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Perceptions about Equity in Public Health: A comparison between frontline staff and informing policy in Ontario

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Health Information Science

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PERCEPTIONS ABOUT EQUITY IN PUBLIC HEALTH: A COMPARISON BETWEEN
FRONTLINE STAFF AND INFORMING POLICY IN ONTARIO

(Thesis Format: Integrated Article)

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Graduate Program in Health Information Science

A thesis submitted in partial fulfillment of the requirements for the degree of Masters of Health
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ABSTRACT

Background: Recent changes in Ontario public health policy call for increased emphasis on equity. However, it is not clear how equity is understood as a concept and how equity is understood as practice. **Methods:** The aim of this study was to understand public health frontline staff (FLS) perspectives on health equity and how these align with provincial public health policy documents. A qualitative content analysis design was used to examine transcripts from six focus group interviews with frontline public health workers and seven key provincial public health documents that have shaped or influenced public health program planning in Ontario. Perceptions and understandings of health equity in public health were compared. **Results:** Findings from the study indicate that several areas of alignment exist between how FLS describe equity in public health practice and how equity is addressed in the provincial policy documents; both focus their discussion of equity as relating to the social determinants of health and priority populations. Several differences between FLS perspectives and policy documents were also identified including barriers encountered in FLS daily practice that are not addressed in the provincial policy documents. **Conclusions:** These alignments and differences provide insights on how FLS incorporate information from provincial policy documents into their practice and suggest the importance of involving FLS in the policy process.

Keywords:

Health Equity, Health Inequity, Social Determinants of Health, Frontline Staff, Priority Populations, Public Health, Provincial Policy, Ontario,

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CHAPTER ONE

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...” (WHO [2], 2013).

Introduction

Health is not only a basic human need, but also a fundamental human right that should be distributed as equitably as possible (Marmot, 2007). One of the most vital and agreed upon goals of a successful public health system is the promotion of health equity (Pinto et al., 2012). Within every program, policy, or component of a public health system there is the recognized goal that outcomes should reflect reduced inequities in health. However, reducing health inequities can be considered one of the most challenging aspects of any public health system in part because of the overall complexity of equity as a concept. Understanding and conceptualizing health equity has been a difficult task for academics and policymakers. Equity is an inherently normative concept as it is understood to be value-based and strongly associated with social advantage or disadvantage (Braveman, 2003; Braveman & Gruskin, 2003; Chang, 2002). Unlike equality, which is understood to be an empirical concept, equity requires normative appraisal to identify (Chang, 2002). For instance, inequalities in health status can typically be explained by biological differences, however, if variations in health status cannot be attributed to biological differences, then it becomes probable that the variations are caused by physical or social factors, and therefore are amenable to human intervention (Chang, 2002). The normative component of a health inequity addresses the role that values play in determining the desirability of interventions (Chang, 2002). Equity, as it applies to health, is considered to be the “absence of systematic disparities in health between social groups” (Braveman & Gruskin, 2003, p. 255). However,

moving beyond this description of equity, there is a lesser consensus when trying to determine what constitutes *inequity*. There continue to be several working definitions of health inequity, most of which are criticized for not fully explaining this phenomenon (Braveman, 2003).

Perhaps the most commonly used definition of health inequity, as first proposed by Margaret Whitehead in 1992, describes the concept as any differences in health among a given population that have been deemed “unnecessary, avoidable, and considered unfair and unjust” (Whitehead, 1992, p.7). Critics of this definition claim it to be over generalized and note that it brings up an additional debate on how best to determine when something is *unnecessary* and *avoidable* (Braveman, 2006; Marmot et al., 2008) .

Whitehead’s definition implicates the importance of incorporating social determinants of health into the understanding of inequity. Social determinants of health, as defined by the World Health Organization (WHO), are “the conditions in which people are born, grow, live, work, and age” (2013, para. 2). Since the concepts of social determinants of health and health equities first emerged in the literature, international debate on the scope of these terms, and how equity should be measured, has grown (Braveman, 2006). As a result, there has been a significant increase in research focusing on this area, which has reiterated how important these concepts are to improving the health of a population (Bryant et al., 2011; Collins & Hayes, 2010). This research has demonstrated the significant influence that social determinants, including race, ethnicity and socioeconomic status, can have on health, the distribution of chronic diseases (as one example), and the course of such diseases (Alberti et al., 2013; Gore & Kothari, 2013). These impactful health determinants “are shaped by the distribution of money, power, and resources at global, national, and local levels” (WHO, 2013, para 2). The WHO’s Commission on Social Determinants of Health determined that these types of inequities are often caused by “a toxic

combination of unfair economic arrangements, poor policies and programs, and bad governance” (Marmot, 2012, p. 2033). Ontario is no exception to this “toxic combination,” as recent fiscal austerity has led to questions on how health policies and programs in the province will address the already problematic issue of health inequity (Ruckert, 2012). Understanding how provincial government policies regarding health inequity are implemented in local public health programs and services is yet another layer of complexity.

Despite acknowledgments of its importance and extensive research attesting to this, equity has not been adequately addressed in public health program planning (Gore & Kothari, 2012). The need to understand and incorporate knowledge on health equity is recognized as important for public health strategies, for example, through preventative interventions and population health strategies, that aim to “promote and maintain health” (Welch et al., 2013, p.1). The importance and impact that health equity has on population health is only sometimes understood and addressed. Although this impact may be theoretically understood, it is not adequately understood by policy makers. It seems there is now a need to study the relationship between provincial policy and how equity is enacted in practice. A disconnect exists between how equity is understood as a concept and how equity is understood as practice. The difficult task of moving existing theories and definitions of equity into tools for practice has become evident now more than ever. The conceptualization of health equity and inequity is often contested among scholars, leading to conflicting messages and leaving policymakers unsure of how to address the issue for successful implementation (Braveman, 2006; Gore & Kothari, 2013). What evidence does exist describing issues of inequity in health are often criticized for not having gone “far enough” and therefore leaves readers, policy-makers, and decision-makers to “make informed guesses” about how to address inequities in health through practice (Kawachi

et al., 2002, p.647). However, given that the current national and provincial public health systems are in the midst of renewal, there is a unique opportunity to directly address this gap through restructuring how the system addresses equity in practice. In order to be successful in this, research needs to provide some understanding of how equity is understood by those providing services and programs and how this aligns with provincial policies.

The process of translating the knowledge that is known about social determinants of health and health inequity into practice has proven difficult (Green et al., 2009; Masuda et al., 2013). The purpose of knowledge translation, in theory, is to disseminate research into practice with the aim of addressing imbalances “between knowledge production and [its] application” (Masuda et al., 2013, p.2). However, given the complexities that exist surrounding our knowledge of health inequities, this dissemination process is not straightforward. Globally, progress towards implementing successful public health policies that aim to address inequities into practice has been disappointing (Ir et al., 2010). Like other areas in health that struggle to incorporate research into everyday practice, issues to consider include evaluating external validity, successful identification of what is evidence, implementation issues and the organizational contexts in which they are applied in, challenges with sustainability, and trust between researchers and decision-makers (Wallerstein & Duran, 2010). However health equity seems to be uniquely challenging for the knowledge dissemination process, as the concept itself is uniquely complex and subjective. Health equity, in essence, is a complex relationship between social hierarchy, economic and financial restraint, and both political and moral ideology. The multiple theories and definitions of health inequity and its inherent roots in social justice and ideology move this problem beyond simply addressing a knowledge gap (Masuda et al., 2013). Implementing theories from research, even if agreed upon by scholars and policy-makers alike,

can often be unsuccessful in effective application (Green et al., 2009). There are several different perspectives on how health inequities are defined, and therefore, how one can act on this by embedding equity into practice is even more challenging (Masuda et al., 2013).

Background and Significance

Ontario Public Health Standards and Call for Renewal

The Ontario Public Health Standards (OPHS) were created in 2008 by the Ministry of Health and Long Term Care (MOHLTC) with the purpose of establishing mandatory requirements for fundamental public health programs as well as guidelines on how best to achieve such requirements (MOHLTC, 2008). These requirements specifically target the improvement of assessment and surveillance of public health issues, health promotion and policy development, disease and injury prevention, and overall health protection (MOHLTC, 2008). As one of its primary components, and unlike previous guidelines, the OPHS aims to better integrate evidence and current science into the established program standards.

The OPHS describe the influence that determinants of health have on public health generally and health inequities specifically (MOHLTC, 2008). The Standards identify four foundational principles by which Boards of Health across Ontario should act in accordance with: Need, Impact, Capacity, and Partnership and Collaboration (MOHLTC, 2008). From these principles, OPHS identifies one foundational standard that outlines the “specific requirements that underlie and support all program standards” (2008, p.11). This foundational standard consists of four specific areas: Population Health Assessment, Surveillance, Research and Knowledge Exchange, and Program Evaluation (MOHLTC 2008). This framework has been created to help depict the

relationship between the principles, the foundational standard and all subsequent program standards and protocols (MOHLTC, 2008).

The OPHS guides all public health programs in Ontario with the aim of reducing health inequities (MOHLTC, 2008). The OPHS identifies the importance of reducing health inequities, however it is unclear how they define equity, and how to determine when something is inequitable or equitable. The ability to fulfil this goal may be challenging without clear and complete understandings of health inequity issues in Ontario.

Defining Health Equity

Research exists discussing the importance of health equity in public health, however upon further examination of the literature it can be found that many use the terms *health disparity*, *health inequality*, and *health inequity* interchangeably (Braveman, 2006). This is because there exists an incomplete understanding of the three terms and how to differentiate them (Braveman, 2006). This has been problematic in the area of public health generally, as there are practical consequences that have accompanied this lack of consensus (Braveman, 2006). Understanding the differences between the terms and when they apply is seen as having a large impact on the development of policies and measures that can evaluate programs to address these issues in public health (Baum et al., 2009; Braveman, 2006). Margaret Whitehead's definition of health equity was considered the most concise and accessible definition for quite some time and has historically been found useful in communications with politicians (Braveman, 2006). However, as research interest in the area grew, further examination of Whitehead's definition found that it was no longer sufficient. There became an increased level of international debate surrounding what constituted health equity in contrast to inequality or disparity (Braveman, 2006). At the end of the 1990s was the emergence of the population health concept in the health policy discourse, which is seen as more positivist by nature and tended to be more concerned with empirical evidence of socio-economic gradients in health (Braveman, 2006; Collins & Hayes, 2007). To a scholar in health promotion, *inequities* referred to "unfair or unjust differences in health outcomes" (Collins & Hayes, 2007, p.338), while the concept for a population health scholar tended to refer to measurable differences in health outcomes, and as a result the terms *health inequality* and *health disparity* acted as more politically neutral substitutions (Collins & Hayes, 2007; Kawachi et al., 2002,).

It is now widely accepted that there are significant differences between equity and equality (Chang, 2002), yet identifying those differences in real world situations has proven difficult (Braveman, 2006; Chang, 2002; Collins & Hayes, 2007). On the surface, the distinction between the two concepts has become clearer, with inequality or equality referring to measurable quantities, and inequity or equity rooted in a “moral commitment to social justice” (Kawachi et al., 2002, p.647). Visible in Whitehead’s use of the term *equity*, as well as more current literature, it is considered an ethical concept, partially grounded in principles of distributive justice (Braveman & Gruskin, 2003). The concepts of fairness and justice are core components of health equity, however making distinctions between something that is fair and unfair can be highly subjective and context dependant. An additional concern with the current understanding of inequity is being able to distinguish when the inequality is avoidable or unnecessary (Kawachi et al., 2002).

This is what makes reducing inequities in health so challenging to politicians, as not all health disparities are unfair (Braveman & Gruskin, 2003), and one’s political ideologies can influence when something is viewed as unnecessary or preventable (Kawachi et al., 2002). It is because of this subjectivity and normative underpinnings that current understandings of health inequities do not suffice. Although the literature on *how* to actually reduce health inequities may be lacking, what is most problematic is the lack of attendance to what literature does exist by politicians and policy-makers. Unequal distribution of resources and social conditions within a society could be considered inevitable, however the WHO’s Commission on Social Determinants of Health believes that when said unequal distribution negatively impact a population’s health, it has become unjust (Marmot, 2007). When the unequal distribution is systematic as well as preventable, depending on issues of fairness or power and agency, it has also become unjust. To

acknowledge that health equity is rooted in moral concepts such as distributive justice, one must also acknowledge that an inequity is the result of uneven distribution of power in a given society, which can lead to “health-damaging experiences” (Marmot et al., 2008, p.1661). It is for this reason that “science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair” (Kawachi et al., 2002, p.648).

Relevance to Health Information Science

This research seeks to address the current gap in our understandings of equity by examining the phenomenon from a new perspective where context and culture are a primary focus with which to unpack how equity is understood in practice. There is a need to understand how policies and front line staff approach and understand equity, as well as how this informs practice. It is imperative that we examine how conceptual understandings of health inequity alter when applied in practice. The aim of this study is to understand public health frontline staff’s (FLS) perspectives on health equity and how these align with provincial public health policy documents which guide practice. Understanding how both these elements affect one another can provide even greater insight into how equity is understood in policy and practice.

Policy, in itself, acts as a source of information, and ultimately is a technology of government or practice. These technologies shape and influence nearly every aspect of frontline work, including the sector of public health. The purpose of policy is to provide direction and when used correctly, it can be a tool to drive thinking, behaviours, and public health perceptions. Through understanding policy related to equity, and how it impacts frontline workers, we can begin to understand how government can support or influence changes. Findings generated

through studying these elements can help inform the development of better health information systems with the purpose of having more systematic identifications and understandings of health inequities (Bambas Nolen et al., 2005). According to the World Health Organization, strong health information systems are those that not only generate information on health planning, but also resource allocation and accountability (WHO [3], 2014), all of which are vital components to tackling health inequities in any public health system. Issues of health inequities tend to be persistent and long lasting due to their connection to the social determinants of health, and as a result, the need for an equity-oriented lens in Ontario's health care and health information systems is of extreme importance (Bambas Nolen et al., 2005). Policy, therefore, is a major component of the health information system, and it is important that what is represented in policy is operationalized effectively by FLS.

Primary Objectives

The primary objectives of this research include:

- To understand how frontline public health staff discuss health equity.
- To examine what alignments exist between front-line staff perspectives on equity and provincial public health documents discussions on health equity.

The Research Project

This secondary qualitative research project compares the perspective on equity held by frontline public health workers in Ontario with those reflected in provincial level policy documents. The purpose was to identify existing alignments or gaps between how the influential

provincial policies discuss reducing health inequities compared to how these policies are operationalized in practice through the work of public health FLS. Using inductive content analysis and informed by an interpretivist lens, the transcripts of focus groups that were previously conducted by the RePHS researchers with public health FLS were examined. Several themes were identified as relating to how FLS perceived equity in health, in relation to their daily practice, as well as in relation to influential policies that guide their work. These themes were then compared to the findings on how the provincial policy documents defined health equity.

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CHAPTER TWO

A concept that is strongly rooted in principles of social justice and fairness, health equity refers to the absence of health differences between more and less socially advantaged groups (Bambas Nolen et al., 2005; Braveman, 2003; Braveman & Gruskin, 2003; Chang, 2002). Understanding and conceptualizing health equity has proven to be a difficult task for academics and policymakers. Social determinants of health, such as the conditions one is born into, grow, live, work and age, are understood to be key contributing factors to inequities in health as they have significant influence on the distribution of health states like chronic disease within a population (Collins & Hayes, 2010; Gore & Kothari, 2013). Social determinants of health often influence and interact with one another, making it important to address them in an upstream way (Raphael, 2003). Social determinants of health are essentially underlying contributors to many health issues that people experience through their lifetimes (Blas et al., 2008). It is these preventable underlying causes of health issues that are often labelled inequitable and unjust (Gore & Kothari, 2012).

Though evidence on health equity is certainly prevalent in the literature, translating this evidence into workable policy that can guide practice has been extremely difficult. Despite acknowledgments of its importance and extensive research attesting to this, equity has not been adequately addressed in public health program planning (Gore & Kothari, 2012). Instead, a disconnect exists between how equity is understood as a concept and how equity is understood as practice. It is important to examine how frontline public health workers perceive and understand equity in health as they represent the mechanisms by which policies are implemented and delivered to the public. The perceptions of frontline staff have the potential to provide context

around issues of equity policy implementation and subsequently allow for a better understanding of how public health policies are operationalized using an equity-lens.

Research Questions

The research questions guiding this study are: 1) *What are front line public health staff perspectives on health equity?* 2) *What are provincial public health government and supporting organizations' perspectives on health equity?* and 3) *To what extent do the perspectives align?*

Literature Review

Understanding how the existing knowledge on health equity in public health has informed policy and, more importantly, can perhaps impact practice, was a key goal for this literature review. The following academic databases were selected: PubMed, Ovid, and Sociological Abstracts. A phrase search was conducted in Google Scholar and Google search engines to ensure the inclusion of gray literature, (such as policy documents, public health program documents and policy analysis), including literature written by any known key researchers in the field of health equity. The search included several phrases and combinations of key word searches, including health equity, health inequity in Canada, health inequality, health disparity, social determinants of health, poverty and health inequity, public health, Canadian public health, frontline health care staff, Canadian health policy, knowledge translation in health, knowledge to action framework, equity in practice, and Ontario Public Health Standards. Research was included in this review if its primary focus was on health equity or any related content, such as social determinants of health, access to care, social justice in health, and equity generally. Research focusing on frontline staff perceptions was also included, as well as research examining policy implementation or practice challenges. All material had to focus on public

health. Canadian-specific context was preferred although literature discussing health equity policy and program problems outside of Canada was still included to gain a broad understanding of the issue. The search was limited to the English language and included anything that was published in the year 2000 or later as this is generally when the issue of health equity and its application first became prevalent in the literature. In 2000, the United Nations Millennium Development Goals were first announced and the UN Millennium Declaration was signed, finally naming issues of equity as key contributors to people's health globally (WHO, 2014). Additionally, with the 2003 SARS outbreak in Canada and across the globe, more research began to emerge on the importance of having a strong public health system in place. These two significant developments guided the timeline for this literature review. This literature review yielded a total of fifteen papers with six studies and nine conceptual papers that were relevant to public health and equity and met the above criteria. These studies and relevant conceptual papers are discussed under four themes: identifying inequities in health, frontline staff perspectives on health inequities, policy attempts to address inequity in public health, and the Canadian context.

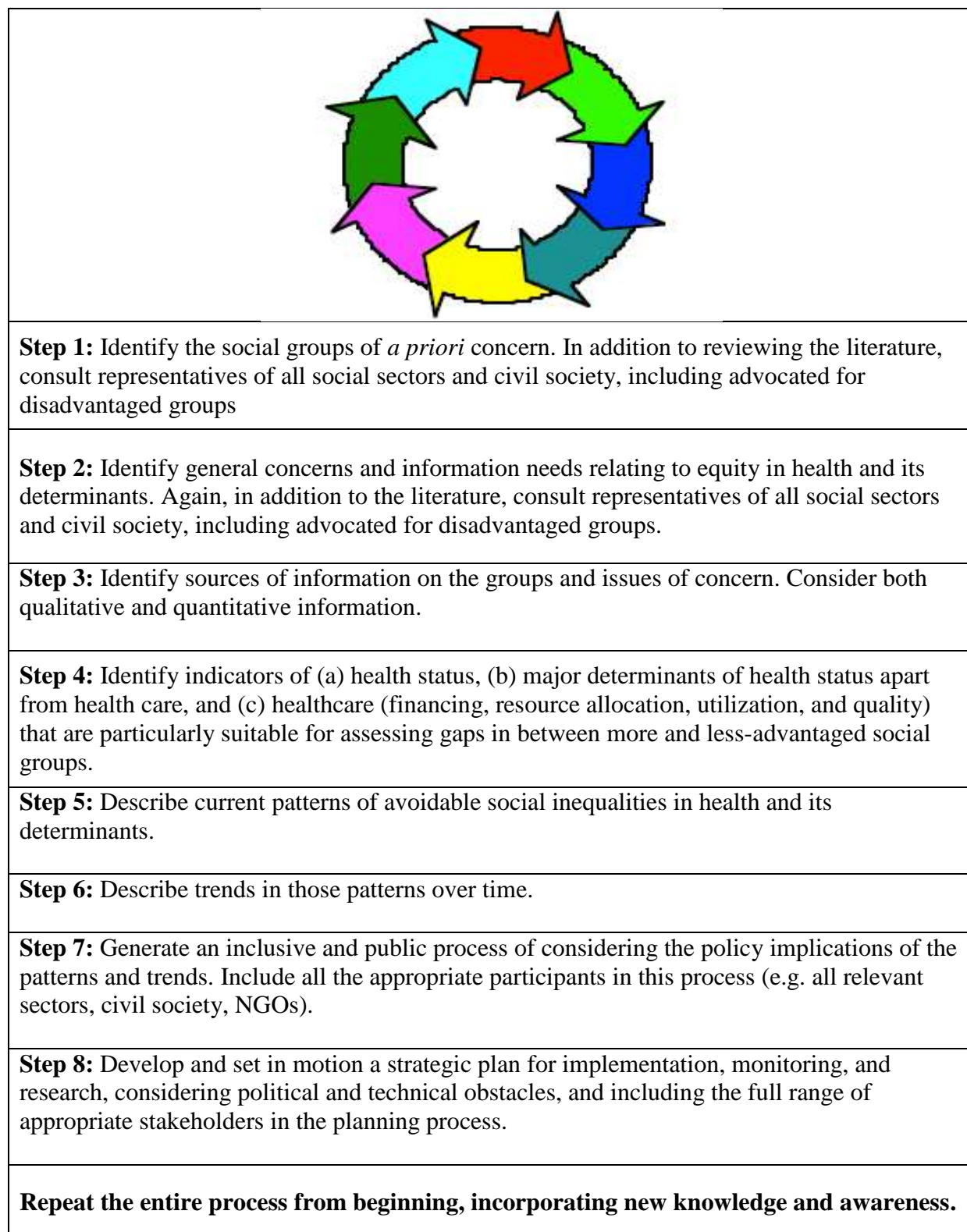
Identifying Inequities in Health

In order for any public health system to effectively reduce health inequities, it is imperative that any possible causal factors of inequity be identified and monitored, although this has proven to be difficult. Paula Braveman, an influential researcher in the field of social disparities and inequities in health, wrote about the importance of monitoring equity where she proposes a conceptual framework directed towards policy-oriented researchers. She argues that likely as a result of how difficult such monitoring can be, very few nations conduct routine monitoring of health equity indicators (Braveman, 2003). In the development of her framework she identifies four key questions that should be addressed during the development of any health

program or policy: What is equity in health and health care? What is monitoring? Why monitor equity in health and healthcare? and What are the essential components of a system for monitoring equity in health and healthcare? (Braveman, 2003). Braveman argues that the primary purpose of monitoring something is to ensure there is a consistent level of practical relevance for policy-making, that people in more and less advantaged social groups tend to experience “unequal opportunities to be healthy”, and as result of this, resource allocation should reflect the priority needs of those disadvantaged (2003, p. 184). She suggests that the best way to identify when this priority should be given is through monitoring, as this may stimulate action at the decision-making level (Braveman, 2003).

Braveman identifies eight steps (**Figure 1**) that she believes are essential in creating a policy-oriented monitoring of equity in health, which she describes as cyclical and on-going as it must always be incorporating new knowledge and awareness (Braveman, 2003). In addition to these steps, Braveman suggests three basic research questions to keep in mind when monitoring equity in health: How do levels of health vary across different social groups? How do levels of key determinants of health vary across social groups? and How have both levels of health and health determinants in different social groups and gaps between the groups changed over time? (Braveman, 2003, p. 186). In the Braveman framework, there is a strong emphasis on the belief that equity in health is a social justice and ethical issue. It is because of this that Braveman warns against the use of terms such as ‘health inequalities’ or ‘health disparities’ since they seem to reflect little concern for the role that social disadvantage plays in how health is distributed (2003).

Figure 1: Braveman’s Eight Steps in Policy-oriented Monitoring of Equity in Health and its Determinants



Throughout the framework, Braveman tries to emphasize that although monitoring alone cannot create action, the information it yields is extremely important in achieving greater equity in health (2003). It is this information that will help bring attention to the needs of vulnerable populations. Although Braveman does make a good case for the importance of monitoring equity in health and healthcare, as she later points out, monitoring alone cannot create change in practice. Her framework does little to account for the barriers that will inevitably exist with implementing monitoring systems, such as changing political climates and economic barriers brought on by fluctuating resources. The success of her framework depends solely on the ability for the eight step process to be on-going and cyclical, which in all likelihood, is an unrealistic requirement. Her framework also does not specify at what level the monitoring should take place; i.e., is monitoring the responsibility of provincial-level policy makers or local municipal governments. If each local municipal government is responsible for monitoring their own communities, there will inevitably be some municipalities with more resources to dedicate to these monitoring systems than others, creating inequity in the ability to yield important information. Nevertheless, this work is valuable for its presentation of a framework that brings together health information monitoring, policy, and practice.

The need for health equity measurement tools has been publicly emphasized by the Canadian Institutes of Health Research and the Chief Public Health Officer of Canada (Kirst et al., 2013). However, despite the fact that this monitoring of socio-demographic indicators is seen as a “key first step” in addressing equity issues, a 2013 Ontario study found that obtaining the necessary information can be extremely difficult due to a variety of barriers, and as result sociodemographic information is not routinely collected (Kirst et al., 2013, p.1). In a mixed-methods study, Kirst and colleagues examined public opinion on the importance of gathering

sociodemographic information for the purposes of health equity measurement using a provincial telephone survey of 1306 Ontarians combined with thirty-four in-depth interviews (Kirst et al., 2013). Through purposive sampling, the researchers recruited healthcare patients from two sociodemographic groups for follow-up interviews: the first being those in the mid/high income range, while the second consisted of members of groups who may be identified as a priority population (Kirst et al., 2013).

Kirst and colleagues found that the public opinion survey demonstrated “mixed support” for the collection of sociodemographic information in health settings (2013, p.4). The researchers found that level of comfort with disclosing sociodemographic information not only varied between the differing socioeconomic subgroups that participated, but there was also variation in comfort depending on the type of sociodemographic information (Kirst et al., 2013). A similar theme was observed from the interview results (Kirst et al., 2013). Kirst and colleagues found that very few participants actually saw how sociodemographic data collection would be beneficial for monitoring purposes, with even fewer recognizing relevance to equity measurement purposes (Kirst et al., 2013). Based on these public opinion results, the collection of sociodemographic information does not appear to be associated with monitoring or health equity measurement. Instead, the public assumes such information is used directly to assist physicians to deliver proper care, or used against them, as a patient, impacting the quality of care received. This indicates there is a significant lack of understanding for the purpose of this data collection as well as a lack of understanding regarding the concept of health promotion beyond the ‘behaviour change model’ (Kirst et al., 2013; Paisley, 2001; Raphael, 2003). Kirst and colleagues conclude that the existing concern over disclosing sociodemographic information reveals a paradox related to assumptions about equitable access to healthcare (2013). They argue

that the “perceived lack of importance of sociodemographic data collection” may indicate that the participants (and perhaps Ontarians, more generally), believe that access to healthcare in Canada is already equitable, therefore negating the need for this type of data collection (2013, p.9). This perception is potentially problematic as it could impede future data collection, therefore hindering the ability to monitor health equity effectively (Kirst et al., 2013; Raphael, 2003; Raphael, 2006). Kirst and colleagues fear that these results, combined with the cancellation of the Long-Form census in Canada could lead existing health inequities to widen (2013). This information is extremely useful in identifying yet another barrier that exists when trying to reduce health inequity. Understanding how the public feels about a practice like monitoring, that has been determined to be crucial in identifying inequities, could help inform changes to how frontline staff interacts with patients while attempting to identify and address existing inequities.

Frontline Staff Perspectives of Health Equity

Much of the published research examines perspectives on health equity from a theoretical standpoint, as opposed to an examination of how those perspectives impact everyday practice. Extensive research exists on the importance of understanding social determinants of health and health inequity, but research that specifically addresses how to embed this knowledge into practice is limited. However, in one US 2013 study, it was found that front line public health staff had a difficult time translating knowledge regarding health equity into practice largely due to the focus on individual risk factors in their professional practice (Knight et al., 2013). Information was gathered through in-depth, open-ended, interviews with 25 key informants (experts on social determinants of health, frontline health care staff, community leaders in health

equity), where questions were grounded in the “knowledge, beliefs, and experiences of the participants” (Knight et al., 2013, p. 2). The purpose of this study was to gain a deeper understanding of what health equity meant from the perspective of each participant. The researchers found that barriers to successful implementation of health equity knowledge into practice were, in large part, the result of cultural understandings of the “core functions of public health” (Knight et al., 2013, p.2). An identified recent shift in language used to describe the issue (shifting from the term “disparity” to “inequity”) was the result of the gradual recognition that social injustice was strongly tied to equity issues (Knight et al., 2013). This research specifically identified the need to improve underlying social and economic conditions, as opposed to a more traditional focus on health outcomes (Knight et al., 2013).

The outcomes of the Knight et al. (2013) study will be helpful in comparing meanings and the practice of health equity in the US and Canadian health care contexts, to possibly show how different experiences, contexts and meanings of health equity can impact its application in practice. This research speaks to the importance of examining barriers in the application of knowledge and how understanding the different perspectives on the meaning of a phenomenon can be crucial to fully understanding how effective application of policy should occur. Given that this was the only study identified that examines perceptions of frontline staff and how policy impacts their practice, there is a clear gap in the literature regarding to the application of theory to practice.

Policy and Program Attempts to Address the Inequity in Public Health

As we begin to understand the complexity of addressing health inequities in public health, it becomes clear that interprofessional collaboration is required to ensure any level of success

(Ndumble-Eyoh & Moffat, 2013). Community groups and frontline public health workers are responsible for bringing an equity lens into everyday practice; however it is still important to understand how the health and social policies that inform their practice can either support or hinder the enactment of an equity lens. Pons-Vigués and her colleagues completed a scoping review in 2014 that attempted to review what social and health policies or interventions existed and how they worked to tackle health inequities. This review examined any interventions (1162 were first identified; 54 were included in this study) that took place in European cities between the years of 1995 and 2011 where the intervention specifically identified the reduction of health inequalities among their objectives (Pons-Vigués et al., 2014). The purpose of this scoping review was to identify what type of literature had been published about health inequalities and health inequities, as well as what types of policy and intervention studies predominate in European cities (Pons-Vigués et al., 2014). Of those fifty-four studies that were included, 74.1 percent were carried out in the United Kingdom, with the remaining 25.9 percent scattered across various European cities in France, Germany, or the Netherlands (Pons-Vigués et al., 2014). When examining the studied interventions, Pons-Vigués found that half of the countries used a universal approach (referring to an intervention for an entire population or community) as opposed to something more targeted specifically towards vulnerable or priority populations (2014). Additionally, of the interventions that were evaluated (46 interventions), 53.7 percent were said to have positive results (Pons-Vigués et al., 2014). Pons-Vigués et al. identified a conceptual framework for how social determinants of health impact health inequalities in European cities, noting that the highest level of influence is type of governance, which subsequently feeds into physical and socioeconomic environmental factors as well as social

settings (such as neighbourhood and workplace), all of which she identifies as “axes of inequality” (2014, p. 2).

Pons-Vigués et al. argues that, although literature is beginning to increase in this area, the number of scientific publications focusing on health inequity and inequalities as a result of social determinants of health is still relatively low (2014). Pons-Vigués et al. sees this as problematic as it hinders the academic world’s ability to evaluate and study the impacts of different types of interventions or policies, therefore limiting the potential for an impactful multidisciplinary collaboration (Pons-Vigués et al., 2014; Raphael, 2003). She acknowledges that policy tends to focus on “healthy behaviour” interventions as opposed to the evidence-supported upstream approaches that better incorporate social determinants of health such as living conditions (Bambra et al., 2010; Pons-Vigués et al., 2014; Raphael, 2003). Through this scoping review, the researchers have demonstrated that even current policy does not adequately reflect the need for more “strategic interventions” that directly incorporate social and structural determinants, such as political systems. (Pons-Vigués et al., 2014, p. 9). Pons-Vigués et al. argues that “many policies aiming to address social determinants require intersectoral action and community participation,” (2014, p.9) yet, unfortunately, these aspects are not made clear in the policies themselves, and this will ultimately hinder their uptake in practice. After an extensive explanation of the impact these inequalities and social determinants can have on health equity, Pons-Vigués et al acknowledges that even still, very little literature exists describing effective initiatives at achieving health equity. Initiatives targeting inequities will only be effective if they are understood and supported by frontline staff.

A 2012 study by Gore and Kothari looked to address the gap that exists in literature that Pons-Vigués et al (2014) discuss by comparing public health policy to actual programs

implemented. This study examined to what extent healthy living initiatives implemented under new policy frameworks in British Columbia and Ontario have successfully addressed the social determinants of health (Gore & Kothari, 2012). The researchers examined initiatives that were active between January 1, 2006 and September 1, 2011, identifying 60 Ontario initiatives to include and 61 British Columbia initiatives for inclusion. Each initiative was reviewed, analyzed, and grouped according to descriptive labels and codes that were developed directly from the data. Three types of initiatives emerged from the themes developed: lifestyle-based initiatives aiming to improve healthy living through individual changes, environment-based initiatives aiming to improve healthy living through influencing the environments in which people live, and structure-based initiatives aiming to improve healthy living by directly addressing impacts of political, social, or economic structures that create inequities. All initiatives were further classified according to the mechanisms by which they were delivered: direct programs, blueprints, or building blocks (Gore & Kothari, 2012).

It was found that in both provinces, very few initiatives were directed towards changing upstream social determinants of health, and instead there exist a dominance of lifestyle-based interventions (Gore & Kothari, 2012). Furthermore, those interventions that did attempt an upstream approach, targeting social determinants of health more directly, saw the level of direct support for the interventions lessen. Gore and Kothari note that this is problematic as lifestyle-based initiatives tend to be counterproductive, placing the responsibility on an individual and therefore not incorporating the impact that structural conditions have on one's health. This approach can also lead to victim-blaming, especially when barriers are too great for individuals to overcome by themselves. Lifestyle-based initiatives can actually perpetuate inequities in health as they may unintentionally reinforce the disadvantages that priority populations must

overcome. This study identifies an important problem that exists in programs attempting to address social determinants of health. The researchers conclude that Canada's public health sector will continue to face substantial barriers in reducing health inequities and addressing social determinants unless more direct structural initiatives are implemented. Political, social, and economic conditions play a large role in how public health interventions are taken up, and as a result, the health sector should incorporate these approaches in finding solutions for health inequities (Gore and Kothari, 2012).

Canadian Context – Policy Attempts to Address the Problem

The same problem of implementing health equity research into practice is of importance in the Canadian context, where public health is the shared responsibility of all three levels of government, at no direct cost to individuals (Pinto et al., 2012). As a result, standards on how best to deliver and ensure quality public health exist in every province (Pinto et al., 2012). A 2012 study by Pinto and colleagues examined the public health standards that exist in British Columbia (BC) and Ontario, i.e., how, and to what extent, these standards incorporate health equity. Through inductive content analysis, this study examined the history and development of the two public health standards policy documents in Ontario (OPHS) and in British Columbia, and the 2005 Framework for Core Functions in Public Health (BC Core Functions Framework). Pinto et al found that while these documents differed in their structure, with the OPHS acting as a set of standards mandated through legislation, and the BC Core Functions Framework as more of a set of best practices documents, they both identified reducing health inequities as a key objective.

Although recurring themes of social justice, accessibility, accountability, and specific actions to reduce health inequities were identified, findings also indicated that significant differences did exist between BC and Ontario policy documents (Pinto et al., 2012). In addition, beyond a brief initial discussion of health equity in the introduction, Pinto et al. found that an explicit focus on health equity was far less prevalent in the remainder of the documents (2012). What are explicitly discussed in the OPHS are three categories of actions that can apply to health equity issues: a stronger focus on surveillance and measurement, addressing the accessibility of public health programs, and lastly, partnerships and collaborations (Pinto et al., 2012). Pinto and colleagues' largest criticism of the OPHS is its lack of explicit discussion of how to reduce inequities, noting that any mention of inequities does not go much beyond "the general concept of certain populations being at risk" (Pinto et al., 2012, p.5).

Contrastingly, Pinto and colleagues note an immediate difference in the BC Core Functions Framework, acknowledging that the goal of reducing inequities is dominant throughout the entire document, describing it as a "duty" and fundamental task of public health (2012, p.5). The BC Core Functions Framework discusses specific actions to reduce health inequities. Unlike the OPHS where the emphasis seems to be placed more heavily on surveillance and population health assessment, the BC Core Functions Framework emphasizes a consistent equity lens (Pinto et al., 2012). Pinto and colleagues note that it is this equity lens that has enabled the BC process to identify more "specific and robust methods to address health inequities" (2012, p.8); something that the OPHS document was lacking. However, both documents were lacking evidence of an analysis of systemic factors and "deeper questions about the roots of inequities" (Pinto et al., 2012, p. 8), which the researchers suggest should be part of any process attempting to highlight inequities. This reflects a recurrent criticism with any policy

or program that deals with reducing inequities in health, i.e., the tendency to only superficially examine the problem. One cannot expect to solve a problem without asking the questions about the deeper roots of the problem.

As a follow-up to the examination of provincial policy attempts to address health inequities in Canada, Pauly and colleagues (2013) describe a research protocol to examine the application of an equity lens in public health in British Columbia, specifically looking at how this contributed to reducing health inequities in public health. This research protocol consists of four inter-related research projects with an overarching collaborative and participatory action approach. Pauly et al.'s (2013) research aims to assist in strengthening public health systems so that they “supports public health providers to have the knowledge, skills, tools and resources” required to adequately address health equity. The study will be looking at how an equity lens has been applied to mental health promotion programs, and prevention of mental disorders and harms of substance programs, as outlined by the BC Core Functions Framework.

Although this study (Pauly et al., 2013) is still in progress, it speaks to the complex variety of factors that can impact whether or not an equity lens will be successfully taken up in public health. It demonstrates the importance of integrating such a lens into the foundation of a public health system, while at the same time helps outline the challenges that will likely arise throughout the integration process. Pauly and colleagues strongly emphasize the impact that contextual factors can have on change in public health policy, noting that contextual interactions make the process of integrating an equity lens into public health impossible to be linear. Furthermore, this research protocol strongly identifies a theme of social justice as the foundational principle of health equity in public health, noting that public health ethics argues for special attention to be paid to the health of disadvantaged groups within the population (Pauly et

al., 2013; Powers & Faden, 2006). Pauly and colleagues argue that not only must this special attention to disadvantaged groups be a primary part of public health, but they go further and suggest that the focus should be on “the degree to which social systems and social conditions” allow for sufficient well-being to be met for these populations (2013, p. 9).

Summary of Literature Review

In summary, this literature review suggests that there is still much to be learned about how to properly address issues of equity in public health. Through the literature examined, it can be seen that identifying inequities in health is often context-specific, indicating that previously implemented generalized programs or policies targeting inequities in health have come across several barriers. They either do not take into account the fact that changing social or environmental factors can impact who is identified as a priority, or they neglect to incorporate the impact that political and social factors can have on the uptake of programs. It is important to identify and recognize the priority populations prior to implementing programs or policies that aim to reduce inequities.

This literature review suggests that research is limited with respect to how equity targets programs and policies are carried out in everyday practice. Fundamental principles of social justice are present throughout literature on health equity, however research examining the processes of moving these ethical principles and theories into practice seems to be limited. This review identified a major gap that exists in the literature regarding perspectives on equity of public health frontline staff (FLS). Given that FLS are predominately responsible for operationalizing the programs and policies that guide their work, their perspectives on the

concept of equity in practice is understudied. The research presented here focuses on comparing the perspectives of FLS on health equity to the provincial public health policies that strongly influence their daily practice, in order to identify gaps or alignments that exist.

Conceptual Framework

Although this research does not have an explicit conceptual framework, the important concepts related to health equity, as described by influential authors in the field, act as a guiding framework for the work. As described by many key authors (Braveman, 2003; Braveman & Gruskin, 2003; Pauly et al., 2013; Powers & Faden, 2006), understanding health equity as an ethical principal, through a social justice lens rooted in the principles of distributive justice, was an important conceptual consideration that directed this research. Understanding that equity, in itself, is a normative concept was extremely influential in the approach taken for this research as it sensitized the researcher to how different values and presuppositions would impact frontline staff perceptions on health equity.

Furthermore, Braveman's conceptual framework (2003) for monitoring equity in health was used to further sensitize the researcher. Elements for this framework were useful for this research and guided the analysis of the provincial policy documents as it presented ways to formulate key questions about defining health equity, the social groups to be compared and the relevant health determinants to be appropriated to them, and a process for applying findings (Braveman, 2003). A major component of Braveman's framework was the acknowledgement that identifying health equity can be guided by values, and the underlying purpose of her framework was to understand how differing values will impact a broader strategy of confronting

political obstacles to greater equity. Braveman (2013) discusses how political will plays a large role in the ability to monitor and tackle issues of equity and therefore not only is it important for policy makers to be influenced and pressured into action, but also for grassroots groups to feel a stake in the action-creation process, therefore supporting community empowerment. This combination of advocacy and community empowerment can help identify equity issues that need to be addressed, ways to address those issues, and can apply pressure on policy-makers to ensure implementation (Braveman, 2003). This research lends itself to Braveman's underlying purpose of understanding equity as a normative concept while incorporating the perceptions of frontline staff.

Methodology

This research was conducted using a secondary qualitative content analysis design. Although content analysis is said to have a long history in research, as far back as the 18th century, its appearance in the literature as a research methodology began in the early 1990s and has been evolving ever since (Hsieh & Shannon, 2005). Content analysis is primarily found in the naturalistic paradigm, based on interpretivism, which assumes that multiple forms of reality can exist and are socially constructed from experiences (Guba & Lincoln, 1994; Hsieh & Shannon, 2005). According to Hardwood and Garry (2003), content analysis is an appropriate method to use when analyzing a variety of data, as it allows for the reduction of a phenomenon into defined categories or themes, thus improving the ability to interpret them. Content analysis is specifically structured to enable the analysis of "open-ended" data, and is especially helpful when analyzing research involving characteristics of language and communication (Elo &

Kyngas, 2007; Hardwood & Garr, 2003; Hsieh & Shannon, 2005). This structure supported the goals of this research as it allowed for the analysis of the semi-structured focus groups with frontline public health workers, enabling the researcher to not only examine the diverse words and language used throughout the interviews, but also to move beyond into *how* the discussed opinions and experiences influenced the perspectives of the frontline staff (Morgan, 1993).

Qualitative content analysis takes a hermeneutic approach and it does not require a testable hypothesis, like one might see in quantitative content analysis (White & Marsh, 2006). Instead, the underlying purpose of qualitative content analysis is to scrutinize and identify concepts and patterns from a data set, which may include written or verbal text (White & Marsh 2006). Qualitative content analysis allows for subjective coding as it values examining how the researcher's perceptions can impact data (Morgan, 1993; White & Marsh 2006). It was useful in identifying the latent meanings that exist in the data set for this research, allowing for the identification of gaps or alignments in perspectives on health inequity among frontline public health staff compared to the provincial policy documents. Qualitative content analysis is fundamentally flexible, as the interpretive process of the analysis is so highly valued (Morgan, 1993; White & Marsh, 2006). It includes an iterative process of "re-contextualizing, reinterpreting, and redefining research" (White & Marsh, 2006, p.34) and therefore it was important to ensure this was ongoing throughout the entire research process of this study. This was beneficial during the constant comparisons between the analysis of the frontline staff focus groups and the analysis of how the key informing provincial public health documents would discuss health equity as it helps with understanding the comparisons, gaps and similarities, and identifying relationships that exist between the focus groups and documents (White & Marsh, 2006).

This type of inductive content analysis allows for a better understanding of the data through total immersion, enabling the identification of hidden meanings through interpretations (Campos & Turato, 2009; Elo & Kyngas, 2007). As a result of this necessary immersion, self-reflexivity played a crucial role in the coding and data analysis phases to ensure the awareness of how subjective elements may be influencing the research. Reflexivity took place throughout the entire research process, acting as a continual and often immediate self-awareness (Finlay, 2002). It began at the pre-research stage where the goal was to reflect on the topic of health equity, itself, as well as personal preconceptions. Examining the literature was an important part of this self-reflexive process (Finlay, 2002). To ensure this process was continual, it was important for the researcher to have ongoing self-conversations about how personal subjectivity or perceptions connect and influence the object of the research itself (Finlay, 2002). Qualitative content analysis allows for dissection of multiple meanings, alternative perspectives, differing ideologies that might impact how the texts are being examined and interpreted (White & Marsh, 2006). This purpose directly relates to the primary objectives of this study as it will allowed for the dissection of how frontline staff perceive equity in their daily work, how they incorporate those perceptions into their practice, and how the possible differences in discussion of health equity present in the provincial public health documents might interfere with or support the day-to-day practice of the frontline staff.

This research uses secondary analysis which involves the “re-use of pre-existing qualitative data,” such as raw transcripts from open-ended interviews, but applying a new research question to this data set (Heaton, 2008, p. 34). This study is a secondary analysis via informal data sharing methods (Heaton, 2008) of data from the Renewal of Public Health System (RePHS) study (RePHS, 2010). The RePHS study, which was in-progress at the time of writing,

is about understanding the implementation and impact of the BC Core Public Health Functions Framework and the OPHS. The overarching goals of the RePHS project include: contributing to the improvement of population health; reducing health inequities; advancing the field of public health services research; informing integration and linkage of public health and primary care services; and training expert public health services researchers (RePHS, 2010). The RePHS research questions are: (1) What are the processes of the public health standards and core functions of implementation for two core public health programs in BC and Ontario, and how do contextual variations within and between each province affect the implementation? (2) What are the impacts and outcomes of the two core programs and how does variation in context and process of implementation affect these? (RePHS, 2010). The multi-phase RePHS project is a collaborative effort between researchers at the University of Victoria, in British Columbia, and Western University in Ontario. This thesis is using a subset of data from the second phase interviews (2011) conducted in the RePHS study, which specifically focused on discussion of health equity and inequity from perspectives of frontline staff (see **Appendix A** for Interview Questions). This thesis specifically looked at data pertaining to the Ontario public health units. These focus-groups were conducted across six different public health units within Ontario to ensure variation in geographic location and contextual factors. In addition to the secondary focus group interview data, seven influential provincial public health policy documents from either the provincial government or key public health organizations in Ontario were selected specifically for this thesis study to determine how equity is discussed at a policy level.

Method

The purpose of this secondary qualitative study was to compare the perspectives on health equity held by frontline public health workers with those reflected in provincial level policy documents.

Setting and Participants

This secondary qualitative study used pre-existing qualitative data derived from the RePHS research study, specifically the six focus groups that took place during phase II of this study. Permission for use of this data was obtained through submission and acceptance of a formal written proposal to the RePHS Steering Committee. Focus group participants were frontline health care staff, all of whom had worked or were currently working in various public health units across Ontario. Understanding that public health encompasses a large area, these participants were specific to chronic disease prevention (CDP) program areas. The 29 participants consisted of health promoters (n=8), public health nurses (n=13), public health dietitians (n=3), public health nutritionists (n=3), youth engagement worker (n=1), and a project officer (n=1). Their experience levels in public health varied greatly (<1 year [n=2], 1-5 years [n=8], 5-10 years [n=9], >10 years [n=11]). Participants were asked about a variety of topics pertaining to the implementation of the OPHS; they were asked to evaluate how the OPHS has impacted their day-to-day work, as it relates to chronic disease prevention, what kind of impact it had on programs they provide, or changes in their responsibilities. These questions were asked in reference to perceptions on health human resources, health equity, and collaboration with primary care. For the purposes of this research study, the questions and responses specific to health equity were of primary focus.

Provincial Policy Documents

The provincial policy documents used in this research were selected through basic searches of major provincial level health organizations and offices: Chief Medical Officer of Health of Ontario, Health Nexus, Ontario Chronic Disease Prevention Alliance, Ministry of Health and Long Term Care, Ontario Public Health Association, and Public Health Ontario (**Appendix B**). Specifically, the search targeted strategic organizations that have shaped or influenced public health program planning in Ontario, especially in chronic disease prevention. It was important to ensure that all constituents impacting public health in Ontario were represented. Once the strategic organizations were identified, the search focused on identifying their key documents that act as the major informing document on public health policy or the organizations' main position paper on public health and equity. This typically included strategic plans, annual reports, or health status reports. All selected documents had to be published in 2008 or later to correspond to the release of the OPHS, which would have a major influence on all existing policies thereafter. The documents selected for this research were:

- Chief Medical Officer of Health of Ontario - Ontario Health Status Report 2011
- Health Nexus and Ontario Chronic Disease Prevention Alliance – Primer to Action: Social Determinants of Health, 2008
- Ontario's Public Health Sector Strategic Plan, 2013
- Ontario Public Health Association Annual Report 2012-2013
- Ontario Public Health Standards, 2008
- Public Health Ontario – Taking Action to Prevention Chronic Disease, 2012
- Public Health Ontario Strategic Plan 2014-2019

The purpose of using these provincial policy documents was to enable a level of comparison between how frontline staff (FLS) perceive and define health equity with how equity is defined in provincial documents that inform or guide FLS practice. The analysis of the provincial policy documents and the perceptions of the FLS provided an opportunity to see how public health workers operationalize provincial policies in their day-to-day practice.

Data Management and Analysis

Focus group transcripts and the provincial policy documents were entered into NVivo 10, a software program used to assist in the organization of large amounts of qualitative data. The first step of data analysis included reading through all of the interview transcripts several times to become more familiar with the focus group questions and responses, the characteristics of the participants, and ultimately to gain a sense of the data as a whole. Additionally, using the NVivo10 software, word frequency queries were performed to identify any recurrent words or themes, such as *equality*, *access*, *chronic disease*, *community*, *collaboration*, *equity*, *population*, *education*, and *fairness*, not as a way to infer meaning but rather, to become familiar with the data set and to simply explore usage of key words (Hsieh & Shannon, 2005). This also allows for an understanding of the context surrounding certain key terms visible in the data (Hsieh & Shannon, 2005). This was important to become truly immersed in the research and begin the reflexive process including comprehending, synthesizing, contextualizing, and re-contextualizing (Elo & Kyngas, 2007; Hsieh & Shannon, 2007; Morgan, 1993; Morrow, 2005; White & Marsh, 2006). Data analysis was based on inductive content analysis methods, sometimes called latent content analysis, referring to the process of interpretation (Hsieh & Shannon, 2005).

After reading the transcripts, the next step was to begin organizing the qualitative data through the method of open-coding (Elo & Kyngas, 2007). The goal of coding in qualitative

content analysis is to organize the data text into smaller content categories (Hsieh & Shannon, 2005; White & Marsh, 2006.). The first stage of inductive open-coding involved creating codes based on major categories prevalent in the interview transcripts. In qualitative content analysis it is important that the codes arise directly from the data, and as result, the development of pre-existing codes was not used (Morgan, 1993). Understanding that the purpose of this research was to capture the participants' perspectives on health equity, re-coding took place to ensure the exact terms the participants used to describe or define *equity* and *health equity* were captured adequately, ensuring stability in the coding process (Elo & Kyngas, 2007; Harwood & Garry, 2003).

As a way to guide the researcher through the process of establishing themes, qualitative content analysis often uses “code counting” (Morgan, 1993). The purpose of conducting code counts, similar to the word frequency queries conducted in the earlier phase of analysis, was to become familiar with the data and help identify major themes (Morgan, 1993). However, code counts go beyond this and are seen as an important part of qualitative content analysis as they assist with interpretation of any patterns found in the data (Morgan, 1993). This acts as part of the re-contextualizing phase that is considered crucial in qualitative content analysis (Elo & Kyngas, 2007; Hsieh & Shannon, 2007; Morgan, 1993; White & Marsh, 2006.). Qualitative content analysis places a strong emphasis on understanding the different contexts that are “revealed by the coding and counting process” (Morgan, 1993, p.115-116). This process is important as it allows for the researcher to answer questions about *how* and *why* the patterns in the data came to be (Morgan, 1993). This type of combined process allowed for the focus on both the *manifest content* and well as the *latent content* (Graneheim & Lundman, 2003). *Manifest* content refers to the analysis of the “visible, obvious components” of the text, while

latent content tends to focus more on the relationships and underlying meanings within that same text (Graneheim and Lundman, 2004, p. 106). The category creation was part of a more descriptive level of analysis and therefore considered part of the manifest content, while the creation of themes tend to involve further interpretation of underlying meanings and was therefore part of the latent content analysis (Graneheim & Lundman, 2004). Qualitative content analysis can often go back and forth between these two types of analysis in order to alternate between the varying levels of in-depth, or “abstract” level of interpretation that is required (Graneheim and Lundman, 2004, p.106). This was particularly beneficial for this research as it allowed for the continuous re-contextualizing of the data that enabled the researcher to gain a deeper understanding of the texts across public health unit locations and multidisciplinary purposes. Additionally, it allowed the research to begin to understand what contributing factors may explain *why* they held these perceptions.

Establishing Trustworthiness

An essential assumption of qualitative content analysis is that text, including texts based on focus groups, is values-bound, context-specific, and therefore often involves multiple meanings (Graneheim & Lundman, 2003). It is because of this that establishing trustworthiness and credibility of the findings was extremely important. According to Graneheim and Lundman, trustworthiness of qualitative content analysis can be established through examining the *credibility, dependability, and transferability* of the data (2003).

Credibility of secondary qualitative content analysis can be assessed by looking at how well the constructed categories and themes cover the data (Graneheim & Lundman, 2003). It is important to ensure that no relevant data have been overlooked or systematically excluded, and

that irrelevant data have not been included (Graneheim & Lundman, 2003). Credibility examines the extent to which the coding captures what the researcher intended to capture (Harwood & Gary, 2003). In order to achieve credibility, the coding, themes and categories created were reviewed by the thesis supervisors, who have expertise in health equity, several times after each round of the coding process had been completed and again once the final coding process was completed. Discussions of the findings took place with both thesis supervisors at different points in time. This allowed for the review of the initial findings from the coding process, and more importantly, established rigour around the credibility of what those findings suggested. In alignment with Graneheim and Lundman, presentation of these findings include “representative quotations” from the transcribed text into the analysis, as this also helps establish credibility (2003, p.110).

Dependability refers to “the degree to which data changed over time and [subsequent] alterations” that were made by the researcher during the analysis process (Graneheim & Lundman, 2003, p.111). Given that this research is secondary qualitative content analysis, the risk of inconsistencies during the data collection process was not applicable for this research. However, through the phases of interpretation and re-contextualization of the texts, new insights were common. Therefore, to ensure dependability on the data and insights, a methodological journal was kept throughout the entire research process which encouraged self-reflexivity as well as on-going review of the data. The purpose of this journal was to keep a log of the rationale behind any decisions made regarding review of the data, the coding processes, analysis phases, and any general thoughts on the project as a whole. It also provided an outlet for reflexive thoughts throughout the research process so the self-conversations about personal subjectivities were appropriately documented. Additionally, keeping an open-dialogue with the thesis advisors

provided an additional resource to further explore any new insights as they developed (Graneheim & Lundman, 2003).

Transferability refers to “the extent to which the findings can be transferred to other settings or groups” (Graneheim & Lundman, 2003, p. 111). Given the interpretive paradigm of the research, it was important to understand that context and changing culture will always impact the data in new ways, and that multiple meanings can exist in any given dataset (White & Marsh 2006). As Graneheim and Lundman argue, “it is the reader’s decision whether or not the findings are transferable to another context” (2003, p.111). For this research, in order to achieve transferability, it was important that clear descriptions of the differing contexts were provided in the presentation of the findings, accompanied by appropriate quotations that would help demonstrate these findings in a rich and distinct way (Graneheim & Lundman, 2003). Providing these types of descriptions assist in establishing trustworthiness as they help establish the context of arguments for the most probably interpretation of the findings (Graneheim & Lundman, 2003). Through distinct descriptions of culture and context, the reader is better suited to make that decision about whether the findings are transferable to another context or not.

Ethics

Ethics approval for the primary RePHS Study was obtained from the McMaster Ethics Review Board (**Appendix C**). Data used for this project were the raw transcripts from Phase 2 of the RePHS study, and as such a confidentiality agreement with the research team was signed (**Appendix D**). A research proposal (**Appendix E**) was submitted to the RePHS Steering Committee in order to receive approval to access and use the transcript data for this project. Confidentiality and anonymity were ensured by not using any actual names of participants or the

public health units in the presentation of the findings. Additionally, all data were kept on a password protected computer.

Findings

In this section, the findings from the content analysis are presented as follows: First, frontline staff perceptions on health equity are presented. Second, the findings from the analysis of the policy documents on health equity are presented. Last, the comparisons of frontline staff perceptions and provincial policy documents discussion of health equity are explored. Illustrative quotes are used to demonstrate these findings. (**Table 1** below is a summary of the key findings).

Table 1: Major Areas of Discussion that Emerged from the Data

	How Health Equity was Discussed/Defined	Health Equity in Practice Themes
Frontline Perspectives	Equal Access	Priority/Vulnerable populations *
	Fairness	Impact of Contextual Factors
	Equal Opportunity	Economic/ Political Constraints
	Social Determinants of Health	Participation in policy-making processes
		Population-wide vs. Target Approaches
Provincial Policy Documents	Priority/Vulnerable Populations *	Goals and Strategies
	Social Determinants of Health	Universal vs. Target Approaches
		Access to Resources

Notes:

- Areas of consistency are highlighted
- * Although both frontline staff and the provincial policy documents discuss priority/vulnerable populations, they were discussed in different ways and therefore were not classified as a consistency for the purposes of this chart

1.0 Perceptions of Frontline Staff on Health Equity

In this section, perceptions of frontline staff on health equity are presented. Given that the data pertained to frontline staff only in chronic disease prevention programs, the findings presented below are limited to that perspective. Although different health units across Ontario participated in the focus group sessions, generally, all frontline staff discussed the same concepts of equity, despite the differing public health disciplines participating. The FLS' understandings of equity in public health were similar to one another yet were informed by their own disciplinary contexts. How frontline staff (FLS) defined health equity is discussed and then how health equity is taken up in their daily practice is described.

1.1 Definitions of Health Equity

Several themes emerged out of the focus group data on how FLS in a chronic disease prevention program defined health equity. The themes of *equal access*, *fairness*, and *equal opportunity* were very dominant in the FLS responses, however, often being given as only a one or two word description of what equity meant to them with no further explanation. From these initial single-word descriptors given by the FLS it was difficult to determine their understanding of equity versus equality. Despite the sometimes limited explanation of a health equity descriptor, many of the emerging themes identified through these FLS definitions often overlapped, as they are very interrelated and therefore brought out the emergence of yet another theme (*social determinants of health*).

The broad notion of *equal access* was used when referring to a variety of resources in health care, including access to primary care, access to prevention services, access to healthy foods, access to equal quality of care, access to a healthy built environment, and also access to resources that can educate people on their rights “in terms of health access” (Participant F5). The

discussion of *equal access* was also linked to a discussion about *equal opportunity*. When asked how they would define health equity, many participants initially seemed to understand equity in terms of equal health outcomes, suggesting that “everybody has equal health in the end” (Participant E4). However, as the discussion evolved, descriptions of health equity became broader.

One participant expanded on what *equal opportunity* meant to her by citing a hypothetical example using cancer screening resources, indicating that several factors can impact one’s ability to access a screening resource:

I have the ability to make an appointment for that screening. And I have everything I need to get to that screening appointment. (Participant B2).

While another participant simply described health equity as “Everyone in the population has an equal opportunity to achieve good health” (Participant C4).

The theme of *fairness* was another dominant FLS descriptor of health equity, and often made in reference to the concept of social justice. Similarly to when the term *equal opportunity* emerged in the discussion, the participants began to move away from thinking about equity narrowly in terms of equality, and instead conveyed their understanding of the two terms as different. As one participant described it: “Equity just means fairness which I think is contrasted by equality” (Participant A3).

Another theme that emerged from how FLS defined health equity was around the idea that *social determinants of health* can act as barriers to health equity. This related to barriers to access, any disadvantage/advantage that exists, disparities as result of social and economic factors, or any type of discrimination. Frontline staff discussion often centered on the idea of priority populations, or as some FLS described them “vulnerable populations.”

...there's certain subgroups, whether it's certain subgroups due to ethnicity or socioeconomic status or education level, you don't want there to be disparities. (Participant C4)

Making sure people aren't limited by their social status. So making sure people can be healthy and it's not going to be limited by their income or whatever influences their living (Participant E1).

Frontline staff noted that health inequity is the result of the unfair impact that social determinants have on an individual's health. Without directly addressing the underlying ethical principles that provide the foundation for health equity, a number of FLS participants talked about these principles in their definitions of health equity. Through their discussions around fairness and elimination of disadvantage, the FLS participants in every focus group agreed that the social determinants of health have the largest impact on health and thus health equity. As one participant described it:

...you know we've always known [that] the medical model isn't always the best model right? Got to focus more on determinants... There's more than just healthcare when you talk about health. (Participant E4).

1.2 Health Equity in Practice

The second aspect of the analysis was the FLS perceptions of *health equity in their daily practice* as well as how they incorporate guiding policies or programs on health equity into their practice, i.e. *health equity and policy*.

When discussing how they address health equity issues in their own practice as frontline public health workers, many participants drew on their work that focuses on “priority

populations”, however when the FLS tried to expand on who these populations were, many indicated that it was hard to define. As described by one participant:

There is this sort of trend towards addressing priority populations but I don’t think a lot of people really understand what that means (Participant A3).

Frontline staff acknowledged that a priority population often differs depending on the geographical area in which one is working. Through this discussion they recognized that variations in context will impact who is considered a priority population. The influencing contexts can refer to anything from geographical location, to disease-specific areas, to the age of an individual, all of which demonstrate how priority populations may change within varying contexts. Often the terms “priority population” and “vulnerable population” were used interchangeably when referring to any subpopulation that is disadvantaged according to any social factor, such as income level, education level, immigration status, primary language spoken, etc. While some FLS participants seemed to be more comfortable using the term “vulnerable population”, other participants found this term too limiting and may not accurately reflect the needs of each varying context. The identification of a priority or vulnerable population might limit who gets identified, and thus targeted, changing how FLS operationalize these terms in practice. This is an issue that FLS staff identified when discussing health equity and their practice. One participant addresses this:

But new parents are vulnerable too. They’re not, maybe not new immigrants or maybe they speak English [and] maybe they have lots of money, but it doesn’t mean that they know everything about raising a baby or how to feed them... Just because they’re not a vulnerable group doesn’t mean that they don’t need information (Participant B1).

The importance of understanding how a priority population can differ depending on varying contexts was expressed by many participants. Many noted that identifying priority populations is foundational to their day-to-day work while attempting to address issues of inequity. While programs and services directed to priority populations are, to some extent, set out by provincial policy, the context in which FLS work also impacts their work with priority populations. For example, in rural areas, public health units may not have the same resources at their disposal as those units located in urban areas. This is something that many FLS participants acknowledged as impacting their daily practice. As one participant explains:

What's going on in each community is not the same as other communities. And we're getting barriers with that (Participant D4).

Many factors that influence their own work are often out of their control. This is where many FLS identify limitations caused by inadequate policies or programs that guide their work.

Participants spoke about how policy decisions are made before they have a chance to interact with anyone on the frontline of public health. Frontline staff do not get the opportunity to help identify who the priority populations are in their health unit's context, potentially leaving some areas of inequity under-examined. This often leads to either missed opportunities for effective work or an unsuccessful program. One participant speaks to how, as a frontline public health worker, you often do not see where the inequities are until the work actually begins:

...it might be difficult because we could have a client who is very French and...does not have access to...all of the information as readily available [as in English], or having a nurse that is bilingual. Sometimes, you know, you can't see the inequity there (Participant D3).

A few participants also spoke about the barriers they experienced while trying to address issues of equity through root-causes approaches throughout their daily practice, such as limitations brought on by "political will" (Participant B2). Staff's knowledge about inequities may not be

incorporated into program design or informing healthy public policy due to the limitations and risks that exist with becoming involved in those processes. For example, some FLS have been told that taking on an advocacy role is not part of their job, therefore leading to the fear that if one does engage in this type of role, their job may be at risk. Advocating for change in terms of how issues of inequity are addressed or becoming involved in any kind of policy development process that focuses on equity is therefore met with conflicting views by many FLS. While some FLS would like to be included in those types of planning processes, others discuss how they have been told that their involvement in those processes “is not part of their job” (Participant B1) as a public health worker. However, all who discussed this seemed to agree that the desire to become involved depends on the current political climate. The FLS may be ready to participate and take on a larger advocating role, but their role may be hindered by the lack of support and empowerment by institutions and governments who may not be ready for this.. Despite admitting they should push harder for a larger role in the program and policy development processes, one participant stated that if it becomes a risk to your job, they tend to back off.

Almost all FLS spoke about the push to incorporate evidence into their daily practice and the development of the programs they provide. This was important to FLS as they recognized how dependant identifying priority populations is on what the evidences suggests. Evidence-informed decision making is an important component in the OPHS, which many FLS refer to as most influential on their daily practice. However, according to many FLS, this has created a struggle between trying to balance what the evidence says and what their own experiences say about how to address perceived issues of equity. Frontline staff understand that although incorporating evidence into program planning is important, sometimes the available evidence

policy makers use is limited and may not align with the tacit knowledge FLS possess as result of their experience.

I think there's a gap between what type of evidence is available [to us] and the type of service that we know or what we're being told needs to be provided. (Participant C3)

Some FLS participants spoke about the importance of incorporating an “equity lens” into their daily practice, noting that this might be the most effective way to ensure their work will inherently address inequity, despite any economic or political constraints that may exist. An equity lens would help FLS focus their daily practice on ensuring addressing inequity was a part of the “regular processes” of their frontline work (Participant C2). One FLS participant recalled an example of inequity that her public health unit had to address, noting that had they previously adapted an equity lens, the problem could have been avoided:

...an example I can give in our new [smoking] cessation strategy that we're doing with primary care providers and public health teams... We have stopped going to the community and providing one on one or group cessation, [and now] we're going to be going through our family health teams...and one of the biggest problems with it...[which] with an equity lens it would have been noticed earlier, is that our highest population of smokers age 19 to 29 – almost 30% of them are smokers, [but] they don't go to family health teams...so it's just a huge gap. (Participant C3)

One of the tensions that the FLS identified with addressing issues of inequity in their daily practice was between using population-wide approaches to practice or targeted individual approaches to practice. As many FLS staff acknowledged when discussing impacts of provincial policies, there is a new push to focus public health approaches on priority populations, which most FLS understand to mean targeted programs. However, often FLS participants also pointed out that many of the same guiding provincial policies they use to inform their practice also advocate for population-wide approaches, obviously creating a conflict for them in terms of how

they should develop projects and programs. This disconnect was noted by almost all of the FLS participants. One participant stated:

I think it's a little confusing. If we're supposed to be doing policy population-wide, it's also focusing on priority populations, you're kind of like well I thought the point was to have a policy-wide implementation. (Participant A2)

This participant also gave an example of how this disconnect has impacted their daily practice:

We're introducing a screening tool for nutrition, for example. We're supposed to only concentrate on the priority populations but it's supposed to be a population-wide screening tool, right? And there is no clear guidelines as to say like [which one] is more effective. (Participant A2)

In summary, study findings indicate that the perceptions of FLS on health equity focus on concepts including equal access, fairness, and equal opportunities to achieve optimal health, all in relation to the social determinants of health. Findings suggest that FLS understand issues of equity to be related to priority or vulnerable populations, who are typically identified according to varying contextual factors. These findings also suggest that FLS have identified barriers to properly addressing the needs of priority populations, including economic and political constraints, population-wide versus targeted approaches to program implementation, and the lack of FLS participation in policy-making processes, specifically in relation to incorporating FLS experiences as evidence to better inform decisions.

2.0 Ontario Provincial Policy Documents

Ontario provincial policy documents were analyzed to understand how equity is conceptualized in the larger public health system. A total of seven provincial policy documents were analyzed, revealing five main themes: 1) *priority populations*, 2) *social determinants of health*, 3) *goals and strategies*, 4) *universal versus targeted interventions*, and 5) *access to resources*.

The theme of *priority populations* was dominant throughout all seven of the provincial policy documents, however some of the documents opted for alternative terms, such as “disadvantaged Ontarians” (CMOH, 2011), or “vulnerable people” (Health Nexus and OCDPA, 2008). All of the documents talked about the importance of addressing priority populations through the public health programs that are in place. Some talked about this more generally, and while not referring to inequity specifically in these descriptions, the provincial policy documents do talk about how these populations are at the highest risk for health disparities and poorer health outcomes as result of their disadvantages.

The CMOH Ontario Health Status Report writes:

Disadvantaged Ontarians bear a disproportionate burden of poorer health, disease, and premature death (CMOH, 2011, p.3).

Many of the documents expand on their initial descriptions of priority populations by identifying specific examples of who makes up these subpopulations. As described in one provincial policy document:

Populations that disproportionately experience these barriers are the homeless, immigrants, refugees, ethnically or racially diverse populations, people with disabilities, FNIM [First Nations, Inuit, and Metis] groups and people with low incomes, among others (Public Health Ontario, 2012, p. 66).

This document works to provide further context for the needs of priority populations, specifically referring to their risk of health inequities by classifying those in greatest need as those suffering from “persistent health inequity” (PHO, 2012). This indicated that there may be variations of inequity according to this provincial policy document. Such variations may also indicate different approaches are needed to address the problems.

As depicted throughout all of the provincial public health documents, any identified priority population has an increased likelihood of engaging in behaviours that negatively impact their health. For example:

Women living in neighbourhoods in the lowest neighbourhood socioeconomic group were more likely to report smoking during their last pregnancy (16 percent) compared to those with post-secondary graduation (four percent). (CMOH, 2011, p. 10)

Highly relevant to the first theme was another dominant theme discussing *social determinants of health*. Once again, descriptions of social determinants of health were present in all seven of the provincial policy documents. These determinants were mainly used to provide further context of how we can classify the priority populations as well as reiterating how important understanding the causal social factors are in determining health outcomes. As mentioned in all of the documents, it is now well understood the role that social determinants have on impacting individual health throughout the life course. Most, if not all, of the social determinants are intertwined and related, making it even more difficult to find an effective solution. The documents note that it can be extremely difficult for those classified as vulnerable or priority populations to make changes on their own as result of this. Solutions to address the problem need to be multidisciplinary in nature in order to demonstrate an understanding of how different kinds of social determinants impact one another. One provincial document demonstrates this by stating:

There are vulnerable people with low incomes who cannot meet their food requirements without compromising other basic needs, such as shelter. (Health Nexus and ODP, 2008, p. 36)

Although not all of the documents used the term “inequities” when discussing the impacts of social determinants of health, they all did acknowledge that in order to improve health

disparities, the economic, social and environmental impacting factors must be addressed. One document did make the direct link between determinants of health and health inequities stating:

Many people in our society experience challenges in accessing resources...because of poverty, homelessness, distance, or related reasons...And because these determinants of health intersect with each other, they may face multiple exclusions and marginalization, such that they may be unemployed, homeless, a new immigrant...This contributes to health inequities. (Health Nexus and OCDPA, 2008, p.5)

The third theme that emerged from the provincial policy documents was *goals and strategies*. Once identifying and describing the problems that exist in public health, particularly around priority populations and the social determinants of health, many of the provincial documents went on to outline some areas of focus and strategic goals that require action to make changes. Many of the documents align their own strategic priorities with addressing issues of disadvantaged populations. Differences existed in how the organizations proposed to carry out these strategies. Some provincial policy documents suggested that the best way to tackle issues of inequity was through broader health policy and health services planning, suggesting that change will be more effective at the policy level (CMOH, 2011). Other provincial documents acknowledged that the goal of reducing inequity in health is best achieved through individual level public health work, suggesting frontline work will have the larger impact:

Addressing determinants and reducing health inequities are fundamental to the work of public health in Ontario. (MOHLTC, 2008, p.4)

Many goals and strategies mentioned in the documents acknowledged that cooperation and collaboration are necessary components for success, especially when trying to reach the highest risk priority populations, such as the First Nations, Inuit and Metis populations in Ontario.

“Structural barriers” (Public Health Ontario, 2012, p.6) were referred to as a major hurdle to overcome as they contribute to health inequities. One document states:

...[through] a comprehensive strategy that engages all levels of government and civil society, and also embraces health equity, these actions will help to reduce both the prevalence of chronic disease and its associated social and economic burdens. (Public Health Ontario, 2012, p.6)

Another document discusses the important role that public health had in fostering relationships to support broader health goals:

...public health not only acknowledges the impact of the determinants of health but also strives to influence broader societal changes that reduce health disparities and inequities by coordinating and aligning its programs and services with those of other partners. (MOHLTC, 2008, p.20).

Although these partners are not explicitly identified, the document goes further, stating that the every Board of Health should consider compatibility of interventions with the scope of programming, barriers to achieving health for individuals, groups, and communities, any relevant performance measures that may exist, and what possible “unintended consequences” interventions may have. (MOHLTC, 2008, p.21).

Although the provincial policy documents seem to share the general goal of improving public health and addressing health disparities through addressing social determinants of health, there does exist variation when discussing the most appropriate and effective approaches to achieve this overarching goal. This led to the emergence of the fourth major theme of *universal versus targeted interventions*. Some provincial policy documents suggested that a universal or population approach to addressing social determinants and improving population health outcomes is most effective, while others say these types of programs do not work, and instead the focus should be on implementing targeted or individual programs that specifically address

the local needs of priority populations. Although not all of the documents mention this theme directly, the ones that do are inconsistent, which leads to extreme confusion in how these provincial policy documents will be inform FLS practice. One document states:

Evidence suggests that policy interventions are more effective than are individual interventions in creating change at the population level... Population health is an approach that aims to improve the health of the entire population and to reduce health inequities among subgroups. (Public Health Ontario, 2012, p.10)

Contrastingly, another provincial document states:

We know from experience that many health interventions that target the whole population do not reach the most vulnerable in our society, so we will develop strategies designed to meet the needs of those at highest risk of poor health outcomes. (MOHLTC, 2013, p. 12)

Another provincial policy seems to support the target approach to program design:

...tailor their programs and services to address needs that are influenced by difference in the context of their local communities...Public health programs and services must consider the health needs of the local population. (MOHLTC, 2008, p.19)

A final theme that was consistent throughout all of the provincial public health documents, but to a lesser degree than the above themes, was *access to resources*. This theme was generally discussed in connection to identifying priority populations. Access to health resources is also closely related to the social determinants in one's life, such as income, geographical location, ethnicity, or language. Generally, these social factors can affect access to resources that impact one's health. These health resources can cover a variety of things such as access to a primary health care clinic or family doctor, to access to healthy foods and opportunities to exercise. One provincial policy document states:

Many people in our society experience challenges in accessing these resources that can help them lead a healthy and full life...[they] may lack access because of poverty, homelessness, distance, or related reasons (Health Nexus and OCDPA, 2008, p.5)

In summary, the findings from the provincial policy documents indicated that there is a strong and consistent focus on discussing issues of equity in health through targeting social determinants of health, though concrete strategy development within these documents may be lacking. The goals that were discussed in the provincial policy documents all acknowledge the role that social determinants have on impacting overall health outcomes of a given population, access to health resources, as well as the opportunities to achieve optimal health. Findings also indicated that priority populations are understood to represent what equity-focused programs ought to target. That being said, the findings indicate that a struggle exists in the provincial policy documents between promoting universal approaches to public health or targeted approaches. This struggle is problematic because universal approaches tend to prioritize health equality, whereas targeted approaches better address health equity. A balance between the two approaches is clearly preferred but difficult to achieve.

3.0 Alignment of Frontline Staff and Provincial Policy Documents on Aspects of Health Equity

The findings of this study provide some interesting insight into how FLS perceptions of equity align with the provincial policy documents that inform their work. Many of the themes that emerged from the analysis of the transcripts and documents did overlap, however there is difference as well as alignment in terms of how FLS and provincial policy describe and understand the concept of equity in public health.

3.1 Areas of Consistency

The FLS focus groups and the provincial policy documents are consistent in how they discussed and defined health equity. Focusing on issues around equitable access to tangible

health resources and equal opportunities for optimizing health were dominant throughout both the FLS discussions and the provincial policy documents. It was clear that understandings of health equity are broad and achieving equity through public health involves a combination of adequate program planning, evidence informed decisions, and operationalizing policies in the most effective ways. In both the FLS transcripts and the provincial policy documents there is the concentration on better integrating knowledge about social determinants of health into the programs, policies, and daily practices in public health. A consistent finding in both the FLS transcripts and the provincial policy documents was a discussion around the importance of addressing inequity in the context of public health practice.

It is clear in both texts that identifying priority populations is central to tackling issues of inequity in public health. It is these populations that are at greatest risk for experiencing inequities as result of the social determinants they experience, and therefore targeting specific needs and incorporating contextual factors is important for programs to be successful. Furthermore, there is some consistency in how FLS and provincial policy documents identify who the priority populations are. Although the provincial policy documents discussed and defined “priority populations” much more systematically, all FLS participants acknowledged that certain subgroups are at greater risk for negative health outcomes as result of their social and economic surroundings.

3.2 Areas of Difference

Despite several areas of consistency between FLS perceptions and discussions of health equity within the provincial policy documents, the findings suggest that moving information from policy to practice has barriers. As result of these barriers, inconsistencies exist between what policy says and what actually happens in practice. Typically, the provincial policy

documents are beneficial for providing broad strategic direction and goals to be enacted in practice. The policies strive for consistency and attempt to apply to an entire population. However, as identified throughout these findings, the goals outlined in policies cannot always be operationalized properly in practice. The insights offered by FLS speak to the areas of inconsistency that exist and how these impact the ways strategic directions and goals are actually operationalized in day to day practice.

Despite the consensus regarding the needed focus on priority populations, there are some differences between FLS and policy documents on which group should be considered a priority population. The provincial policy documents were very clear and definitive in outlining how they define priority populations, tying this directly to disadvantage as a result of social and economic factors. The FLS participants included these subgroups in their understanding of a priority population, however many spoke about how determining what constituted “priority” was highly context-specific. The provincial policy documents discuss priority populations much more broadly while FLS offer great insight on priority populations at the practice level. Frontline staff put much greater emphasis on how varying contexts in a community or in a disease area will shift the need and priority accordingly. The context surrounding who is identified as a priority had the potential to significantly define and change how FLS perceived issues of inequity, and therefore how they performed a task or designed a program. As result, many FLS participants agreed that priority populations should go beyond the typical description found in the provincial policy documents.

The findings indicate that additional challenges exist surrounding the delivery of public health services and programs as result of impeding economic and political constraints. Often policy does not anticipate or incorporate these types of challenges when first being formed. It is

only once there is an attempt to move from policy to practice that these challenges surface and impact how FLS perform day to day tasks. This was identified by FLS as a consistent barrier to properly implementing health equity-focused programs. Given that the provincial policy documents are limited to providing broad strategic directions and goals, the insights offered by FLS on the constraints they face with their daily practice are helpful in identifying shortcomings in policy.

Additionally, the findings of this research show an interesting contrariety regarding evidence-based program implementation. While both the provincial policy documents and FLS discuss the importance of basing decisions on supporting evidence, FLS spoke about the risks of overreliance on what is suggested by the evidence. Frontline staff identify a struggle in their daily practice between balancing what informing evidence suggests and what their own experience has taught them, noting that the evidence that is most often available to policy makers can be limited and may not align with the tacit knowledge that FLS possess. The gap between what type of evidence is available and the type of service FLS know is actually needed can create a barrier to program development in their daily practice. This conflict between research evidence and tacit knowledge speaks to the debate between universal versus targeted interventions, as universal interventions might rely more heavily on research evidence whereas targeted interventions may be better informed with tacit knowledge. The challenge that exists is finding out how to re-contextualize research findings to fit an individual's need, or a priority population's need, rather than applying the research to the general population. Incorporating and applying the tacit knowledge possessed by FLS in a targeted invention setting could allow for that re-contextualization.

In summary, the areas of alignment identified (i.e. the focus on the importance of social determinants, and finding a balance between universal versus targeted interventions) between the FLS perceptions and the provincial policy documents can act as a partial foundation for FLS to effectively incorporate the guidance from the provincial policy documents into their daily practice. However, through further examination it becomes clear that other barriers exist, according to the FLS participants, which the provincial policy documents do not seem to discuss, thus creating confusion. Many FLS described how these barriers often frustrate them throughout their day-to-day work. The gaps that have been identified in the provincial policy documents appear to have an impact on the practice of FLS in public health.

Discussion

The findings of this study suggest that there exist some areas of consistency between FLS perceptions of health equity and how health equity is discussed in influential provincial policy documents. Similarities exist in how FLS and provincial policy define health equity, largely seen through the alignment in importance placed on adequately understanding the role of social determinants of health. This understanding of health equity is also consistent with the existing literature, specifically with regard to how social determinants and economic surroundings will impact opportunities that exist to achieve optimal health (Blas et al., 2008; Bryant et al., 2008; Marmot et al., 2008; Raphael, 2003; Reutter & Kushner, 2010). However, existing literature on health equity places a strong emphasis on understanding the concept through the foundational principles of social justice (Kawachi et al., 2002; Masuda et al., 2013). These inherent roots were present in FLS's discussion of equity, as many used the specific terms *justice* and *fairness* when describing how they understood equity, more generally. These principles were not as evident

within the provincial policy documents. For frontline staff, social justice and fairness were important considerations in how they practiced, noting that this may influence their day-to-day work. This point of view is consistent with arguments in the literature about difficulties of addressing health equity due to perceptions of equity being highly subjective and context-specific (Braveman & Gruskin, 200; Kawachi et al., 2002).

Both FLS and the policy documents discussed issues related to accessing resources as an important consideration regarding equity. Frontline staff talked about how subjectivity in determining what population should be considered a priority may create challenges for them in their daily practice, as often the informing policies they use to guide their work do not account for how influential contextual factors may be. Many FLS told stories about how they would see issues of inequity once they were in the field working, yet the programs that were already in place did not allow for the flexibility to adjust to changing circumstances. This aligns with the literature that discusses how important understanding the context of inequities is when trying to tackle said inequities (Reutter & Kushner, 2010). Recognizing instances of injustice or inequity requires awareness of historical, social, and political factors that can lead to inequity on any level (Reutter & Kushner, 2010). The impactful varying context of health inequities includes anything from the nature of the inequity to how one experiences a potentially inequitable situation (Reutter & Kushner, 2010). Frontline staff felt that they were better able to assist in identifying areas of need once they had the chance to work with a population group first hand as this allowed for a better understanding of contextual factors at play. This was a major barrier to practice that many FLS identified, but was also mentioned in the OPHS provincial document as a method to identify where the largest areas of need are. The OPHS document states that the Standards will “allow for flexibility in local public health program planning...” (MOHLTC, 2008, p.19).

However, the level of flexibility the Standards will allow might be minimal as they plan to accomplish this through surveillance measures. This could be problematic as literature on the subject suggests that health inequities are not easily measured or identified due to their local circumstance, and influential nature and diversity (Braveman & Gruskin, 2003; Kawachi et al., 2002; Marmot, 2007).

In both the FLS transcripts as well as the provincial policy documents the issue of population/universal interventions versus targeted interventions in public health was an area of inconsistency. Analysis of the provincial policy documents revealed that some of the provincial documents argue for population-wide approaches to implementation, such as population-wide monitoring for diseases, population-based health education programs for citizens to improve healthy behaviours, citing evidence that suggests this approach would be the most effective to address social determinants of health. Despite this, there were also provincial policy documents that reported how evidence suggests that a targeted approach is actually the better option for addressing social determinants of health as it allows for a stronger focus on the priority populations. Often the criticism of population health approaches to public health is that it is too general and therefore does not take into account the local needs of a priority subgroup (Frohlich & Potvin, 2008; Gwatkin et al., 2004). This is obviously an area of concern for addressing health inequities. This major disconnect creates a confusing message as to which method is better suited to address issues of inequity in public health. As determined throughout this research, and in alignment with the literature on health equity, the major contributing factors to health inequity are result of the social determinants of health and the need to address priority populations (Anand, 2002; Frolich & Potvin, 2008; Raphael, 2006). However the provincial policy documents seem to depict that these two areas require opposite approaches. Although a few of

the provincial policy documents do acknowledge that “public health programs and services must consider the health needs of the local population” (MOHLTC, 2008, p.19), and that “careful consideration must be given to the balance between universal and targeted interventions” (PHO, 2012, p.62), there was a certain level of confusion around what type of intervention should take precedence by FLS, as well as what intervention should be supported and funded at the local level.

The study findings showed that many FLS described how they are told to design and implement public health programs at a population-level, however, they also described that through their own work, and through what is known about public health more generally, these types of approaches do not often reach the priority populations that need the programs the most. This problem is consistent with criticisms of population-based approaches that are examined in the literature, as the needs of priority populations are constantly changing or evolving, allowing new people to enter the at-risk populations frequently, and population-based approaches that are unable to keep up, subsequently widening health gaps (Frolich & Potvin, 2008; National Collaborating Centre for Determinants of Health, 2014). Public health programs are often deemed unsuccessful and subsequently cancelled, despite the FLS arguing that they are simply just inaccurately targeted. Targeting within universalism is a concept that works to blend a population-based approach with targeted approaches in order to close health inequity gaps (National Collaborating Centre for Determinants of Health, 2014). Although some of the provincial policy documents do state that balance should be reached between the two approaches, FLS feel that they are left without guidance on how to accomplish this. The National Collaborating Center for Determinants of Health released a document on targeting within universalism in public health initiatives noting that this type of approach should be reflective in

nature in order to incorporate both clients' and frontline staffs' perspectives into program planning (National Collaborating Centre for Determinants of Health, 2014).

The study's findings demonstrated a struggle identified by the FLS between evidence and experience. All provincial policy documents were clear about the importance of implementing programs that were based on evidence, and while FLS generally agreed with this type of thinking, many spoke about how the evidence that is available to them, as frontline public health workers, is often too broad, not context-specific, and in many cases, not relevant. The lack of appropriate evidence greatly impacts FLS practice and how they approach issues of inequity in public health. The need for tailored strategies based on context-sensitive evidence is discussed in the literature as one of the most important factors to enable successful implementation of evidence-based policy into daily practice (Grol & Grimshaw, 2003; Welch et al., 2013). Study findings demonstrated that many public health programs implemented by FLS attempting to target issues of inequity among the priority populations were discontinued as result of lack of supporting evidence. As described by FLS, there was no evidence that contradicted the programs or proved they would be ineffective, but rather the proper evidence simply did not exist. As result, there was no way for the program to be deemed effective or not, and therefore it was discontinued. Findings revealed that FLS considered this problematic because instead of using other methods to evaluate the effectiveness of a program, such as through consultation with experienced FLS, the public health units chose to discontinue programs that could have made a potential impact on a population that was in need. This is not necessarily an issue of lack of evidence, but rather an indication of what is considered acceptable evidence, and as the FLS identified, gathering information through consultation with FLS, and subsequently incorporating

their experiential knowledge, could have provided greater insight on contextual variations that might impact how best to implement and evaluate a program.

Incorporating evidence into public health often reveals different challenges than incorporating evidence into clinical care due to the larger impact that changing contexts and real-world environments have on the uptake of information (Brownson, Fielding, & Maylahn, 2009; Kothari & Armstrong, 2011). Literature suggests that one of the more effective ways to acknowledge the impact of context is through incorporating the expertise of frontline health workers (Brownson, Fielding, & Maylahn, 2009) Many FLS expanded on this problem, stating that they are setting themselves up for failure by relying solely on what the existing evidence suggests, noting that what works in theory does not always equate to practice. This theme of evidence to practice disconnect is highly prevalent in the literature (Braveman, 2006; Brownson, Fielding, & Maylahn, 2009; Gore & Kothari, 2012; Gore & Kothari, 2013; Green et al., 2009; Ir et al., 2010; Kawachi et al., 2002; Masuda et al., 2013).

The study findings enrich the knowledge and understanding around how complicated issues of inequity are enacted in public health, specifically in relation to how equity is discussed in provincial public health policy documents compared to how frontline staff perceive the issue. The areas of alignment identified between the FLS perceptions and the provincial policy documents create a confusing foundation for FLS to effectively incorporate the information from the provincial policy documents into their daily practice. However, through further examination it becomes clear that other barriers exist according to the FLS participants that the provincial policy documents do not seem to seem to discuss. The study's findings help demonstrate how important contextual factors, such as current political systems, and the varying needs of communities, are in how issues of inequity should be addressed. These factors range from

community environments and influence of managers on FLS day to day practice, to individual circumstance of a community member and FLS having a voice, all relating to differing social determinants of health. Many FLS described how limitations in policy understanding and appreciating the role of context often frustrate them throughout their day-to-day work. The gaps that have been identified in the provincial policy documents appear to have a significant impact on the practice of FLS in public health.

Implications for Research, Policy, and Practice

Findings from this research may have implications for public health research, policy, and practice. With respect to research, a clear theme that emerged out of both datasets was the crucial role that evidence is now playing in both public health policy as well as frontline staff daily practice. However, what is currently understood to be acceptable evidence is somewhat limiting as this does not seem to include the experiential tacit knowledge of FLS. Policy-makers tend to rely almost solely on epidemiological evidence, while the qualitative evidence that can be useful for FLS in public health is underrepresented. The necessity for evidence is well known, as the benefits of evidence-informed practice and decision-making have been well documented in the literature (Bambas Nolen et al., 2005; Haines, Kuruvilla, & Borchert, 2004; Thamlikitkul, 2006). However, this study identified that when research evidence gaps exist but the need is observable, challenges are created for FLS's daily practice as result of policy that requires evidence-based programming overshadowing observable community need. It is this qualitative public health research that could help capture and reveal the experiential knowledge of FLS and the contextual variations that impact program effectiveness.

Of course, it would be unrealistic to expect that evidence always exists for every changing context and circumstance in public health, but this research suggests that perhaps alternative approaches to guide FLS practice should be explored when the needed evidence does not exist, such as better integration of FLS experiences or other informal knowledge sources into decision making processes. As described by McKenzie and Wharf, “policy is all about choosing directions in situations where evidence is, at times, incomplete and contradictory and where values inform the fundamental question of who pays and who benefits” (2010, p. x). This quotation is particularly relevant to this research regarding health equity, as this concept is fundamentally understood as value-based. In the context of health information science, this issue speaks to the importance of appropriate knowledge translation from research to policy and subsequently the practice that operationalizes such policy. It is the implementation stage of the policy process where connections between research, policy, and practice become integral components to one another (Green et al., 2009; McKenzie & Wharf, 2010; Welch et al., 2013). It is at this stage that research information becomes a technology and tool for action used by government and frontline health workers. Ensuring this transition is successful requires cooperation and collaboration between all levels of the decision-making and implementation process, including the knowledge gained through experiences of frontline staff.

This also leads to implications for both policy and practice in public health, especially regarding approaches to address issues of inequity. Service providers and frontline health workers are not often incorporated in the policy making processes as they are often considered unimportant (McKenzie & Wharf, 2010), but as made clear through this research, the perceptions and work experiences of frontline staff can provide important information about how policy can actually be carried out in practice, if at all. Policy is often shaped with the view that it

should address “what needs to be done generally,” opposed to practice, which looks directly at what needs to be done in a specific situation (McKenzie & Wharf, 2010, p.x). This research demonstrates this disconnect perfectly, bringing to light many issues that can rise out of this viewpoint. As McKenzie and Wharf argue, taking that type of approach indicates that the two sides (policy and practice) are disconnected, when in reality, the two are very much influenced by one another, especially when examining the impacts policy can have on how FLS carry out practice. Findings from this study reinforce the need to involve FLS in the public health policy making processes that directly inform their work. As outlined in the *principle of affected interests*, those who will be affected by a policy have a right to participate in its formation (McKenzie & Wharf, 2010). Furthermore, this research speaks to how valuable incorporating FLS experiences into decision making could be for public health program planning.

Limitations

As a secondary analysis study, a limitation was the lack of control the researcher had over the data collection process, specifically regarding the focus group questions asked in RePHS study, phase 2. The researcher was limited to analyzing data from research questions that were not specifically designed for the purposes of this study. However, this limitation was addressed by focusing analysis on the data that captured FLS perspectives on equity. A second limitation was that there were only six focus groups conducted with FLS in the RePHS study. Although the variation in location of the focus groups allowed for the data to be considered somewhat representative of the province, this research could have benefited from a higher number of focus groups and participants. A final limitation of this research was that the policy documents used are one step removed from organization’s documents, which might have a stronger influence on

each public health unit's practices. However, using organization documents that directly corresponded to each public health unit would have compromised the anonymity of the health unit.

Conclusion

In conclusion, this study was undertaken to understand and compare how frontline staff perceive health equity compared to how influential provincial public health policies in Ontario discuss health equity. The purpose was to identify if any gaps existed between the two understandings, and how that might influence the day-to-day practice of FLS. Study findings suggest that FLS perceptions may align with the belief that equity is deeply rooted in principles of social justice and therefore can be understood as an ethical concept. Understanding the social determinants of health is a key component to understanding health equity, and more importantly, how context-specific factors may influence social determinants and impact who is considered a priority population with specific needs. The findings of this study contribute to the limited amount of research on FLS perceptions of inequity in public health, specifically in relation to how provincial policy documents impact their daily practice.

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CHAPTER THREE

Summary of Key Findings

This qualitative study addresses a knowledge gap that exists in understanding how frontline public health workers perceive health equity compared to how provincial public health policy documents discuss health equity. The analysis of FLS understanding of equity identified four main themes: 1) equal access, 2) fairness, 3) equal opportunity, and 4) social determinants of health. The second aspect of the analysis was the FLS perceptions of healthy equity in their daily practice, including themes of: 1) priority populations, 2) impact of contextual factors, 3) economic and political constraints, 4) participation in the policy-making process, and 5) population-wide versus targeted interventions, as well as how they incorporate guiding principles or programs on health equity into their practice. The analysis of seven provincial policy documents for their discussion of health equity revealed five main themes: 1) priority populations, 2) social determinants of health, 3) goals and strategies, 4) universal versus targeted interventions, and 5) access to resources. The analysis demonstrated that there are both areas of consistency and differences between how FLS understand the concept of health equity and how equity is discussed in provincial policy documents.

Findings from this study suggest that FLS and the provincial policy documents define equity in similar ways with emphasis placed on understanding how social determinants impact certain populations' experiences in producing health and preventing illness. Identifying and understanding the needs of priority populations is central to how both FLS and the provincial policy documents discuss issues of inequity. Frontline staff are more inclined to discuss health equity in relation to principles of social justice and place more emphasis on the impact of contextual influences in a given circumstance. This thesis identifies two important points about

context: First, local context influences who is considered vulnerable for inequity, and second, context also influences what FLS are able to do about the vulnerable in their daily practice. For example, contextual factors such as available resources for programs or support to do advocacy can affect how FLS work, and may impede their ability to address issues of inequity. The findings from this study revealed that incorporating the perceptions and tacit knowledge of FLS might lead to greater insight on how to improve the identification processes of priority populations and how to provide appropriate services regardless of what the evidence says (or does not say). Frontline experience can also allow for a better understanding of how local circumstance may impact program implementation.

This secondary qualitative study suggests the need for additional investigations of the perceptions of frontline staff on health equity in the Canadian context. A similar study by Knight et al. (2013) in the US context found that FLS had difficulty enacting equity in practice largely due to the focus on individual risk factors in their practice. In contrast, this study found challenges due to policy inconsistencies and context, suggesting perhaps a stronger mandate between policy and practice in the Ontario setting. It would also be useful to gain a better understanding of how FLS experiences and knowledge could assist in the public health program development process with the incorporation of an equity-lens. Implications for research, public health program planning, and public health policy as they relate to health information science are discussed in the following sections.

Implications for Research

Findings from this study reveal that the perceptions FLS hold on health equity might have an impact on how policy targeting this issue will be implemented. Understanding that the

relationship between policy and practice is cyclical and that they influence one another is important for policy makers and frontline staff alike. While policy tends to be rooted in evidence-based explicit knowledge useful for providing broad strategic direction, frontline staff possess tacit, and sometimes internal knowledge that is unique and context-specific (Landry et al., 2006). In the knowledge management literature in health, knowledge gained through work experience of frontline staff is seen as especially important with respect to knowing how to solve problems and adapt to changing or unique circumstances in real-world practice (Landry et al., 2006). Future research could look at how best to involve frontline staff in early policy development processes. Little primary research exists focusing on perceptions of frontline staff on health equity, especially in the Canadian context. A longitudinal study could follow FLS over a period of time to gain a better understanding of how influential policy affects their daily practice, and how knowledge of FLS could be incorporated in a policy-development process.

Alternatively, it would be beneficial for future research to examine public health managers' perceptions of health equity compared to influential policy documents. This could provide a more complete understanding of how health equity issues at the local level are addressed in policy and practice. As identified in the 2013 Knight study, there is a need to improve the understanding of structural influences on health equity. A 2014 scoping review that examined how social and health policies or interventions tackle issues of inequity in Europe determined that the highest level of influence on health inequity is type of governance (Pons-Vigués et al. 2014). Research focusing on perceptions of managers on health equity and how policy influences administrative practice and governing arrangements would contribute to the literature about structural influences on addressing equity. A broader range of evidence sources needs to

be utilized by policy makers in order to develop policies that are sensitive to local contexts that contribute to local inequities.

Implications for the Relationship between Policy and Practice

Many of the inconsistencies in how provincial policy documents and FLS discussed the different components of health equity contributed to the barriers that FLS identified as present in their daily practice. Three points will be raised in reference to these inconsistencies. First, it is important to understand policy development as an iterative process dependant on a successful relationship between research, policy, and practice. Second, there is a need for flexibility to inform public health policy that allows for policy to evolve along with circumstance, while still providing broad strategic direction. Third, there should be an increased level of FLS involvement in the policy development process.

The first important consideration brought on by the inconsistencies identified in this thesis is in reference to understanding policy development as an iterative, non-linear process. The findings of this research speak to literature that addresses the difficulties of policy-making and implementing processes in public health. Specifically, this thesis speaks to the relationship between incorporating policy and informing documents into the daily practice of frontline staff in public health. There are numerous policy making models discussed in the literature that identify different approaches to developing policy, all of which possess their own limitations for successful implementation (McKenzie & Wharf, 2010). Implementation and proper operationalization of policy in public health can be difficult but it is important to understand that there exists a relationship between research, policy and practice that will impact if a policy is

successful or not (Ir et al., 2010; McKenzie & Wharf, 2010). It is the implementation stage of the policy process where connections between research, policy, and practice become integral components to one another (Green et al., 2009; McKenzie & Wharf, 2010; Welch et al., 2013). Ultimately, policy is responsible for integrating evidence produced within the research domain into decisions made, and attempts to create an avenue for that research to be assimilated into daily practice. As Ir and colleagues (2010) discuss, there is a need for a better understanding of the interfaces that exist between research and policy, and policy and practice. Policy is meant to guide action, especially in situations where evidence may be lacking or incomplete (McKenzie & Wharf, 2010).

Policy development itself can be impacted by a variety of contextual factors such as current political culture, the influence of ideology, or social and economic characteristics (Collins & Hayes, 2010; McKenzie & Wharf, 2010). The influence of these factors should be understood throughout the policy-development process. Policy-making, therefore, should be an iterative and interactive process, that involves actors from the research realm, the policy realm, and the practice realm, in order to better account for possible contextual influences, as well as incorporate the knowledge and perceptions that research and practice have to offer (Ir et al., 2010). As Masuda and colleagues argue, this is of particular importance when referring to policy that focuses on addressing issues of health inequity (Masueda et al., 2013). Given that health equity is normative, and what is deemed to be unjust can be subjective, the contextual factors that become prevalent in public health practice have a significant impact on the uptake of research and policy (Masuda et al., 2013). Masuda and colleagues argue that the relationship between research, policy, and practice, as it refers to equity, is more social constructivist by nature, as it should incorporate the realities of local circumstance (Masuda et al., 2013). The

relationships that exist between research, policy, and practice are extremely influential on one another, and connections should be ensured constantly.

The second implication of this research to consider is the need to have flexible public health policy that allows for programs to be altered and adapted according to the local circumstance in which they are implemented. As many predominant authors discuss in health equity literature, the local context and social factors in which people live have a great impact on their health (Anand, 2002; Braveman, 2003; Graham, 2004; Marmot, 2012; Raphael, 2006; Whitehead, 1992). Local context and changing circumstance also have a great impact on public health policy development and program implementation (Collins & Hayes, 2007; McKenzie & Wharf, 2010; Raphael, 2006). Often policies may be created with the intention of addressing widespread problems, and therefore focus on the issue more broadly. However during implementation, it becomes clear that the policy does not account for realities of local contexts (McKenzie & Wharf, 2010). The findings of this thesis research found that FLS often identified the lack of adaptability of policies as a barrier to successful application. The provincial public health policies that were legislatively mandated to guide FLS daily practice were often too limiting, as they did not account for changing circumstances and could not be adequately applied to a program that was implemented. It is important to understand that policy is not immune to changing circumstances. Although the general purpose of policy is to provide broad strategic direction for frontline staff, policy evolution is important to ensure gaps are not created between what the policy targets and how it is, or can be, operationalized in real-world contexts. McKenzie & Wharf argue that if policies retain some level of flexibility, frontline staff will be better able to adapt services to the needs of individuals (McKenzie & Wharf, 2010). Local contexts will impact

how a policy is taken up and it, therefore, becomes important that policies are flexible enough to allow evolution and adaptation to better fit the local circumstance in which it is implemented.

The third implication for the relationship between policy and practice as identified through this research is the need for frontline staff involvement in the policy development process. This thesis research suggests that when implementing policy as a type of health information, it is important to incorporate more than just statistics and other quantitative data into practice-level decision-making processes; context and other sources of information are important elements of policy development. Perceptions of frontline health workers are not often incorporated in the policy making processes (McKenzie & Wharf, 2010), but as made clear through this research, these perceptions can provide important insights about how policy can actually be carried out in practice, if at all. This thesis research reveals that FLS naturally respond to the local context to deliver optimal and effective public health programs and services. Frontline staff must be able to adapt practices according to their identification of the areas of need.

As described by McKenzie and Wharf, the *principle of affected interests* suggests that those who will be affected by a policy have a right to participate in its formation (2010). Given that FLS are responsible for operationalizing public health policies and tackling issues of equity firsthand, it stands to reason that their perceptions of equity would be extremely beneficial to incorporate throughout a policy-making process. Policy makers are too-often removed from the day-to-day practice of FLS (McKenzie & Wharf, 2010), and as result it is understandable that “a disconnect” is created between a given policy and the environment in which it is implemented. This is particularly relevant in public health where policy implementation occurs in local public health units within the community. Integrating perceptions of FLS into the policy-making

process, creating an active partnership between policy makers and frontline staff, could help close that gap (McKenzie & Wharf, 2010). This research demonstrates how FLS can offer insights into the type of barriers that exist in implementing certain policies, especially regarding health equity, as this is an inherently normative concept. Often broad strategic goals (e.g. provincial-level policy documents) can overlook the complexities that exist with equity issues in health, particularly at the local level (Baum, 2007). The perceptions of FLS about their practice and interactions with the population are valuable for bringing to light the complex set of factors that contribute to inequities. Given that FLS are responsible for the execution of public health policies, programs, and services, their perceptions must be incorporated in policy making processes.

Conclusion

Health inequity is a complex problem in public health, encompassing issues relating to social determinants of health, social justice, access, and opportunity to achieve optimal health. Although recognized as one of the most important areas to address, public health policy may fall short when tackling complex issues of inequity. The perceptions of frontline staff on health equity (and the complex factors that contribute to the equity and inequity) offer insights into how equity is understood in local circumstance and real-world practice. Understanding how FLS perceptions and public health policy document discussions of health equity align is important for understanding how these policies are operationalized, or not, in the daily practice of FLS.

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APPENDICES

Appendix A

Phase II: ON Front Line Staff Interview and Focus Group Guide – Equity, Fall 2011

1. How do you define equity?
2. How do you define health equity?
3. Have you experienced changes in the emphasis on equity in your work in relation to the new OPHS?
4. How is the concept of equity applied to the services you provide related to CDP/STIP?
5. Are you aware of any tools/resources that are available to you to help promote the integration of equity in your work?
6. What supports do you need to incorporate a focus on equity in your CDP/STIP work?

Appendix B: Provincial Policy Document Organizations Summary Chart

Provincial Organization	Provincial Policy Document Examined	About the Organization
Chief Medical Officer of Health of Ontario (CMOHO)	“Ontario Health Status Report 2011”	The annual report released by the Chief Medical Officer of Ontario through the Ministry of Health and Long Term Care
Health Nexus	“Primer to Action: Social Determinants of Health 2008”	<p>A non-profit health promotion organization with a focus on health equity, chronic disease prevention and early child development. Purpose is to support health service workers and health promotion organizations develop and implement strategies to improve the health of their communities.</p> <p>Source: http://www.healthnexus.ca/leadershipaward/about_health_nexus.html</p>
Ontario Chronic Disease Prevention Alliance (OCDPA)	“Primer to Action: Social Determinants of Health 2008”	<p>Organization formed to address the need for integrated action and collaboration on the issue of chronic disease prevention through work that includes providing overviews on the determinants and risk factors for chronic disease development, addressing the economic cost of chronic disease in Canada, and identifying the priorities of action in chronic disease prevention</p> <p>Source: http://www.ocdpa.on.ca/about-us</p>
Ministry of Health and Long Term Care (MOHLTC)	“Make No Little Plans – Ontario’s Public Health Sector Strategic Plan”	<p>Office of the Ministry of Health and Long Term Care for the province of Ontario.</p> <p>Source: http://www.health.gov.on.ca/en/common/ministry/default.aspx</p>
	“Ontario Public Health Standards 2008”	
Public Health Ontario (PHO)	“Taking Action to Prevent Chronic Disease 2012”	<p>A Crown corporation dedicated to protecting and promoting the health of all Ontarians and reducing inequities in health. Aims to link public health practitioners, frontline health workers, and researchers to the best scientific intelligence and knowledge from around the world.</p> <p>Source: http://www.publichealthontario.ca/en/About/Pages/Organization.aspx</p>
	“Public Health Ontario Strategic Plan 2014-2019”	

<p>Ontario Public Health Association (OPHA)</p>	<p>“Ontario Public Health Association Annual Report 2012-2013”</p>	<p>A not-for-profit organization that provides a strong, unified, independent voice for all citizens, public health professionals and volunteers committed to improving the health of Ontarians. Serves as a catalyst for development in the public health sector.</p> <p>Source: http://opha.on.ca/About-OPHA.aspx</p>
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Appendix C: McMaster RePHS Study Ethics Approval Letter



RESEARCH ETHICS BOARD



REB Office, [Redacted]

- Research Ethics Board Membership**
- Jack Holland MD FRCP FRCP(C)
Chair
 - Suzanne Sabers PhD
Vice-Chair/Ethics Representative
 - Mary Bielek CCHRA (C)
Privacy Officer
 - Monica Bajdman MD FRCP(C)
Haematology
 - John Carrothers MLT
Research, Transfusion Medicine
 - Adriana Carabial MD, MSc, PhD
Psychiatry
 - David Clark MD PhD FRCP(C)
Medicine
 - Jean Grosse MHS
Rehabilitation Science
 - Lynn Donohue BA(Hons)
Community Reintegration
 - Melanie Griffiths FRCP (UK)
Diagnostic Imaging
 - Cindy James BScN
Gastroenterology
 - David Jewell M. Sc., MHS
Geriatrics
 - Graham Jones BSc, MSc, PhD, MD, FRCP, FCCP
Peter Karasik PhD
Laboratory Medicine
 - Rosanne Keir RN BA MHS(M)
Cardiology
 - Carolya Kozal RN
Pediatrics
 - Oliver Kizilek, BA, M. Div
Research Ethics Officer
 - Georgios Leonidas MD PhD,
Gastroenterology
 - Steve Lloyd MD Family Medicine
 - Cheyl Main MD FRCP, Medical
Microbiology and Infectious Diseases
 - Shelly McLean MBA
Community Reintegration
 - Madhu Natarajan MD, FRCP, FACC
Cardiology
 - Ariana Giv Perry BA, LL.B, LL.M
Candidate, Legal Representative
 - Koona Reddy MB BS FRCS(FAES)
Neurosurgery
 - Gita Sabhu BSc Pharm
Pharmacy
 - Brian Timmons PhD
Pediatrics
 - Marc Townsend BA(Hons), MBA
Administration
 - Graham Turpin MD FRCP
Medicine
 - Andrew Warster MD
Emergency Medicine
 - Jan Wright BSc MD
Radiation Oncology
 - Ed Younglin PhD
Otorhinolaryngology
- The REB/REB operates in accordance with the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans (the Tri-Council Policy Statement: TCPS 2) and the Clinical Practice Guidelines (CPG) and the applicable laws and regulations of Ontario. The membership of the REB also complies with the membership requirements for REBs as set out in Canada's Food and Drug Regulations (Division 5, Drug for Clinical Trials Involving Humans (S.101)).

March 31, 2010

PROJECT NUMBER: 10-086

PROJECT TITLE: Public Health Services Renewal in British Columbia and Ontario

PRINCIPAL INVESTIGATOR: Dr. Ruta Valaitis

This will acknowledge receipt of your letter dated March 23, 2010 which enclosed the revised Participant Information and Consent Forms for the above-named study. These issues were raised by the Research Ethics Board at their meeting held on February 16, 2010. Based on this additional information, we wish to advise your study has been given **final** approval from the full REB. The submission, study protocol version 1 dated January 26, 2010 including the Participant Information and Consent Form/For Social Network Analysis, version 2 dated March 9, 2010 was found to be acceptable on both ethical and scientific grounds. **Please note** attached you will find the Consent Form with the REB approval affixed; all consent forms and recruitment materials used in this study must be copies of the attached materials.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the REB meeting on February 16, 2010. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or information sheet must be approved by the Research Ethics Board.

The Hamilton Health Sciences/McMaster Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.

PLEASE QUOTE THE ABOVE-REFERENCE PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,
[Redacted Signature]

Jack Holland, MD, FRCP, FRCP (C)
Chair, Research Ethics Board

Appendix D: RePHS Confidentiality Agreement



Faculty of Health Sciences
School of Nursing



<http://www.fhs.mcmaster.ca/nursing>

PLEDGE OF CONFIDENTIALITY

In order to ensure that all members of the research team involved in *Public Health Services Renewal in British Columbia and Ontario (RePHS)* fulfill their obligations to the Study Participants, anyone with access to confidential information of third parties must make this Pledge of Confidentiality.

1. I recognize and acknowledge that in the course of my involvement in the research study *Public Health Services Renewal in British Columbia and Ontario (RePHS)*; I may gain access to certain "Confidential Information" (as defined below). I shall not use any Confidential Information at any time except for purposes of performing my duties with respect to the Research Study. I shall not disclose any Confidential Information in any manner, at any time, to any individual or entity that is not bound to confidentiality provisions with McMaster University, School of Nursing and/or any Research Partners similar to the ones imposed by this Agreement. I shall continue to observe strict confidentiality of this information when I cease to be involved with the Research Study.
2. "Confidential Information" means information you gain access to in the course of your participation in the Research Study, that is, private information pertaining to an individual or organization or information that is of a confidential or secret nature and that may be related to the Research Study including, without limitation, the protocol, methods, processes, procedures, strategies developments, results, and outcomes.
3. I acknowledge that I have had sufficient time to review this Agreement and fully understand its contents and its effect on me.

RESEARCH TEAM MEMBER

WITNESS

Katherine Rizzi

Printed name of Team Member



Signature of Team Member

Masters student

Role on Research Team

Nov 5, 2013

Date

SANDRA REGAN

Printed name of Witness



Signature of Witness

NOV 5, 2013

Date



Appendix E: RePHS Study Student Project Involvement Proposal – Katherine Rizzi (MHIS Candidate)

Health Information Sciences Graduate Program, Western University

Background:

Health inequities are widely visible across Canada and manifest in a number of various social determinants (Bryant, et al. 2011). One of the most vital and agreed upon goals of a successful public health system is the promotion of health equity (Pinto, et al. 2012). Within every program, policy, or component of a public health system there is the recognized goal that outcomes should strive to reflect reduced inequities in health. However, reducing health inequities can be considered one of the most challenging aspects of any public health system in part because of the overall complexity of equity as a concept in health. Understanding and conceptualizing health equity or inequities has proven to be a difficult task for academics and policymakers. Despite acknowledgments of its importance and extensive research attesting to this, equity is not adequately addressed in public health program planning (Gore and Kothari, 2012). Given the fact that the importance and impact health equity has on population health is understood, it seems there now exists a need to study *why* this evidence is so difficult to appropriately apply to public health programs. A disconnect exists between how equity is understood as a concept and how equity is understood as practice.

The difficult task of moving existing theories and definitions of equity into tools for practice has become evident now more than ever. The focus must shift towards embedding equity into health care practice. Given that the current national public health system is in the midst of renewal, there is a unique opportunity to directly address this gap through restructuring how the public health system addresses equity in practice. In order to provide a new perspective, qualitative analysis would be an ideal approach. More specifically, using a qualitative content analysis inductive approach will allow us to uncover the deeper meaning of equity by dissecting the meanings behind how people talk about equity in different contexts, through their practice and lived professional experiences. Comparing these meanings of health equity with dissected meanings of health equity that emerge from public health unit policies and programs texts will allow for an in-depth look into how different understandings of health equity align, if at all.

Research Questions:

The primary objectives of this research include:

- To understand how frontline public health staff talk about health equity.
- To examine what kind of alignments or gaps exist between front-line staff perspectives on equity and how public health unit policies/programs are operationalized.

Methodology:

This research will be conducted using a secondary qualitative content analysis design. According to Hardwood and Garry (2003), content analysis is an appropriate method to use when analyzing a variety of data, as it allows for the reduction of a phenomenon into defined categories or themes, thus improving the ability to interpret them. Content analysis is specifically structured to enable to analysis of “open-ended” data, and is especially helpful when analyzing research involving characteristics of language and communication (Hardwood and Garry, 2003, Elo and Kyngas, 2007). Qualitative content analysis tends to take more of a hermeneutic approach and it does not require a testable hypothesis, like one might see in quantitative content analysis (White and Marsh, 2006). Instead, the underlying purpose of qualitative content analysis is to scrutinize and identify concepts and patterns from a data set, which may include written or verbal text (White and Marsh, 2006). Qualitative content analysis allows for subjective coding as it values examining how perceptions can impact data (White and Marsh, 2006). Its general objective is to “capture the meanings, emphasis, and themes of messages to understand the organization and process of how they are presented (White and marsh, p.35, 2006).” Qualitative content analysis is fundamentally flexible, as the interpretive process of the analysis is so highly valued (White and Marsh, 2006). It includes an iterative process of “re-contextualizing, reinterpreting, and redefining research” that should be ongoing throughout the entire research process (White and Marsh, p34, 2006).

This type of inductive content analysis allows for the researcher to become immersed in the data, enabling a better understanding of the data, and the ability to identify hidden meanings through their interpretations (Elo and Kyngas, 2007, Campos and Turato, 2009). As a result of this necessary immersion, self-reflexivity will play a crucial role in the data analysis phases. It is important in qualitative content analysis to be constantly and consistently reviewing one’s own growing interpretations of the data and engaging in constant comparisons back to the texts (White and Marsh, 2006).

This methodological aim aligns with the aim I have for my research in that I want to develop a deeper understanding of inequity in health and specifically how it can be applied in practice. By developing a better understanding of how health inequity is discussed in a given context, I will hopefully be able to identify the latent meanings that exist in my data, allowing for the identification of gaps or alignments in perspectives on health inequity. Through my inductive approach, I will be examining a variety of data including interview transcripts of frontline staff discussing health inequity and comparing this to how health inequity is discussed in public health unit-level policy documents and procedures. Inductive content analysis includes a combination of techniques when trying to make sense of the data including: open coding, coding sheets, grouping, categorization, and abstraction (Elo and Kyngas, 2007). Qualitative content analysis allows for dissection of multiple meanings, alternative perspectives, differing ideologies that might impact the texts being examined (White and Marsh, 2006). This purpose directly relates to the primary objectives of my study as it will allow me to dissect how frontline

staff workers perceive equity in their daily work, and how the differing ideology behind an organizational public health policy might interfere or support those perceptions.

Request for Access to Data:

In order to complete this research I will need access to the raw data transcripts for Phase II of the RePHS interviews and focus groups. I will specifically be looking at the questions pertaining to 'equity.' In addition, I will access select public health unit policies/program documents collected in Phase I and II including public health unit "show and tell" documents.

Expected Timeframe:

This secondary analysis begins January 2014 and concludes July 2014, as it must coincide with my graduation from the Masters of Health Information Science program and the University of Western Ontario. Stage 1 will take place from January 2014 until Feb 2014. This includes the review of raw transcripts and the public health unit policies/programs documents. The purpose here is to make sense of the data as a whole and begin organization of the data. Stage 2 will take place during March 2014. This stage includes the analysis of the data through open coding, coding sheets, grouping, categorization, and abstraction. The purpose of this is to make sense of the data by breaking it down and dissecting similarities and differences. Stage 3 will take place during April 2014 and May 2014. This final stage will complete the analysis, report on the analyzing process and examine my results. The purpose of this is to apply the results and present them in a systematic way.

Supervisors:

RePHS co-investigators Dr. Anita Kothari and Dr. Sandra Regan will be overseeing my research as they are my co-supervisors.

Curriculum Vitae

Name: Katherine Rizzi

Post-Secondary Education and Degrees:

McMaster University
Hamilton, Ontario, Canada
2008-2012, Hon. BA (Political Science and Health Studies)

Western University
London, Ontario, Canada
2012-2014, MHIS (Masters of Health Information Science)

Related Work:

Teaching Assistant
Western University, 2012-2014

Research Assistant
Western University, 2013-2014

System Performance and Diagnosis & Clinical Care Intern
Canadian Partnership Against Cancer, Toronto, 2013

EMR Clerk
St. Michael's Hospital Health Centre, Toronto, 2011

Policy Analyst Intern – Government Relations
AstraZeneca Canada Inc. (biopharmaceuticals), 2010