing bus tickets or on-site childcare for prenatal education classes or drop-in sessions with a public health nurse.

5.5.4 Education and Literacy

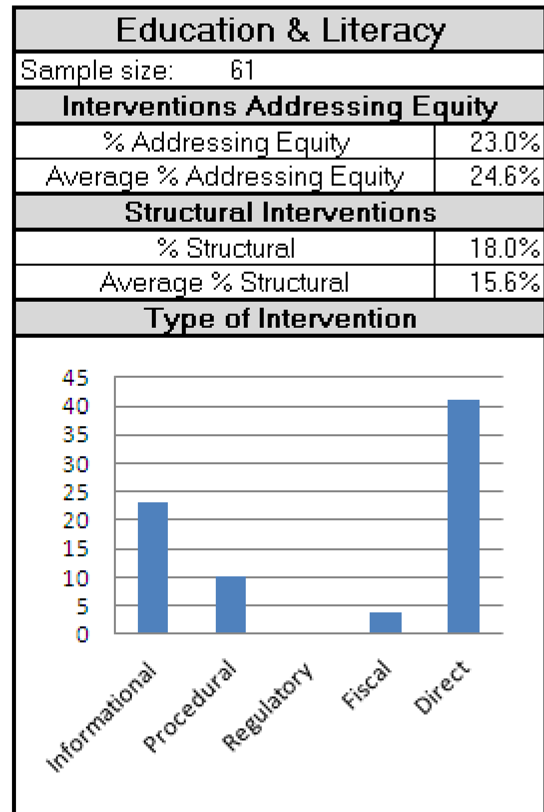
Main Activities

Most interventions that address education and literacy do not do so as their primary objective, but as a secondary component of a larger program. This is the case for example with many rehabilitation interventions or addictions treatment interventions which aim to connect patients with housing and educational or vocational development opportunities. Speech pathologists that work with children would be an example of this kind of intervention.

Health literacy is also addressed from two directions through informational and procedural interventions. Informational interventions such as label reading courses help patients to understand instructions for medications to minimize the risk of improper use of prescription medication administered by patients to themselves, or by parents to their children. Procedural interventions are also in place in some areas to encourage physicians to write instructions legibly, without abbreviations, and in plain language to ensure that pharmacists understand and deliver the proper medications, and that patients understand instructions from the physician on proper medication use. Some informational interventions also target nutritional literacy by

hosting tours through grocery stores where nutritionists will take example products and explain the nutritional information and answer questions about how to read nutrition labels.

Some hospitals also have direct interventions to enable children to continue with their schooling while staying in hospital for extended periods. Teachers with special training work with these hospitals and develop individual programs for children at various stages of education.



Education & Literacy	
Sample size: 61	
Interventions Addressing Equity	
% Addressing Equity	23.0%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	18.0%
Average % Structural	15.6%
Type of Intervention	

A small number of interventions in the sample target the built environment and education and literacy by either adapting the physical environment of the school or by making modifications to children's assistive devices to reduce barriers to full participation in school by children with disabilities. Some fiscal interventions also provided bursaries for students in certain areas or from certain demographics to study in the health field.

Some interventions are aimed directly at building literacy skills among children and adults. In Nova Scotia, for example, health authorities have partnered with a community organization to provide each baby born in the province with a bag containing CBC-produced rhymes and lullabies, children's books, information for parents on how to read to children and the importance of developing literacy skills, and discounts at local bookstores (IWK Health Centre, 2009b).

Summary of Key Analysis Questions

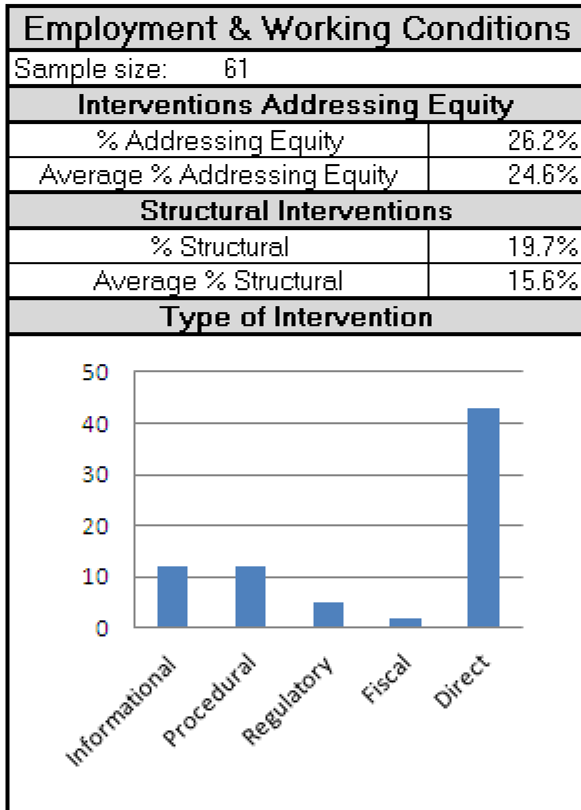
Education and literacy programming in the sample that contain an equity component are often focused on addressing the barriers to accessing educational resources such as schools. Grants for students with disabilities or for the development of educational facilities to accommodate students with special needs are examples of this.

Structural interventions in this area tended to address community capacity to act on literacy or to bring a health lens to other areas such as education by building partnerships for healthy schools.

5.5.5 Employment and Working Conditions

Main Activities

As with interventions aimed at education and literacy, many direct interventions address employment and working conditions as a secondary focus of the intervention. Rehabilitation and occupational therapy interventions, as well as addiction interventions such as methadone maintenance programs often aim to increase the patients' employability. In some cases, this involves physically preparing patients for work, and in other cases it involves providing training in resume writing, interviewing, and other skills.



Employment & Working Conditions	
Sample size: 61	
Interventions Addressing Equity	
% Addressing Equity	26.2%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	19.7%
Average % Structural	15.6%
Type of Intervention	

Some interventions also provide opportunities for patients to gain direct work experience. These most commonly target patients with mental health diagnoses. Patients are placed in a variety of work environments, from a recycling facility in Newfoundland to woodworking shops in Nova Scotia, to food service and retail outlets. In Alberta, some patients are given an opportunity to both gain work experience and contribute to the hospital environment by operating in-hospital activities such as a cafeteria and video rental service.

Procedural and regulatory interventions included initiatives aimed at ensuring occupational health and safety standards were met or exceeded, and included public health inspections and voluntary initiatives on the part of health authorities.

In Quebec, women who are pregnant or expecting to become pregnant can have an occupational health inspector come to their workplace to assess the environment for any features that might pose a risk to either mother or child.

Summary of Key Analysis Questions

Interventions aimed at employment and working conditions that had an equity focus tended to address barriers to access, often with a focus on rehabilitating individuals to remove barriers to their participation in the workforce. Some structural, procedural interventions also focused on vulnerable groups by aiming to create a representative workforce that respects diversity. Most of these initiatives tended to focus on Aboriginal populations.

The structural interventions in this category were varied, and included efforts to build community capacity to address vocational training, and making the health authority as an employer more accessible to workers from under-represented segments of the population.

5.5.6 Food Security

Main Activities

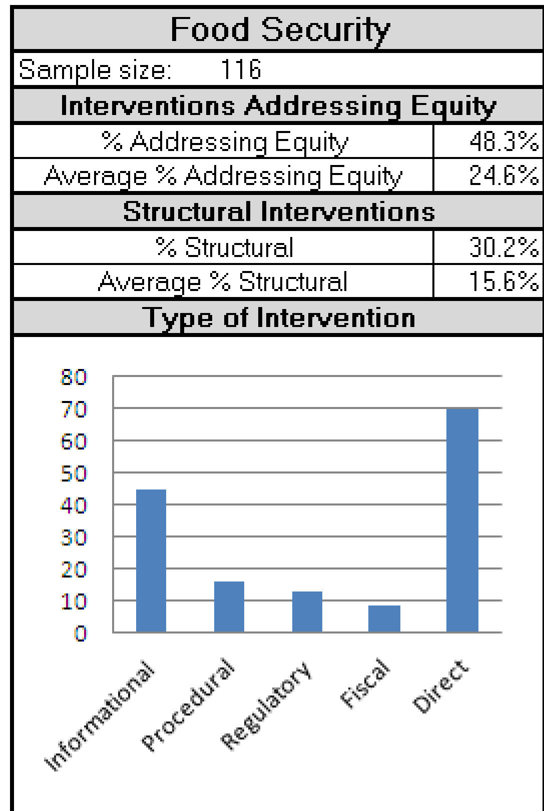
Interventions aimed at food security were most often direct, but informational interventions were also prominent. Regulatory policy instruments are more common in food security than most other social determinants because of public health inspections of restaurants and other food providers. The fiscal interventions in the sample tended to be subsidies for low-income pregnant women, including milk coupons or vitamins.

Many health regions operated meals on wheels programs, which provided isolated seniors with daily access to hot nutritious meals, and some of the meals on wheels programs also recognized their role in providing social interaction for an otherwise isolated population.

Some advocacy-oriented interventions encouraged local restaurants to provide organic or locally grown foods or to increase the representation of vegetables on their menu.

Summary of Key Analysis Questions

Food security interventions tended to be both more structural in nature than average, and more concerned with equity. Many of the structural interventions were aimed at building the capacity of community organizations to address food security at a local level, and often were part of larger plans to build capacity for action on poverty and other determinants as well. The Cote Nord provided the framework below for action on food security to target the underlying determinants of food insecurity (Côte Nord, 2008).



Food Security	
Sample size: 116	
Interventions Addressing Equity	
% Addressing Equity	48.3%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	30.2%
Average % Structural	15.6%
Type of Intervention	

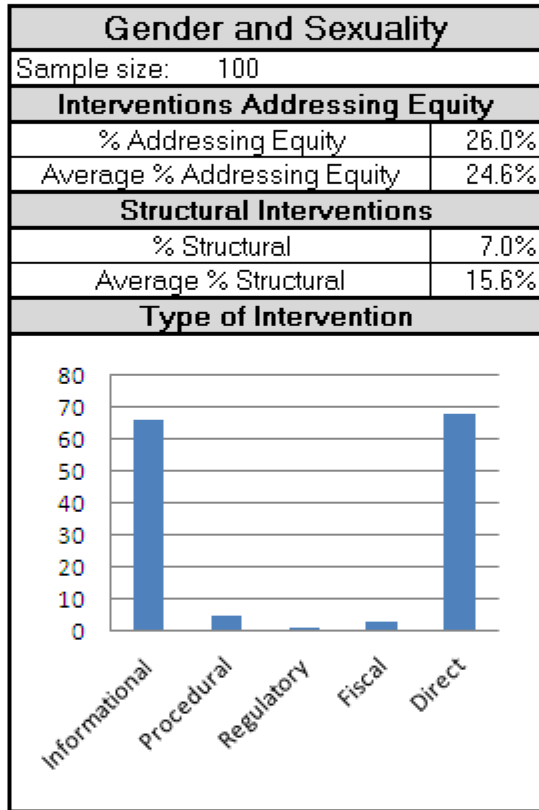
Almost half of interventions aimed at food security had an equity component, the most common of which was addressing barriers to access, with the transportation barrier being addressed commonly by meals on wheels programs in many health regions. Addressing frail seniors with meals on wheels and other similar interventions, and a focus on low-income groups in other interventions were also responsible for the high proportion of interventions in the category coded as addressing equity.

5.5.7 Gender and Sexuality

Main Activities

Many interventions addressing gender and sexuality are coded both as direct and informational interventions. These are largely sexual health clinics and other services that offer direct services such as pregnancy testing or testing and treatment of sexually transmitted infections and also offer counseling discussing healthy relationships and sexuality. Those interventions addressing only healthy sexual practices were coded only as personal health practices (those aimed at encouraging condom use, etc.). In order to be coded in the category of gender and sexuality, the program had to also address questions around the conceptualization of socially constructed gender roles and offer counseling with regards to what a healthy relationship can look like, a healthy body image, or other issues of that nature related to gender and not just sexual health.

Some direct interventions were eating disorders clinics that made an effort to combat the social construction of an unhealthy body image for women at the root of some eating disorders and exposure to the risks of elective plastic surgery.



Gender and Sexuality	
Sample size: 100	
Interventions Addressing Equity	
% Addressing Equity	26.0%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	7.0%
Average % Structural	15.6%
Type of Intervention	

Some interventions in this category may have had an unintended adverse impact on the social determinant of the construction of gender roles. “Look good, Feel Better” programs are provided for female cancer patients and provide free makeup and other beauty products and assist women in connecting with providers of wigs and other products. These services are provided in an attempt to make women feel better about their bodies after cancer treatment. However, these interventions are not available for men, and may serve to reinforce the idea that women should derive more of their sense of worth from their appearance than men should, and might exacerbate the negative consequences of the social construction of femininity and its relationship with physical appearance and sexuality.

Few interventions were aimed at changing the social construction of the ideal body image for either gender, and all of those in the sample that did were focused on a healthy body image for women. In the Yukon, for example, a girls night out was held that displayed art from local photographers celebrating that breasts come in all shapes and sizes and that becoming comfortable with your body is important for your health. A similar theme was conveyed through theatre, and childcare was provided on site to increase access to the program. Some eating disorder interventions also made attempts to influence the public perception of an ideal body image.

Summary of Key Analysis Questions

Interventions aimed at gender and sexuality were slightly more likely than average to address equity, but less likely to be structural in nature. Those interventions that were structural in nature tended to redistribute wealth by providing subsidies for birth control for low-income women. The interventions addressing equity had a focus on addressing vulnerable populations, most often victims of abuse. These included specific services for survivors of sexual assault that supported women in counseling after the crime and continued to support the women throughout the trial process by providing evidence and expert testimony. Other such interventions included shelters for battered women and counseling interventions aimed at changing the behaviour of abusive men by providing alternatives to violence.

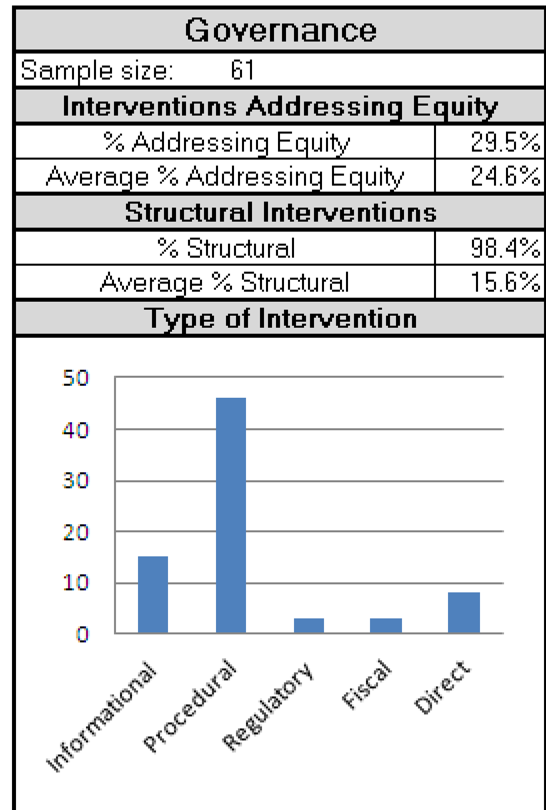
5.5.8 Governance

Main Activities

The most common form of intervention in this category was building the decision-making capacity of the health sector. This was often done through population health or health promotion groups who conducted needs assessments of the population served by the health authority or conducted evaluations of health interventions. Decision-making capacity was also addressed by a

number of health authorities aiming to transition their medical information into electronic health records to facilitate access to information, increase the amount and availability of information for decision makers, and reduce the duplication of procedures among other goals. Building community capacity was often addressed by providing grants to community organizations or supporting local organizations in building their own capacity through training and other methods.

Health system planning was democratized by rolling out engagement strategies for consulting the public, including sometimes specific groups such as Aboriginals, or by establishing permanent advisory bodies composed of community members who would provide input on the planning and delivery of local health services.



Governance	
Sample size: 61	
Interventions Addressing Equity	
% Addressing Equity	29.5%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	98.4%
Average % Structural	15.6%
Type of Intervention	

Non-health sector governance was addressed by making an effort to bridge research and policy. Dialogues with policy makers from sectors other than health, such as community planners, were held to bring a population health approach to their work and in an effort to work towards a health in all policies approach, recognizing the impact of non-health sector decisions on the factors that determine health.

One notable example from this section is the practice of health equity impact assessments (HEIA) done by Local Health Integration Networks (LHINs) in Ontario. This practice encourages decision makers to consider the unintended impacts of new interventions on different populations, and their effects on different social determinants. HEIAs also encourage thinking about how to mitigate such negative consequences and how to monitor the effects of policies to ensure that they are not having negative effects on marginalized populations or the broader determinants of health.

Summary of Key Analysis Questions

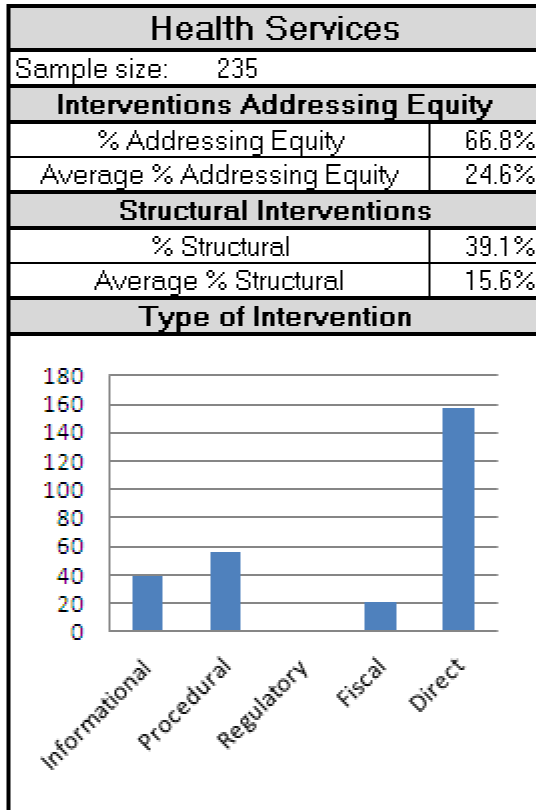
Because of the structural nature of the social determinant of governance, almost all interventions in this category are coded as structural. Most are also procedural because they operate at an organizational level. Further detail is provided in Figure 10.

5.5.9 Health Services

Main Activities

Many of the health services interventions are direct and have an equity component because they are concerned with improving access to primary care services in rural and remote areas, by making primary care services more culturally relevant, or by improving access to specialist care through technology.

Many target vulnerable groups and aim to improve access to care. For example, no fixed address vans and other services are concerned with bringing primary care services directly to hard to reach populations.



Health Services	
Sample size: 235	
Interventions Addressing Equity	
% Addressing Equity	66.8%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	39.1%
Average % Structural	15.6%
Type of Intervention	

Telehealth initiatives were used to remotely monitor the health status and medication compliance of patients with chronic conditions. They were also used to provide access to secondary and tertiary level care to patients in rural and remote areas. Several of the telehealth interventions were also used with mental health patients to provide direct counseling services from psychologists, psychiatrists, and other specialists.

Some of the procedural interventions also make use of telehealth technology and provide cultural competency training and other professional development opportunities to physicians and other staff in remote facilities.

Phone services were also common, such as nurse hotlines to provide direct access to healthcare professionals to answer questions. This has more of an impact in rural and remote areas where those specialists might be harder to reach normally.

Satellite clinics, travelling specialists, and mobile screening stations were also common, especially for breast cancer screening.

Summary of Key Analysis Questions

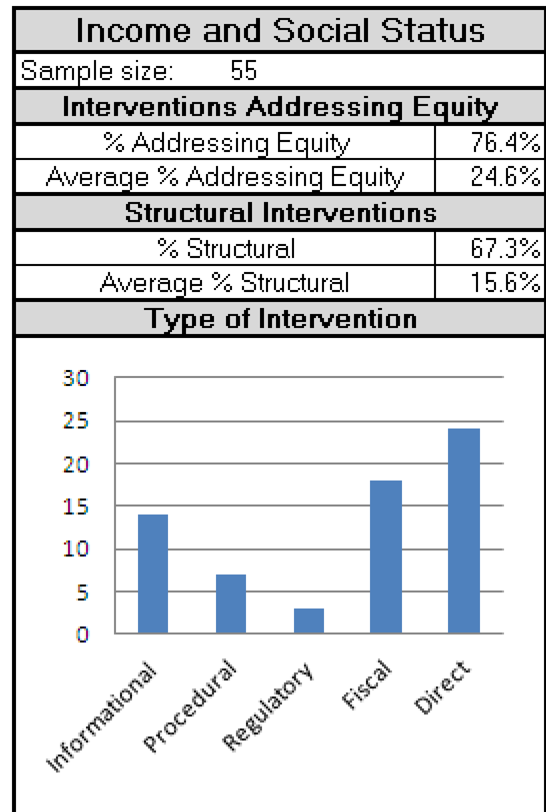
A high percentage of these interventions were coded as addressing equity, primarily for addressing access to health services on a system-wide level. This is also partially responsible for the high percentage of interventions coded as structural. The barriers addressed tended to be access to services in rural, remote, and isolated communities. Transportation was also addressed as a barrier to service by volunteer services and program-specific buses that collect patients and bring them to services. Some of the fiscal interventions in the sample are also for subsidizing travel from rural and especially northern communities to urban centres for specialized treatment, especially cancer treatments.

Vulnerable groups were also addressed, with Aboriginal groups being the most often addressed vulnerable population in this sample, and other interventions aimed at homeless populations. Vulnerable populations were also targeted with crisis services, which sometimes paired mental health nurses or other staff with police so that health services could intervene quickly even in situations where patients presented a risk to themselves or others.

5.5.10 Income and Social Status

Main Activities

Income and social status was the least commonly addressed determinant of health, although it is often recognized as one of the most important determinants of health.



Income and Social Status	
Sample size: 55	
Interventions Addressing Equity	
% Addressing Equity	76.4%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	67.3%
Average % Structural	15.6%
Type of Intervention	

Those interventions that do address income and social status do so in a number of ways, depending on the policy instrument used. Fiscal interventions, for example, tend to redistribute wealth and in so doing address equity by addressing cost barriers and targeting low-income populations. Procedural interventions and structural interventions that did not redistribute wealth often addressed the capacity of community organizations to address poverty at a local level, often through advocacy for poverty reduction strategies from different levels of government.

Some informational and direct interventions were aimed at building the financial literacy skills of the population and provided training in filing taxes and other financial activities that could connect patients with financial benefits they might not have been aware of, including tax credits.

In Manitoba, for example, two health regions provide volunteers who assist low-income populations in filling out their income tax returns, which are required to be eligible for certain credits and other benefits such as the child tax credit or the GST rebate.

Some of the equity-oriented interventions also redistributed wealth in the form of providing subsidies for supportive housing or other community living arrangements. Subsidies are also available for medication, for ambulance use, for nutritional supplements, and for other health services and equipment. Some interventions provide free loans of equipment that is not covered under provincial health insurance, such as crutches for patients who have broken a bone in their leg.

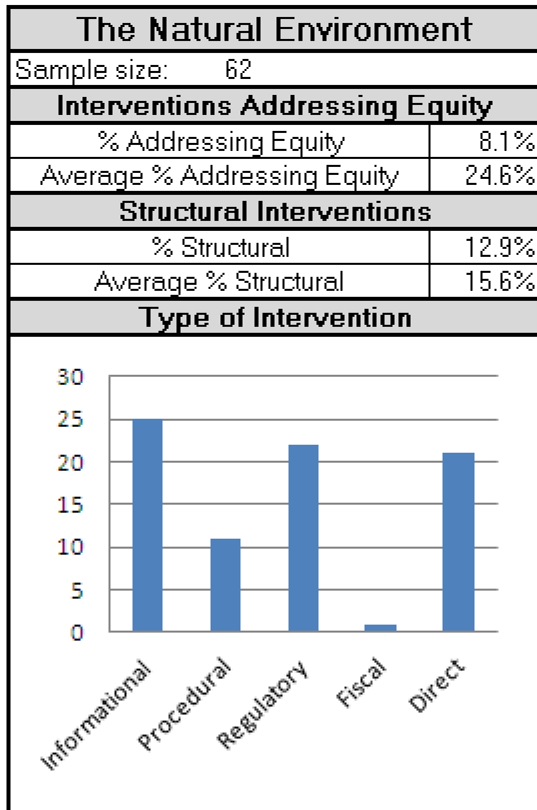
Other equity-oriented interventions were focused on low-income populations and provided subsidies for low-income caregivers who had to dedicate a certain number of hours per week to the care of a friend or relative. Some other interventions aimed to provide flexibility in home care provision by providing funding for patients to choose their own care providers.

Summary of Key Analysis Questions

This common focus on redistributing wealth, largely through small subsidies and bursaries is responsible for the high percentage of interventions coded as structural, and the focus on cost-related barriers to accessing care and on low-income populations in general accounts for the higher than average number of interventions addressing equity. Those focuses of these

interventions are in large part responsible for interventions aimed at this determinant having the highest percentage of interventions with an equity component.

5.5.11 Natural Environment



The Natural Environment	
Sample size: 62	
Interventions Addressing Equity	
% Addressing Equity	8.1%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	12.9%
Average % Structural	15.6%
Type of Intervention	

Main Activities

The natural environment interventions differ from the built environment interventions in a few notable ways. Not only are they less common generally, but they are also more likely to be informational or regulatory in nature. The most common aspects of the natural environment addressed were water quality and outdoor air quality.

Some of the informational interventions provide information in pamphlets and other formats for emergency preparedness, guiding residents on how to prepare for and respond to events such as flooding or hurricanes. Some informational interventions appreciate the desire of the population to contribute at an individual level to global efforts to mitigate global warming and provide information on how residents can contribute to such efforts by reducing their energy consumption and waste.

Many of the regulatory interventions are public health inspections of water sources and outdoor air quality. Some provide support for health authority residents to comply with regulations, for example regulations that require the eradication of allergens such as ragweed from personal property.

Many of the direct services, like the built environment interventions, are laboratory services that provide water quality testing and other services.

The procedural interventions include emergency preparedness planning documents to prepare communities and health authorities to respond in the event of a heat wave or other environmental hazard that endangers the population. Others are organizational level policies that operate on a smaller scale. Capital Health in Nova Scotia, for example, uses a CarShare program instead of taxis to preserve the environment and to save money for the health system.

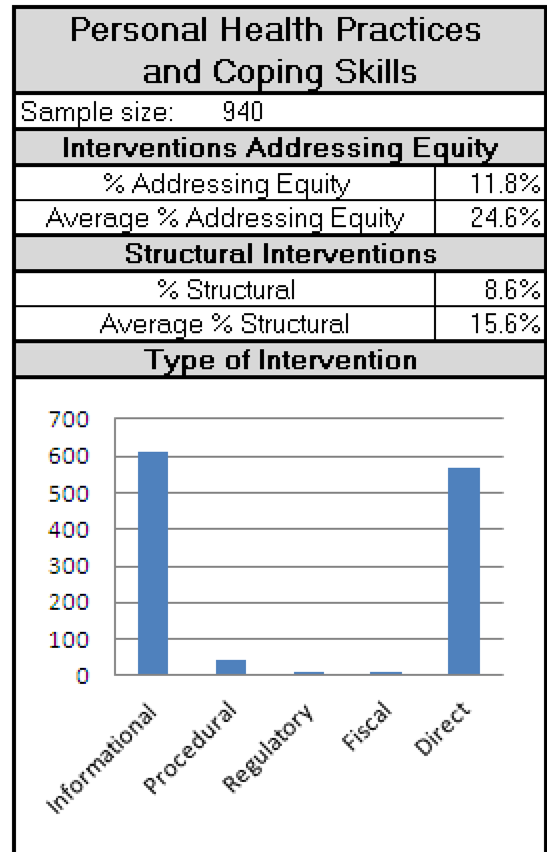
Summary of Key Analysis Questions

This category contains the lowest percentage of interventions with an equity component, and a lower than average number of natural environment interventions produce structural change. The most common element of structural change in this category is an effort to address climate change on a global scale.

5.5.12 Personal Health Practices and Coping Skills

Main Activities

Interventions addressing personal health practices and coping skills are almost exclusively informational or direct interventions, with many interventions employing both policy instruments.



A number of interventions are aimed at improving the self-management skills of patients with chronic conditions, including most prominently diabetes, chronic obstructive pulmonary disorder, asthma, and heart disease. These interventions often offered both educational sessions and supervised exercise or consultation with dietitians. A number of similar initiatives were in place to support cancer patients in their treatment, as a healthy lifestyle can somewhat mitigate the suffering commonly associated with cancer treatments such as radiation therapy.

A number of the direct interventions were tied to addictions counseling interventions, tobacco cessation interventions, or community exercise interventions which provided expert assistance and support to improve health behaviours and encourage healthy lifestyles.

The relatively few regulatory interventions in this category were most commonly related to keeping the physical grounds of health authorities smoke-free. Some interventions included a fiscal component, for example by providing prize money for winners of a quit smoking contest.

Some interventions went beyond attempting to encourage healthy behaviours through the standard encouragement of healthy eating, regular exercise, and reducing or eliminating intake of tobacco. A few interventions aimed to build the resilience of individuals and help them cope with existing stressors in their life or help patients identify and remove stressors.

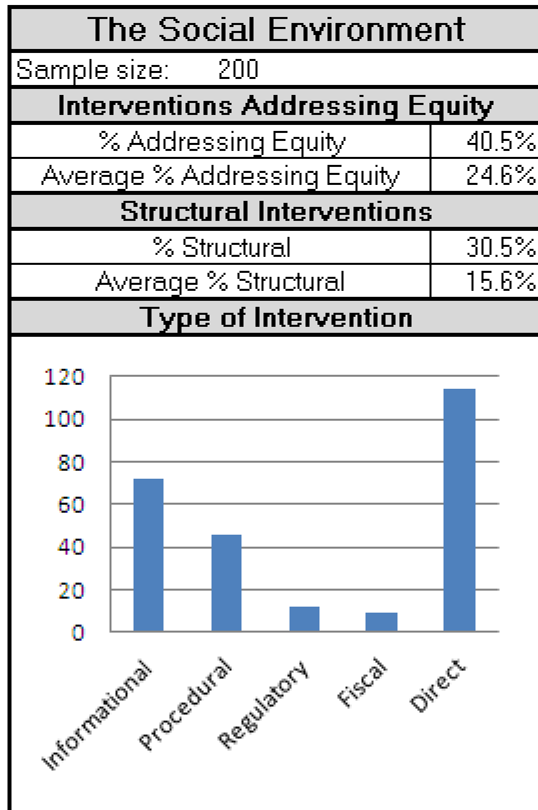
Addressing personal health practices through the provision of information was often a secondary feature of a larger program that was often hospital-based and focused more directly on providing care for patients with conditions influenced by health behaviours. Encouraging healthy sexuality was often tied in with harm reduction interventions which distributed free condoms.

Summary of Key Analysis Questions

Interventions in this category tended not to address equity or produce structural change to the same extent as interventions in other categories. This is likely due to the use of policy instruments and the relative potential ineffectiveness of informational interventions at producing changes in behaviour.

Those interventions that did have an equity component often addressed equity by reducing barriers to full social participation for marginalized groups through providing training in life skills to allow for independent living and participation in educational pursuits or the workforce.

5.5.13 Social Environment



The Social Environment	
Sample size: 200	
Interventions Addressing Equity	
% Addressing Equity	40.5%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	30.5%
Average % Structural	15.6%
Type of Intervention	

Main Activities

Interventions targeting the social environment are a mixed batch of interventions. Many address the social environment as a secondary function of larger program objectives, especially for direct initiatives. Direct initiatives often consist of counseling or other interventions which include a goal to create a home-like environment, such as by providing plants and other décor for retirement residences. This is a common theme with many palliative care interventions as well.

Some procedural interventions aim to make the health authorities safe spaces for patients of differing sexual orientations or different cultures by creating appropriate services and sensitizing staff. Some of these initiatives were also regulatory in a few cases, with specific standards being set for different environments such as retirement homes that need to be certified.

Some of the informational interventions in this category are efforts to raise awareness about medical and social conditions to reduce the stigma associated with them. Many of these interventions focus on mental illness or HIV, for example. Television and radio advertisements, posters, websites, and the designation of days, weeks, and months for specific issues to raise awareness were some of the common ways that stigma was addressed by bringing little understood issues to the public's attention. These interventions sometimes targeted barriers to full social participation by different groups and in that way created a healthier environment by assisting marginalized or socially excluded groups.

A number of these interventions aim to improve the home environment by addressing abuse and parental relationships to create a healthier environment for child development. Other interventions aim to improve community safety by promoting the use of seatbelts and car seats and providing disincentives for drunk driving and other detrimental behaviours.

Summary of Key Analysis Questions

Interventions aimed at the social environment are more likely than average to be structural in nature and are also more likely to address equity. Equity-oriented interventions in this category target a number of barriers to accessing their services and also target a number of vulnerable groups, though the most common vulnerable group addressed in this category is victims of

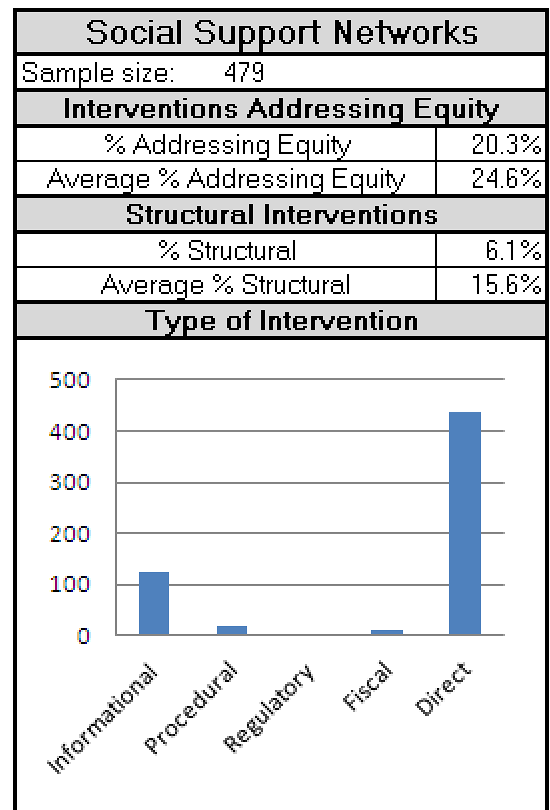
abuse. Victims of abuse were often targeted by child protection services in jurisdictions where health and social services are delivered together, as is the case in Quebec.

The most commonly addressed aspect of structural change in these interventions was building community capacity for action on the social determinants.

5.5.14 Social Support Networks

Main Activities

Social support networks were often addressed as secondary components of interventions, but were sometimes the sole purpose of a program. Social support networks were commonly associated with interventions aimed at personal health practices. For example, smoking cessation groups were very common, along with support groups in other addictions programming for alcoholism, drug addiction, and problem gambling.



Social Support Networks	
Sample size: 479	
Interventions Addressing Equity	
% Addressing Equity	20.3%
Average % Addressing Equity	24.6%
Structural Interventions	
% Structural	6.1%
Average % Structural	15.6%
Type of Intervention	

Some support services included a peer component. Some mental health counseling services, for example, paired newly diagnosed patients with peer counselors. This served both the new patients by providing them with support and older patients by providing them with a paid role on a health care team and allowing them to benefit by sharing their experience and having their contributions recognized.

In addition to recovery and relapse prevention support groups, there are also grief and loss support groups. Palliative care services and spiritual support services offer bereavement and grief counseling, both for terminally ill patients struggling with philosophical questions about life, the end of life, and death and for the patients' families who are struggling with the loss of a loved one. Most spiritual care services appear to be notionally non-denominational, but most volunteers and religious workers involved are strongly associated with Christianity, though they see all patients. This is especially true in smaller communities. Some health authorities also allow access for Aboriginal elders to visit patients through the spiritual services program.

Other support groups were also associated with specific conditions, especially for those receiving a diagnosis of a potentially fatal illness such as cancer. Much of the time, such groups also included support for the patients' families.

Many social support interventions were also closely related to early childhood development, as there are a number of groups for new parents and for women experiencing issues with breastfeeding. Some of these groups provided social support networks for both parents and children, by bringing the same mothers and children together. With children of a similar age, new parents can meet to discuss parenting challenges at each new fun and challenging stage of

childhood development as new issues arise over the years. The children are also given an opportunity to socialize and form their first circle of playmates.

Summary of Key Analysis Questions

These interventions were much less likely to be structural in nature than most interventions aimed at the social determinants of health, and somewhat less likely to address equity. Those that are coded as structural most commonly address the distribution of wealth, suggesting that building social support networks was not the primary focus of those interventions. Equity-oriented interventions in this category addressed both barriers to access and vulnerable groups.

5.6 Discussion

The focus of interventions aimed at the determinants of health seems to be on addressing individuals' behaviour through their personal health practices, often with informational interventions aimed at encouraging healthy lifestyle choices. Significantly less attention is placed on addressing underlying determinants such as income and employment, though these may be more important determinants of health than individual behaviour. Early childhood development and social support networks were also common focus areas. Many interventions aimed at early childhood development were also informational, often in the form of parenting resources for new parents.

Most interventions tended to be informational or direct, if not both. Other available policy instruments tended when used to have more of an equity impact. Fiscal interventions, for example were used almost exclusively as a tool for redistributing wealth, if only on a very small scale. Regulatory interventions were limited with some exceptions to the public health units responsible for enforcing food safety and environmental regulations and legislation.

Only approximately 16% of the interventions identified were structural in nature, demonstrating that much of the focus is on the daily living conditions. While very important, these downstream interventions are demonstrative of a choice to allocate funding away from upstream structural interventions as would follow from a population health approach. Instead, the choice to focus on downstream interventions indicates a conception of the primary role of health authorities as being providers of care, rather than as improvers of public health. Though health regions are tasked with improving the health of the population, this does not appear to have penetrated into the funding allocations and policy directions that would move the structure of direct care provision more towards upstream interventions aimed at the determinants of future health.

A number of interventions appear aimed at restructuring the health system to make it more diverse, equitable or efficient. The appearance of telehealth technologies and electronic health records are some examples of interventions aimed at finding efficiencies. Cultural competency training, health human resources initiatives to build representative workforces, Aboriginal engagement initiatives, and community health boards are some of the ways in which health system decision making and operations are being made more culturally sensitive to provide appropriate care.

There are interventions in place to address all the determinants identified as important, but it is not clear if the choice of policy instruments is most effective or if those services available are matched to community needs. Further analysis of this dataset would allow for identification of

regional priorities and what policy learning might be possible if health regions with experience addressing specific social determinants were to collaborate with other regions with different specializations and experience. There are innovative approaches to addressing each of the social determinants, though it is not clear if these are to be evaluated and if the lessons learned from them are to influence health region planning elsewhere in the country.

6.0 OPTIONS

This research has identified several interesting findings, some of which suggest options for future research. One of the most interesting findings was the lack of publicly available evaluations. This possible direction is expanded on using part A from CIHI's Analytical Proposal Template. An in-depth analysis of any one determinant or aspect of equity-oriented or structural interventions could be the focus of an analytical work. This research is also substantial in itself and would likely hold appeal for the social determinants of health community of researchers and practitioners.

6.1 CASE STUDY

This research identifies some gaps in health services at the regional level, such as the provision of services relating to income and social status. While few, there are some interventions that address these gaps. Case studies of these interventions would enable some discussion of their effectiveness and their value, and might enable more widespread adoption of promising practices for addressing the social determinants of health.

6.2 EXPLORE POLICY LEARNING AT THE HEALTH REGION LEVEL

TOPIC/ANALYTICAL QUESTION

The focus of this research would be on the current knowledge transfer practices of health regions, and what is done with the evidence obtained from program evaluations. The role of policy learning in organizational efficiency could also be explored at a higher level.

PURPOSE/RATIONALE

This research would address a question left after the initial research of why so few evaluations of population health interventions are publicly available on health region websites. The purpose of this research would be to identify opportunities for more effective knowledge translation at the health region level that might lead to more efficient or effective program delivery.

1. Identify ways in which policy learning contributes to organizational efficiency
2. Examine the current knowledge transfer practices of health regions with regards to program evaluation results, and the extent to which evaluation is considered as a normal part of the planning process in health regions
3. Consult with health authorities for their view on current knowledge exchange practices
4. Examine how other organizations have gained efficiencies through policy learning and what lessons from this might be transferable to Canadian health authorities

Such analysis would respond to the overarching recommendations of the WHO's 2008 report, *Closing the Gap in a Generation*, by exploring the state of program evaluation for health equity-oriented interventions in Canada.

Background/Context
CPHI has been considering program evaluation as a part of the policy cycle, with program evaluation identifying new policy issues for which policy options can be considered and implemented before once again being evaluated to continually refine a program area. In this scan of health authority websites for descriptions of interventions, only 0.68% of interventions were identified as having been evaluated. However, 1% of programs were themselves identified as evaluation bodies, having responsibility for the evaluation of services within a specific area or for the health region in general. This has left an unanswered question of what becomes of the work of these evaluation units within the different health authorities, if the results are not posted publicly.

Target Audience
This research would be primarily geared towards the needs of health authority decision makers, but would also inform the work of program evaluators and could also be of interest to health system funders, including the Government of Canada, and researchers working in the field of policy action on the social determinants of health.

Proposed Work Plan and Partnerships
This research would involve a literature review of the place of policy learning in organizational efficiency, and interviews with health authority evaluation bodies. A number of these have been identified during the initial research and a list of potential interviewees can be generated by this dataset.

Methodology

Data Sources
Interview subjects could include evaluation bodies identified in the original research or other health policy developers at the health region level. Academic literature would also be consulted in the early stages of research.

Population of interest
The population to be studied in this case is program evaluators and decision makers at the health region level.

Risks
Getting buy-in from a diverse set of health authority evaluation bodies and different levels of health policy decision making will be a complex process. Disseminating the results of this research to relevant populations may also be a hurdle. This risk could be mitigated by involving the health authorities through consultation to discuss the aims of the project, the method, and the sample.

6.3 In-Depth Analysis
Any of the social determinants explored could provide material for an in-depth analysis of interventions in that area. Such an in-depth analysis could provide details on regional variations in priorities and might identify gaps in the barriers addressed or regions where the services are not provided.

The findings section of this paper gives a brief overview of the findings for each determinant to present interesting differences between interventions aimed at different determinants and to give an idea of the nature of equity-oriented activities in certain program areas. In-depth analyses could also be focused on different aspects of equity-oriented action on the social determinants of health in general, or for a specific determinant, population, or barrier. Further analysis and follow-up of interventions coded as possessing an equity focus or being structural in nature could also be revealing of the policy directions currently guiding practice at the health region level in Canada. Any number of such analyses could be undertaken and their focus would vary depending on the topic, purpose, and audience.

Identifying gaps in determinants addressed and associated lack of services could also be useful. For example, the scarcity of interventions addressing financial literacy could be explored from a number of angles, including the equity implications. These gaps could be discussed in terms of service areas, populations not represented in consultations, or once again in terms of geographic regions.

The scarcity of interventions aimed at bringing a social determinants or a health equity lens to non-health sector governance could also be examined in light of an emerging trend of health-in-all-policies approaches appearing internationally.

An analytical piece exploring structural inequalities as described by the WHO could be informative. Observing the pressures being put on systems to transform from within and to exert external pressure on other drivers of structural change could build our understanding of how the process of structural change is currently playing out and what other important drivers identified in other contexts could be addressed in Canada in order to more effectively address structural inequalities in health.

6.4 Academic Publication

The results of this research, explained throughout the findings section of this paper, could be condensed and presented for an academic audience. Such a wide-ranging scan of health policies on the social determinants of health would hold appeal for the community of social determinants of health researchers and practitioners in Canada and elsewhere. Given that the data collection, data cleaning, and analysis have already been undertaken, organizing the findings into a manuscript would be a relatively easy endeavour and could likely be completed as a side-project with one or two analysts supported by the rest of the policy analysis and decision support group.

7.0 Recommendation

Option 6.1 is recommended. While the breadth of this research is vast, few of the overall findings will be surprising to those familiar with the current landscape of health services. The value of this research lies in its breadth; not because of the overall picture of the health system that it paints, but because of the few interventions it uncovered that are not commonly adopted across numerous health regions. A case study of promising practices in areas underserved by health regions would use the real strength of this research and could enable the spread of promising practices from innovative health regions and their organizations to other regions facing similar challenges.

8.0 CONCLUSION

This research is limited by the methodology and therefore describes most accurately the programming of health regions that invest in their websites. It provides an overview of interventions in Canada at the health region level aimed at the social determinants of health. A number of interesting findings call for future research and present some possible future directions for CPHI, but some of the findings are interesting in themselves as an overview.

Approximately a quarter of interventions that address the social determinants of health in Canada at the health region level address health equity, mostly implicitly by addressing barriers to service access or by targeting vulnerable groups. More health regions profess to address equity in their vision/mission/values statements than consistently promote health equity in their programming. Few of the interventions (15.64%) are structural in nature, and the most commonly addressed determinant is personal health practices though it might not be the most important determinant of health. This research provides some insights into how the social determinants of health can be addressed in ways beyond disseminating information in an attempt to influence health behaviours. Further examination of the database created to support these analyses can be used to identify gaps in health services programming.

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APPENDIX A: BREAKDOWN OF THE SAMPLE

Jurisdiction	# Health Regions Included	Total Entries
Alberta	1/1	403
British Columbia	6/6	412
Manitoba	10/11[4]	217
New Brunswick	0/2[5]	0
Newfoundland	4/4	104
Northwest Territories	8/8	51
Nova Scotia	10/10	290
Nunavut	1/1	8
Ontario	14/14	192
Prince Edward Island	1/1	40
Quebec	16/18[6]	254
Saskatchewan	13/15[7]	271
Yukon	1/1	41
TOTAL	**85/92**	**2283**

[4] The Churchill Regional Health Authority does not list any information on available services on their website.

[5] The websites of health regions in New Brunswick were not complete by November 20th 2011 following a recent amalgamation of health regions.

[6] The Outaouais region was undergoing maintenance that was not complete by November 20th 2011, and the Nunavik Region did not include any information on services on its website.

[7] The Athabasca Health Authority and Northern Medical Services do not provide any information on available services on their websites.

APPENDIX B: CODING SHEET

Column Heading	Significance	Coding
Intervention	Name of intervention (not site or document)	Short Text
RMID	Reference Manager identification	Number
Jurisdiction	In which province or territory is the intervention taking place?	AB, BC, MB, NB, NFLD, NS, NU, NWT, ON, PEI, QC, SK, YU
Health Region	Health Region/Authority/etc. name	Health Region Name
Type (Pal's)	Type of intervention	Please see Appendix C
Equity Focus	Is addressing health equity an explicit goal of the intervention?	Please see Appendix C
DLC vs. S	Does the intervention address daily living conditions or structural inequities?	Please see Appendix C
Equity notes	Space to write any other relevant details (ex. is there a barrier to address? Was the targeted group engaged in the policymaking process?)	
Built Environment		Yes/No
Culture		Yes/No
Early Child Development		Yes/No
Education and Literacy		Yes/No
Employment & Working Conditions		Yes/No
Food Security		Yes/No
Gender and Sexuality		Yes/No
Governance		Yes/No
Health Services		Yes/No
Income & Social Status		Yes/No
Natural Environment		Yes/No
Personal Health Practices		Yes/No
Social Environments		Yes/No
Social Support Networks		Yes/No
Evaluated?	Was the intervention evaluated (or is it scheduled to be evaluated)? Is the intervention in itself responsible for evaluating services?	1 = yes 2 = evaluation pending 3 = evaluation body
Outcomes Evaluated	Long term or short term outcomes evaluated (NOT outputs)	
Indicators used	List of indicators used to measure progress towards outcomes	
Other Description	Qualitative description of what the intervention is	
Source	URL or link to saved PDF	

APPENDIX C: EQUITY, STRUCTURAL INTERVENTIONS, INTERVENTION TYPE, AND SDOH

EQUITY

Explicitly Addresses Equity: In the description of the program, the health authority describes the intent to address equity or reduce disparities or inequalities.

EQUITY COMPONENT ADDRESSED	CODE
Addresses macro level factors that contribute to the existence of barriers (poverty, low literacy, etc)	110
Addresses barriers to accessing the service	120
• Transport • Availability in rural/remote areas • Cost • Language or cultural barriers • Childcare • Other	121 122 123 124 125 126
Addresses vulnerable group[8]	130
• Aboriginal groups • Low-income groups • Victims of abuse • Homeless • Refugees • Injection Drug Users • Frail Elderly	131 132 133 134 135 136 137
Explicitly states an intention to reduce inequities but does not specify how	140

Implicitly Addresses Equity: The program, without explicitly stating an intention, will still have the effect of…

EQUITY COMPONENT ADDRESSED	CODE
Addresses macro level factors that contribute to the existence of barriers (poverty, low literacy, etc)	210
Addresses barriers to accessing the service	220
• Transport • Availability in rural/remote areas • Cost • Language or cultural barriers • Childcare • Other	221 222 223 224 225 226

[8] These vulnerable groups were selected from a list of commonly occurring vulnerable groups in the literature. They were selected based on Frohlich & Potvin's definition of a vulnerable group as a group "at risk of risks" (2008, p.1). Other commonly cited vulnerable groups such as children, those with a physical disability or living with a mental illness were excluded because of the number of interventions addressing these groups, a wide variation within the groups, and limitations with the methodology. Specifically, it is not clear from the often limited information available on health authority websites about individual interventions which groups among the spectrum of those living with a mental illness or other condition are being addressed, and whether or not this has an impact on equity. Relatively few groups therefore are included under this framework in order to preserve clarity, though this list is by no means exhaustive of groups that could be reasonably identified as vulnerable or socially marginalized.

Addresses vulnerable group	230
• Aboriginal groups • Low-income groups • Victims of abuse • Homeless • Refugees • Injection Drug Users • Frail Elderly	231 232 233 234 235 236 237

DAILY LIVING CONDITIONS VS. STRUCTURAL INTERVENTIONS

Interventions that address the social determinants of health without addressing the structural level are coded as 1 for addressing the daily living conditions in which Canadians live, work, learn, and play.

STRUCTURAL COMPONENT	**CODE**
Addresses the distribution of wealth (including providing subsidies to certain groups for medical services)	21
Addresses systemic barriers to access across the whole system, not on a case by case basis	22
Advocates for public policy change around the SDOH	23
Addresses non-health sector governance	24
Democratizes health system planning (through consultations or community health boards, for example)	25
Aims to improve the physical environment on a global scale	26
Builds community capacity to address the SDOH	27
Builds decision making capacity of the health sector by building evidence (stats and evaluations)	28

INTERVENTION TYPE

INTERVENTION TYPE	CODE
Informational (including classes, informational pamphlets, one on one education, etc.)	1
Procedural (organization-level processes, frameworks, policies, that are not imposed by government)	2
Regulatory (including on-location by-laws and the enforcement of legislation and regulations)	3
Fiscal (including subsidies, grants, bursaries, investment funds, etc.)	4
Direct service (for example, counseling, physician services, case work, etc.)	5

Social Determinants of Health

Built Environment

- Relates to housing quality, availability, or affordability (including heating, etc.)
- Relates to the design of communities, such as bike paths, transit systems, etc.
- Relates to indoor air quality

Culture

- Relates to the acceptance and valuing of indigenous or other cultures
- Relates to making services culturally relevant (ie. available in other languages, compatible with Aboriginal traditions, etc.)
- Assists new immigrants in integrating successfully into society

Early Child Development

- Relates to maternal nutrition or other aspects of prenatal development
- Early childhood education and care interventions
- Provides support to parents with young children for the purpose of aiding the development of the child, including parenting classes
- Relates to breastfeeding promotion or support
- Immunization programs are not included (unless they address access in which case they would appear under health services)

Education and Literacy

- Provides access to education or employment-related training
- Provides training in literacies
- Aims to improve student learning in schools

Employment and Working Conditions

- Relates to the provision of employment or the mitigation of unemployment, temporary, and informal work
- Relates to labour laws or workplace health and safety
- Relates to the physical environment at work
- Improves employability

Food Security

- Enhances the availability or affordability of nutritious foods
- Aims to mitigate the proliferation of excessively sugary, salty, or other unhealthy foods
- Provides food relief to target populations, such as school breakfast programs
- Enhances the safety of available foods such as through inspection

Gender and Sexuality

- Designed to mitigate inequalities between sexes or sexual orientations
- Combats unhealthy body image for men or women
- Addresses gender-related medical conditions resulting from gender, NOT sex (ie. Not breast cancer, but bulimia, etc.)

GOVERNANCE

- Improves the voice of populations in policymaking through consultation processes or otherwise
- Encourages health in all policies
- Aimed at granting aboriginal self-governance over health services or other areas

HEALTH SERVICES

- Improves access to health services
- Helps patients navigate complex health systems

INCOME & SOCIAL STATUS

- Redistributes income in some way to lower income groups
- Aims to improve the distribution of wealth
- Removes or mitigates cost barriers to services

NATURAL ENVIRONMENT

- Aimed at improving outdoor air quality
- Improves source water quality
- Mitigates pollution
- Prepares for adaptation to climate change
- Prepares for or recovers from natural disasters

PERSONAL HEALTH PRACTICES AND COPING SKILLS

- Educates individuals or public on healthy eating, active living, stress management or the risks of harmful substances or practices
- Facilitates uptake of healthy cooking practices, active living, or quitting smoking, drinking, drug use, etc.
- Promotes practices that support the health of others (ex. Organ donation)
- Improves life skills and/or social skills
- Builds patients' capacity for disease self-management

SOCIAL ENVIRONMENTS

- Aims to create a healthy, more accepting environment
- Targets domestic violence/abuse to improve the home environment for victims of abuse
- Aims to change social perceptions to reduce stigmatization and allow all members of society to feel valued
- Community safety (ex. Initiatives to reduce drunk driving, expand use of car seats)

SOCIAL SUPPORT NETWORKS

- Provides a forum for social interaction among individuals requiring support (ex. seniors)
- Provides support for people that require it (ex. hotlines)
- Caregiver respite
- Connects patients with peers
- Bereavement support

Appendix D – Data Tables

Figure 2 – Interventions with an Equity Component

How is Equity Addressed?	n of interventions	% of interventions
No Equity Component	1659	75.41%
Explicit Equity Component	38	1.73%
Implicit Equity Component	503	22.86%

Figure 3 – Health Regions Striving for Equity in their Vision/Mission/Values Statements

How is Equity Addressed?	n of regions	% of regions
No Equity Component	49	58.33%
Explicit Equity Component	27	32.14%
Implicit Equity Component	8	9.52%

Figure 4 – Components of Equity Addressed

Components of Equity	n of interventions	% of equity interventions	% of total interventions
Address Vulnerable Groups	302	51.36%	13.73%
Address Barriers to Access	252	42.86%	11.45%
Explicitly states intention to mitigate inequities	19	3.23%	0.86%
Address macro-factors such as poverty	15	2.55%	0.68%

Figure 5 – Barriers Addressed

Barriers Addressed	n of interventions	% of interventions addressing barriers	% of total interventions
Other	72	28.57%	3.27%
Availability in Remote/Rural Areas	66	26.19%	3.00%
Transport	57	22.62%	2.59%
Language and Cultural Barriers	31	12.30%	1.41%
Cost	21	8.33%	0.95%
Childcare	5	1.98%	0.23%

Figure 6 – Vulnerable Groups Addressed

Vulnerable Group Addressed	n of Interventions	% of interventions addressing vulnerable populations	% of total interventions
Aboriginal groups	81	26.82%	3.68%
Victims of Abuse	71	23.51%	3.23%
Low-Income	56	18.54%	2.55%
Not Specified	25	8.28%	1.14%
Injection Drug Users	24	7.95%	1.09%
Frail Elderly	24	7.95%	1.09%
Homeless	14	4.64%	0.64%
Refugees	7	2.32%	0.32%

Figure 7 – Breakdown of Structural Interventions

Aspects of Structural Interventions	# of interventions	% of Structural interventions	% of total interventions
Addresses systemic barriers to access	98	25.45%	4.45%
Builds community capacity to address SDOH	92	23.90%	4.18%
Addresses the distribution of wealth	58	15.06%	2.64%
Builds decision-making capacity of the health sector	46	11.95%	2.09%
Advocates for public policy change around SDOH	35	9.09%	1.59%
Democratizes health system planning	32	8.31%	1.45%
Addresses non-health sector governance	21	5.45%	0.95%
Aims to improve the physical environment on a global scale	3	0.78%	0.14%

Figure 8 – Interventions by Type

Policy Instrument Type	n of interventions with a component of this type	% of instruments in this sample	% of interventions with a component of this type
Informational	977	35.4%	44.4%
Procedural	234	8.5%	10.6%
Regulatory	69	2.5%	3.1%
Fiscal	74	2.7%	3.4%
Direct	1408	51.0%	64.0%

Figure 9 – Equity by Determinant of Health Addressed

Determinant of Health	n of interventions	% of interventions	n addressing equity	% addressing equity
Personal Health Practices & Coping Skills	940	42.73%	111	11.8%
Early Childhood Development	522	23.73%	104	19.9%
Social Support Networks	479	21.77%	97	20.3%
Health Services	235	10.68%	157	66.8%
Social Environment	200	9.09%	81	40.5%
Built Environment	130	5.91%	35	26.9%
Food Security	116	5.27%	56	48.3%
Culture	115	5.23%	87	75.7%
Gender & Sexuality	100	4.55%	26	26.0%
Natural Environment	62	2.82%	5	8.1%
Education & Literacy	61	2.77%	14	23.0%
Employment & Working Conditions	61	2.77%	16	26.2%
Governance	61	2.77%	18	29.5%
Income & Social Status	55	2.50%	42	76.4%