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Evolving Understanding of Health Equity and Health Equity Action in British Columbia Canada

Marjorie MacDonald, Bernie Pauly, Wanda Martin, Trevor Hancock, Warren O'Briain, Cheryl Martin, Victoria Lee

University of Victoria, Victoria BC, Canada

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Funders

Michael Smith Foundation for Heath Research

- Team planning and start up grants

Canadian Institutes of Health Research

- CIHR Knowledge to Action Grant
- CIHR Emerging Team Grant
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- CIHR Travel Grant

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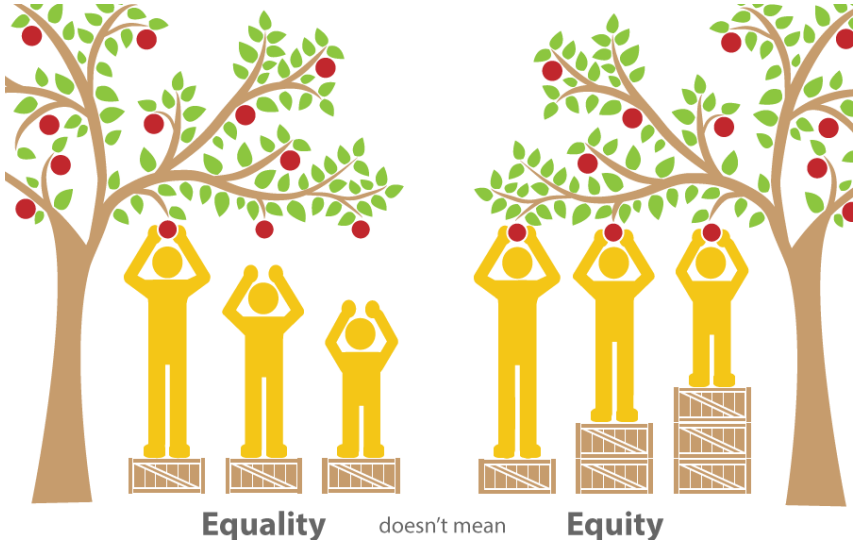
- To present the results of a secondary analysis synthesizing data on health equity from four public health policy intervention studies
- To discuss changes over time in health equity action and practitioner understanding about

Health Equity Definition

- **Health equity** exists when all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance (Whitehead & Dahlgren, 2006)

- **Health inequities** are differences in health status that are **systematic, unfair, and avoidable** (WHO Commission, 2008)



http://www.communityview.cainfographic_SHR_health_equity_2014.html

Study Description and Participants

Study 1: Evidence informed practice (2009-10)

- Food safety and Unintentional Injury Prevention programs
- 3 BC health authorities, MOH
- 41 participants- interviews and FGs, FL staff, directors, managers, coordinators

Study 2: Renewal of PH System 3 phases of data (2011-15)

- Healthy Living and STI prevention programs
- 5 BC health authorities, MOH
- Phase 1 N=56, Phase 2 N=44, Phase 4 N=45
- FL staff, managers, senior directors

Study Description and Participants

***Study 3: Food Gone Foul* (2011-2012)**

- food safety and food security PH programs
- Cases = urban chickens, community kitchens, unpasteurized milk, farmer's markets
- 34 participants (9 health care, others crossed multiple cases)

Study 4: Equity Lens in Public Health (2013-14)

- 5 regional HAs, 1 provincial HA, MOH
- Mental health promotion and preventing harms of substance use PH programs
- 167 participants – FL staff, managers, directors, senior executives

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Methods

Qualitative interviews, taped and transcribed

- Each study originally coded separately using constant comparison then recoded to answer the three questions posed in this analysis:

1. What do participants understand by the term “health equity”?
2. What strategies are used to promote health equity?
3. What are the barriers and facilitators to promoting health equity?

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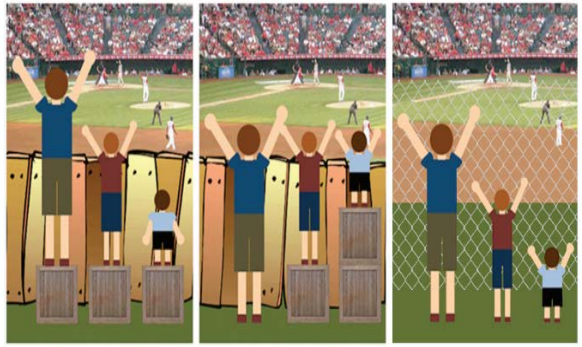
Evolving Understandings of Health Equity

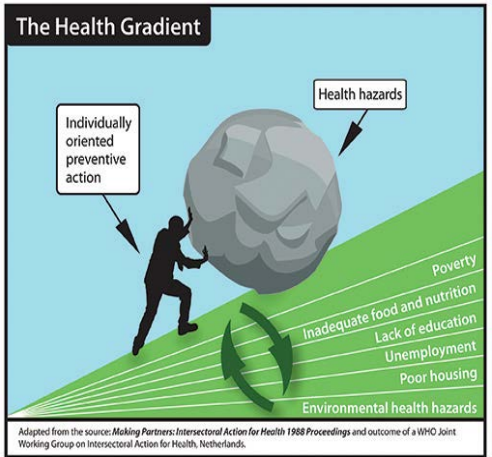
Early	Mid-point	Later
*HE as working with priority-vulnerable-marginalized pops *HE as equal access to services *HE as equality- treating everyone same *HE as targeted services *HE as related to SDOH *HE as fairness and Justice *Limited Understanding of HE	*HE as related to SDOH *HE as equality – treating everyone same *HE as targeting services to vulnerable-marginalized populations *HE as equal access to services or conditions for health *HE as fairness and justice	*Increasing recognition that equity is not equality *HE as equitable/equal access to services *HE as working with priority-vulnerable-marginalized pops *HE as targeting services *HE as fairness and justice *Overall, Increasing understanding of HE as fitting our definition of HE (closing the gap, the health gradient, addressing the “isms”, proportionate universalism)

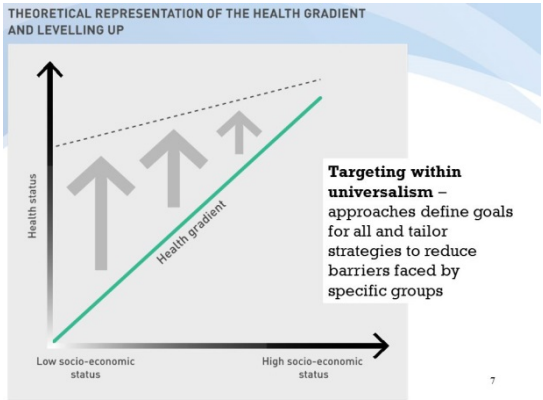
Evolving Understanding of Health Equity

We don't know what health equity means!



Equality Equity Systemic Barrier Removed





"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" – Marmot

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives- the-marmot-review 9

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Strategies to Address Health Equity

EARLY	MID-POINT	LATER
In general, strategies were program specific, vague, and very general, such as: *Applying an aboriginal lens *Equal application of regulations and policies to all *Exceptions on the basis of culture, disadvantage *Developing a health equity tool *Gathering community data on inequalities in health status *Targeting services and programs to particular populations or communities in need *Starting with the community's issues	Overall, health equity more visible, now part of planning, with a greater emphasis on identifying health inequities using data *Identifying and targeting at risk or priority populations *specific programs or strategies for food safety (food redistribution, vouchers, Community kitchens) *employment and skills enhancement *developing standards and protocols *community engagement *facilitating geographic access *removing barriers to service (cost, structural barriers)	Many remain vague and general, but increasingly more concrete and specific. *using inequities data for planning *using equity tools *a combination of individual and population or structural level strategies *free birth control, child care, transport *level of intensity based on needs *removing barriers to access *a women's health plan *infrastructure, training, build capacity *advocacy for HE *embedding HE in strategic plans *using mix of targeted and universal in keeping with an understanding of proportionate universalism

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Barriers and Facilitators to Implementing an Equity Lens

EARLY	MIDPOINT	LATER
Most important influence on applying equity lens was leadership. *understanding of HE by leaders *support/encouragement for HE *leader involvement in HE *HE champions among leaders *PH leaders at executive table *Understanding of HE and agreement on its meaning *belief HE is "not our business" *Not knowing how to do it *Organizational supports/resources *Organizational change *Community engagement *Tension between universal and targeted programming	**Having a shared understanding of HE most important.** *tension between universal and targeted programming *getting buy in and selling HE *leadership and HE champions *communication about HE *standardization of services *paying lip service to HE *belief that HE not our issue *PH Structure and organization *HE not valued in HA *Community engagement	**More facilitators but barriers were more influential.** *resource limitations and cuts to universal programs *Leadership and HE champions *HE as a value *Community engagement and involving those with inequities *Standardization of services *Organizational support *Team collaboration *Intersectoral collaboration *Local government involvement *"HE is hard work" *Tension between universal and targeted programing

Conclusions

- Understandings of HE have shifted over time to be more sophisticated and to better reflect the established definition of HE, moving from equal access to proportionate universalism, *but we are only starting to get there*

- Strategies are often program specific and have shifted from being vague and general to more concrete, more population focussed, and to better reflect the more sophisticated understandings of HE

- Major influences on implementation of HE lens include: leadership, having a shared understanding, organizational resources and support, recognition of need to ensure a balance of universal and targeted programs, engaging the community, and staff capacity.

Contact Information

Marjorie MacDonald

University of Victoria

marjorie@uvic.ca

Equity Lens in Public Health

http://www.uvic.ca/research/projects/elph/