SIMCOE MUSKOKA DISTRICT HEALTH UNIT'S APPROACH TO ADDRESSING THE DETERMINANTS OF HEALTH

A Health Equity Framework

May 2012

simcoe muskoka
DISTRICT HEALTH UNIT

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FORWARD FROM THE MEDICAL OFFICER OF HEALTH

When someone is asked what they wish for their life and the lives of their family, their response is often related to happiness, having a home, a good job, family and friends, and being independent. In common language this is what is meant by the social determinants of health; it is those essential elements a person has that contribute towards a long and healthy life.

The socioeconomic factors that affect health are complex and intertwined throughout the life course of individuals. Known as the social determinants of health, they include: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, and health services. To improve health and to narrow the health inequities created by these socioeconomic factors, we must look beyond health care and focus on understanding and finding solutions to these root causes of poor health.

The Simcoe Muskoka District Health Unit (SMDHU) is committed to improving the health of our residents and reducing health inequities amongst population groups. Our Strategic Plan 2012-2016 includes determinants of health as one of the four main goals that support our Vision: The people who live, work and play in Simcoe Muskoka lead healthy, fulfilling and productive lives.

As a first step we have undertaken an exploration of social determinants of health from a public health perspective to be better prepared to respond to and work with our communities. A result of this work is the creation of this foundational document, which is internally focused to guide the health unit in its work to address the social determinants of health.

Although the document speaks to actions and recommendations for the Simcoe Muskoka District Health Unit, I believe it is important to share it with our community stakeholders and partners in an attempt to foster stronger community collaboration. We recognize the tremendous amount of work taking place in our communities through agencies, organizations and individuals who are working or volunteering to address the determinants of health. Tackling the issues that are nested in the social determinants of health and finding solutions that will improve the health of our population is not something we can do alone. As a collective, I believe we can create significant positive change in the social factors that affect our overall health and well-being.

We welcome your feedback about the document, as well as ideas on how to achieve our collective goal of creating healthier people and communities. Please send your comments to *Your Health Connection* by visiting www.simcoemuskokahealth.org or calling 705-721-7520 or 1-877-721-7520.

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Medical Officer of Health

EXECUTIVE SUMMARY

Social determinants of health (SDOH) as a phrase may mean little to many people. Yet those same people know intuitively what they wish for the children in their lives. Often their answers are related to happiness, having a home, a good job/money, family and friends and being independent. That is what is meant by SDOH. It is having those elements in your circumstances that will help to provide you with a long and healthy life.

Health disparities are growing, giving rise to long lasting negative health outcomes. Grappling with how public health can address the determinants of health is imperative yet complex because the concepts revolve around cultural and individual values. Many of the determinants of health are mandated by other jurisdictions and taking action involves collaborating closely with other sectors to effect policy change. Even though public health has historically worked on health inequities, there is the sense today that this is new or extra work[2] and this notion needs to be challenged . In fact, throughout its history, public health has impacted on SDOH and improved the health of communities worldwide. The most common examples cited are routine immunization and safe water systems.

An environmental scan at both the national level and the provincial level has identified potential roles and activities to address the social determinants of health. Based on the literature and socio-political climate, it is clear that public health is being asked to do more.[1;3-6]

Addressing determinants of health (DOH) and reducing health inequities are fundamental to the work of public health in Ontario. The Ontario Public Health Standards (OPHS) incorporate and address the determinants of health throughout and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.[7]

Simcoe Muskoka District Health Unit (SMDHU) has identified the DOH as a strategic direction with the goal of addressing the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes.[8]

The information and the suggested recommendations in this document will support achieving the following outcomes identified in the Simcoe Muskoka District Health Unit Strategic Plan 2012–2016:

- Populations at risk of health inequities, that require a coordinated and comprehensive agency response, are prioritized annually.

- Populations at risk of health inequities, that require a specific service area response, are prioritized annually.

- Within one year of a priority population being identified, a determinants of health plan for action to address the critical risk conditions to meet the priority population's public health needs is developed, approved, operationalized and tracked.[8]

The purpose of this document titled *Simcoe Muskoka District Health Unit 's Approach to Addressing the Determinants of Health - A Health Equity Framework* is to guide the health unit staff as they strive to meet the Strategic Plan 2012–2016 DOH goal and future health equity endeavors. Included in this document is an overview of common terminology; discussion about common models; background related to the OPHS, and information about identifying priority populations. A framework developed by National Collaborating Centre for Determinants of Health (NCCDH) is provided examining four key roles along with six strategies that support these four roles for public health. A list of recommendations has been developed to direct a shift in the organization's culture and practice to better address reducing inequities and achieving improved health outcomes for all.

Terminology is important to discuss because most people are not familiar with concepts of SDOH.[5;9] There are many DOH, each defined in a variety of ways that can influence health. There are several lists of DOH that continue to evolve as greater understanding develops across many disciplines. Simcoe Muskoka District Health Unit has adopted the term DOH using the definitions provided by the Public Health Agency of Canada (PHAC). Other key terms include health inequities, health inequality, social gradient and leveling up.

Good health comes from a variety of factors and influences; of which 75% are not related to the health care delivery system; 50% can be explained by socio-economic factors such as education, income, early childhood development, employment, work conditions, culture and gender and personal health practices; 15% relates to biology and genetics, while the physical environment accounts for the remaining 10%.[10]

The social-economic factors are complex and intertwined throughout the life course of individuals. As a result, the only way to improve health and narrow the health gap in an equitable way is to bring up the level of health of groups of people who are worse off than that of groups who are better off, referred to as "leveling up."[11]

A model widely used to describe the DOH is Dahlgren and Whitehead's Rainbow Model.[12] The model categorizes the determinants based on their level of influence by individuals, commercial or political decisions and highlights the interactions that occur among the various layers of influence.[12;13]

Figure 1. *The Main Determinants of Health[12]*

Identifying populations at risk of health inequities will be an important aspect of SMDHU work and will be reflected in the annual program planning cycle. A key component of the requirements outlined in the OPHS is to identify and work with local priority populations.[7] To determine a population that is at risk of health inequities will require integrating knowledge from diverse sources including and beyond traditional epidemiological data. Collecting information that reflects quantitative, qualitative, participatory and experiential will be required.

Some methods to assist in identifying populations at risk of health inequities are identified in this document. However, using the Health Equity Impact Assessment (HEIA) by the Ministry of Health and Long Term Care and the Public Health Unit's Supplement Guide by Public Health Ontario will be excellent tools to support this work. This document also includes an overview of the determinants of health statistics for Simcoe Muskoka to determine populations at risk.

Typically, statistics addressing the DOH include education, income, employment and housing. In order to better understand the implications for which populations are at risk, a closer examination is required. For example, examining the levels of physical activity among different income levels or across neighbourhoods will provide a higher level of understanding than just levels of physical activity of the general population. It is important for SMDHU to develop a collection of health equity indicator data to allow for more accurate analysis. When the health sector does not generate the data, it will be necessary to use other sectors' data such as the Early Development Instrument (EDI), a population measurement tool for assessing trends among children.[14]

Four key roles and six capacity building strategies were developed by the NCCDH. The four roles are:

1. Assess and report on the health of populations describing the existence and impact of health inequalities and inequities and effective strategies to address those inequalities/inequities.

2. Modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations.

3. Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs.

4. Lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in the health determinants/inequities.[2]

The six capacity building strategies that support these four roles as stated by NCCDH are:

1. Leadership

2. Develop/apply information and evidence

3. Education and awareness raising

4. Organizational and system development

5. Skill development

6. Partnership development.[2]

Figure 2 illustrates the relationship between the four roles and six strategies. The four roles are not linear in application but revolve around each other and are supported by all six strategies depending on the needs.

Figure 2.   *Public Health Roles and Strategies*
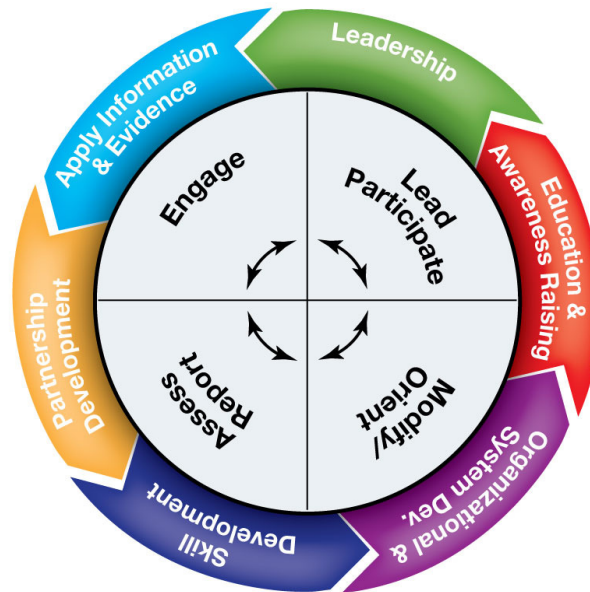
The literature has identified the following barriers that must be overcome in order to adopt the four roles:

- Preoccupation by public health with behaviour and lifestyle approaches.

- Lack of skills related to community development, engagement, and mobilization.

- Bureaucratic and controlling nature of health units.[2]

Not addressing these barriers will hamper the health unit's capacity to address SDOH.[2]

It is no longer acceptable to "focus solely on behaviour risk factors and lifestyle approaches or to place the burden of achieving health on the individual as these are seen as the greatest barriers to addressing the DOH."[15] It is incumbent upon health units to assess current processes and approaches to program planning and implementation and the skills of their workforce to determine if these barriers exist within their practice.

In order to support the organization to address the DOH strategic goal the following ten recommendations have been developed and will need to be implemented to fully integrate the framework in order to meet the Strategic Plan 2012–2016 DOH goal and future health equity endeavors. They are as follows:

Recommendation 1

The Executive Committee, Service Area Directors and program managers/supervisors will use the MOHLTC Health Equity Impact Assessment and PHO Public Health Supplement Guide as agency, service area and program policies are developed and reviewed. The SDOH Steering Committee will review the Request For Service from External Clients policy in 2012.

Recommendation 2

The Agency Management Committee will ensure cross program collaboration for DOH initiatives.

Recommendation 3

The SDOH Steering Committee will commit to creating a professional development plan for implementation beginning in 2012 to enhance knowledge and skills on content areas enhancing staff's ability to address DOH as outlined in Appendix E.

Recommendation 4

The SDOH Steering Committee will develop a proposal outlining best strategies to support health equity work beyond 2012, including utilization of the SDOH PHN funding provided by MOHLTC for Executive Committee's consideration.

Recommendation 5

The SDOH Steering Committee will identify priority populations as a whole for SMDHU, as well as develop health equity indicators based on the Strategic Directions 2012-2016 outcomes that address reducing inequities for programs and services. The Evaluation Specialist will be engaged in indicator development for inclusion in the Balanced Scorecard Performance Management Tool. The indicators will align with performance indicators created at the provincial level, when applicable.

Recommendation 6

The Executive Committee and Managers/Supervisors will use a consistent planning process, and tools, including the HEIA to determine and prioritize priority populations annually. Programs will determine best strategies reflecting the four roles and six strategies as reflected in the Capacity Building Framework by NCCDH.

Recommendation 7

Corporate Service will enhance the existing assessment and surveillance resources to systematically include health equity indicators. These health equity indicators will be updated over time as new data and indicators become available. The initial list of health equity indicators will be developed by the SDOH Steering Committee in 2012.

Recommendation 8

Managers/Supervisors will ensure that all SMDHU reports include health equity information, and that a communication and dissemination plan is developed.

Recommendation 9

Executive Committee will ensure priority will be given to the development of both internal and external DOH communication strategies reflecting a multi-faceted approach including social media.

Recommendation 10

The Directors, AMOH's, MOH, and the Board of Health will seek and engage in advanced leadership opportunities to promote health equity, including doing the following:

•   influence priority setting and allocation of resources, and

•   model desired behaviours.

By adopting the recommendations, the health unit will be well prepared to address the complex DOH issues both with existing and with newly formed partnerships from different sectors representing different segments of the population.

Health disparities are growing, giving rise to long lasting negative health outcomes. We echo the many voices across all sectors including those living with disparities when we say–it is time to act now!

INTRODUCTION

Social determinants of health (SDOH) as a phrase may mean little to many people. Yet those same people know intuitively what they wish for the children in their lives. Often their answers are related to happiness, having a home, a good job/money, family and friends and being independent. That is what is meant by SDOH. It is having those elements in your circumstances that will help to provide you with a long and healthy life.

The purpose of this document, *Simcoe Muskoka District Health Unit's Approach to Addressing the Determinants of Health - A Health Equity Framework,* is to guide the Simcoe Muskoka District Health Unit (SMDHU) staff as they strive to meet the Strategic Plan 2012–2016 (Appendix A) determinants of health (DOH) goal. The Strategic Plan states that SMDHU will "address the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes."[8] The information and the suggested recommendations in this document will support achieving the strategic plan outcomes which are:

- Populations at risk of health inequities, that require ***a coordinated and comprehensive agency response***, are prioritized annually.

- Populations at risk of health inequities, that require a ***specific service area response***, are prioritized annually.

- Within one year of a priority population being identified, a DOH plan for action to address the critical risk conditions to meet the priority population's public health needs is developed, approved, operationalized and tracked.[8]

Included in this document is

- an overview of common terminology,

- a discussion about common models,

- background related to the Ontario Public Health Standards (OPHS), and

- information about identifying priority populations.

A framework developed by the National Collaborating Center for Determinants of Health (NCCDH) is provided examining four key roles along with six strategies that support these four roles for public health. A list of recommendations has been developed to direct a shift in the organization's culture and practice to reduce inequities and achieve better health outcomes for all.

The information has been gathered based on current literature. However, new information will continue to emerge due to the increasing interest across many sectors to develop evidence and find better strategies on improving health inequities.

Addressing DOH and reducing health inequities are fundamental to the work of public health in Ontario. The Ontario Public Health Standards (OPHS) include a broad range of population-based activities designed to promote the health of the populations and reduce health inequities by working with community partners.[7] Public health programs and services that are informed by evidence are the foundation for effective public health practice. The goal of the Foundational Standard is that "public health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being."[7] Three of the thirteen requirements under the Foundational Standard stipulate the inclusion of the determinants of health and health inequities information in addition to programming to meet local needs, including those of priority populations, to the extent possible based on available resources.

Aside from the Ministry of Health and Long-Term Care (MOHLTC), many organizations within the public health sector such as Public Health Ontario (PHO), National Collaborating Centre on the Determinants of Health (NCCDH), Health Nexus and public health units are striving to improve health across the province and in local communities by addressing inequities and supporting priority populations.

Despite these efforts, health disparities are growing, giving rise to long lasting negative health outcomes. There are many voices across all sectors including those living with disparities who say–it is time to act now!

COMMON TERMINOLOGY AND MODELS

Understanding Common Terminology

As many people are not familiar with the concepts of SDOH, a report was developed to create better understanding about SDOH by the Robert Wood Johnson Foundation titled, _A New Way to Talk About the Social Determinants of Health_.[9] Simple ways to create understanding and conversation from their report are outlined in the following phrases:

- Health starts long before illness, in our homes, schools and jobs.

- All people should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.

- Your neighbourhood or job shouldn't be hazardous to your health.

- Your opportunity for health starts long before you need medical care.

- Health begins where we live, learn, work and play.

- The opportunity for health begins in our families, neighbourhoods, schools and jobs.

These phrases have become embedded in many social marketing resources such as the "Let's Start a Conversation" campaign initiated by the Sudbury District Health Unit (SDHU). [16]

An environmental scan of Ontario public health unit's activities concluded the language and concepts of SDOH are complex. Within the realm of research, there is confusion about the terminology and its interpretation among countries including Canada, United States, Australia and Britain.[17] There is a need to develop shared understanding.[18] The following section will provide definitions of common terminology used when describing differences in health status.

Determinants of health are a range of factors that influence the health status of individuals or populations. At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. They do not exist in isolation from each other.

The Public Health Agency of Canada (PHAC) has identified 12 determinants of health as follows:

1. Income and social status
2. Social support networks
3. Education and literacy
4. Employment/working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

A great on-line resource to understand more about the determinants of health which includes the social and economic factors can be found in The Canadian Facts by Dennis Raphael.[1]

Definitions on each determinant can be found in Appendix B.

According to the Public Health Agency of Canada (PHAC), at every stage of life, health is directly or indirectly influenced by key DOH. Within the broader DOH, socio-economic factors such as income, education or employment, often referred to as the "social determinants of health" can cause or influence the health outcomes of individuals and communities. These factors relate to an individual's place in society–the circumstances in which people are born, live, work, play, interact and age. Often these factors are influenced by wealth, status and resources that, in turn, also influence policies and choices leading to differences in the health status experienced by individuals and populations.[3]

Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces such as economics, social policies and politics.[19] According to the World Health Organization (WHO), poverty is the single largest DOH.[13]

The difference between the "determinants of health" and the "social determinants of health" is that the social determinants of health can be understood as the social conditions in which people live and work.[2]

What is important is whichever social factors are being considered as determinants of health, it is important to note that none of the determinants exist in isolation from the others; rather, the social determinants interact with each other to produce health.[2]

There are several lists of DOH that continue to evolve as greater understanding develops across many disciplines. Both the terms SDOH and DOH are used, however, the predominant terminology is SDOH. This document will be using the terms "Social Determinants of Health" and "Determinants of Health" interchangeably, based on how it is reflected in the literature, websites or agencies/organizations. The SMDHU Strategic Plan 2012–2016 uses the term "Determinants of Health."[8]

Good health comes from a variety of factors and influences; of which 75% are not related to the health care delivery system; 50% can be explained by socio-economic factors such as education, income, early childhood development, employment, work conditions, culture and gender and personal health practices; 15% relates to biology and genetics, while the physical environment accounts for the remaining 10%.[10]

For many, a focus on health has meant a focus on service delivery, access to health care and modification of individual behaviour. Examples of modifying individual behaviours would include addressing physical activity, diet or the use of alcohol and tobacco.[20;21] Too often the focus on improving health has focused on behavioural risk factors; however, there has been little evidence to show that using behavioural interventions improves health for vulnerable populations.[21] While public health interventions have targeted behavioural risk factors, it has been in the context of policy and supportive environments as well as individual behaviour change so that the population as a whole is aware of the health impacts and healthier choices are supported in the broader environment where people live, play, learn, and work.

"Too often, the health care system reacts after the fact, once diseases and illnesses (many of them preventable) have occurred. Clearly, health is more than health care and, of them all, the socio-economic environment is the most powerful of the determinants of health".[10]

Health inequalities are differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made or by chance, but often they are due to unequal access to key factors that influence health, for example, income, education, employment and social support.[22]

Health inequalities lead to differences in health status. For example, those with the lowest incomes and education levels, who live in inadequate housing, work in poorer conditions, have limited access to health care, lack early childhood support and/or social support are more likely to develop poorer physical and mental health outcomes than those living in better circumstances.[3;22]

Understanding the causes of these inequalities through health surveillance and population health assessment activities, and developing interventions that reach these groups are essential elements of public health action.[22]

Health inequities are differences in health that are systematic, socially produced (and thus can be changed or avoided) and therefore are deemed to be unfair.

Health equity is "the absence of unfair and avoidable or modifiable differences in health among population groups defined socially, economically, demographically or geographically."[23]

The distinction between equality and equity is that the identification of health inequities entails a moral judgment based on one's beliefs or attitudes about what is fair or just.[2;24]

Health disparities are differences in health status (such as incidence, prevalence, mortality, burden of disease and other adverse health conditions) that occur among population groups defined by specific characteristics. The most useful characteristics are those consistently associated with the largest variations in health status. The most prominent factors in Canada are socio-economic status, Aboriginal identity, gender and geographic location.[25] For example, ill health is distributed disproportionately to specific groups, notably Aboriginal people, individuals and families whose incomes are low. Figure 3 shows health disparities among aboriginals as compared to non-aboriginals.[10]

Figure 3. *Inequalities in Health Determinants*

	Non-Aboriginal Canadians	First Nations	Inuit	Métis
Health Status				
Life Expectancy at Birth (Men)	76	69	68	n.a
Life Expectancy at Birth (Women)	82	77	70	n.a
Education (% 15 Years and Over)				
No Degree, Certificate or Diploma	33	55	66	46
Bachelor's Degree Graduation	16	4.1	1.9	5.3
Employment (% 15 Years and Over)				
Unemployment Rate	7	22	22	14
Worked Full Year, Full Time	37	23	23	31
Income (% 15 Years and Over)				
Low Income in 2000	16	40	24	28
Lifestyle (% of Population)				
Daily Smoking	22	38	61	37

Social gradient is about how people's health is based on their socio-economic status including their level of education, occupation and income. The evidence shows that in general, the lower an individual's socio-economic position, the worse their health becomes; life expectancy is shorter and most diseases are more common.[19;24]

The social gradient has been seen across all sectors of society, not just the poor, as reflected in studies among middle class office workers where education, income and occupation are a factor (see Figure 4). Studies have shown that lower ranking staff experience more disease and earlier death than higher ranking staff. [26] Inequities in health are not just a matter of differences between those with low social-economic status (SES) and others, but persist in gradient fashion along the entire spectrum of society.

Figure 4. *Occupational Class Differences in Life Expectancy, England and Wales 1997 – 1999* [26]
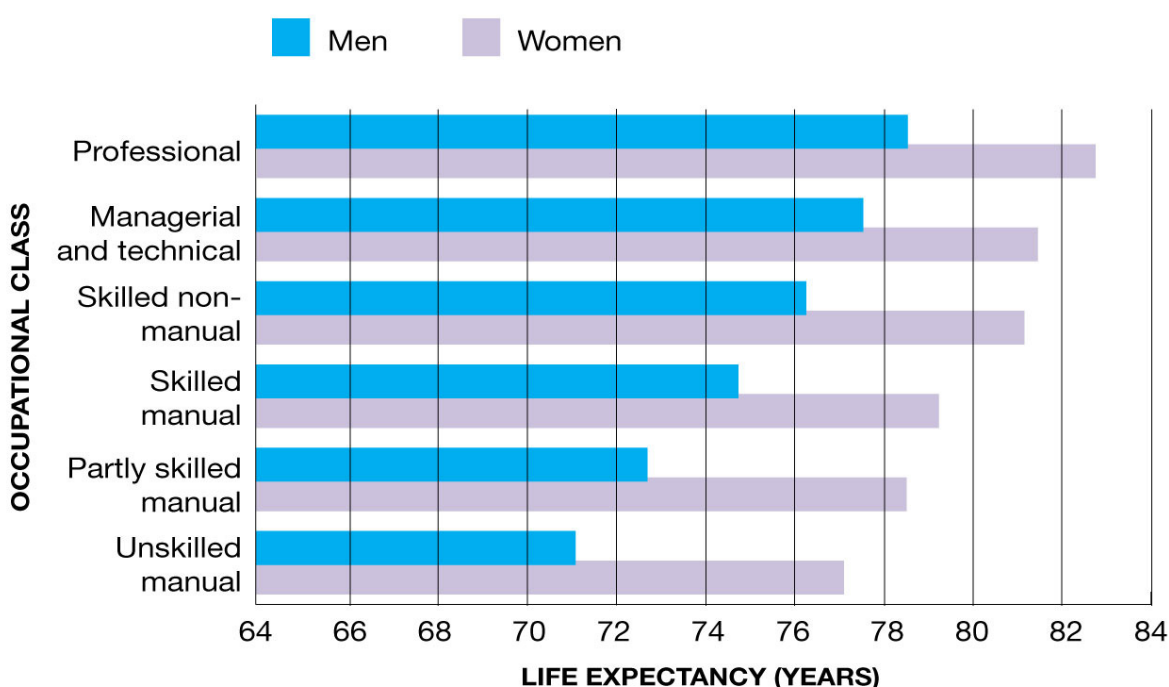
Leveling up is a term used to address minimizing the social gradient where everyone's health needs to improve. However, the only way to narrow the health gap in an equitable way is to bring up the level of health of the groups of people who are worse off to that of the groups who are better off.[11] It has been found that societies with large income inequalities tend to have a higher percentage of people living in poverty, and it is poverty that has the adverse health effects.[12] It has also been found that rates of mental illness are five times higher, imprisonment is five times higher and obesity is six times higher than in more equal societies.[27] A question often comes up about how equality affects the rich. Many studies have determined that greater equality will result in substantial gains across the population including those at the very top. By leveling up the population, everyone will benefit.[27]

Tackling inequities in health – to level up the health status of disadvantaged groups to the same level of health as already experienced in advantaged groups – is today, one of the most important public health challenges.

Leveling up the health status of less privileged socio-economic groups to the level already reached by their more privileged counterparts should therefore be a key dimension of all international, national and local health policies.[12]

Campaigns that focus on leveling up the population are Doctor's For Fair Taxation, Robin Hood Tax and Occupy Wall Street campaigns. These can be found under Appendix C tools and resources.

Targeting within universalism occurs when "extra benefits are directed at low-income groups within the context of a universal policy design".[28]

There have been many debates about the effectiveness of targeted versus universal approaches to address poverty and social inequity. Universalism occurs when the entire population is the beneficiary whereas, targeting involves only a specific sub-group of the population.[28] An example of targeting commonly seen is screening for financial assistance to participate in recreation facilities. Some developed countries, including Canada, have universal social and health policies, using targeting to make the universal approach more effective.[23] Public health has many examples. An example of universalism in which everyone is a beneficiary is Ontario's School Food and Beverage policy that includes nutrition standards for food and beverages sold in schools.[29] Approaches that are more universal in nature tend to be more effective in reducing poverty than targeting for the following reasons. They are:

- Less likely to exclude those who need them.

- Less stigmatizing (stigmatization reduces participation by those needing the program, and is damaging in and of itself).

- Avoids excess use of resources used to means-test that is often required with targeting.

- Supported more by the population as a whole.

- Better funded.

The argument against universalism is the assumption that everyone has a single common set of needs.

Targeting within universalism is a preferred approach in order to improve the health seen among the populations at risk of poorer health, thereby leveling up. For example, it has been identified that multi-unit dwelling social housing units have a high prevalence of environmental tobacco smoke exposure. A targeted approach would be to advocate for a policy to support the creation of smoke-free social housing units. However, if this policy was embedded within a general policy to support smoke-free requirements for all multi-unit dwellings (including high-end condominiums) the desired targeted outcome would be achieved through a universal approach without stigmatizing those who require social housing. It is important for all sectors, including public health, to consider systematically reviewing their programs and services to identify

opportunities to address the unmet needs of priority populations, using targeted approaches supported within universal strategies with the goal to "level up" those populations at risk of poorer health.[11;12]

Target populations are defined as the population group to which public health actions are directed. It can also be understood as the 'audience.' Many activities have a 'target group' or audience to whom the specific activity is directed. An example of this is the Healthy Smiles Ontario program which is targeted at children under the age of 17 from low-income families.

Sometimes having a target group does not necessarily mean that the activity addresses the priority populations within the target group. An example is targeting all women over the age of 50 to participate in regular breast screening. Some socially produced inequities for many women who become excluded from the program include language, culture, education, and/or access to services, to name a few.

Target groups can have priority populations within them. An example is offering free breakfast programs to children and youth who may experience socially produced inequities such as having unemployed parents, living in inadequate housing, or limited access to affordable and healthy food.

It should be noted that the OPHS does not always use the terms 'priority populations' and 'target groups' differently. It is important to consider whether a population being considered is a target and/or a priority group or a population could be a priority group within a target group. This distinction has important implications when determining best strategies to achieve health equity.[30]

Programs, policies or any public health activity should spend focused effort on both priority and target populations, but should be clear about the rationale for either. A priority population is chosen based on epidemiology and inequity/social factors whereas a target group is chosen based on epidemiology alone.[30]

Gini-coefficient is the most commonly used measure of income inequality. The Gini Coefficient is often associated with a Lorenz Curve that visually displays disparity in income distribution. Economists use the Lorenze Curve to measure and report on social inequality. A Lorenz curve plots the cumulative percentages of total income received against the cumulative percentages of recipients, starting with the poorest individual or household. The deeper a country's Lorenz curve, the less equal its income distribution.[31]

Researchers have found that in affluent societies the distribution of income might be more important than the overall level of wealth. Using the Gini-coefficient to analyze the relationship between income inequality and population health, the results suggest that countries like Sweden and Norway with a more equal distribution of income have longer life expectancy.27 "At the population level, a more important factor than overall national income is the distribution of income. In other words for populations, equality appears to be healthier whereas for individuals, wealthier is healthier".[27]

In Simcoe Muskoka, income is more equally distributed among households compared to Ontario as seen in the Lorenz Curve in Appendix D under income distribution. To learn more about the social gradient and the Gini-coefficient see the short video listed under tools and resources Appendix C.

Improved Health as a Determinant of Economic Growth

Studies have found that improved health does impact economic growth because it increases labour productivity, provides a greater workforce supply and increased educational achievements and savings in social and health care costs. One of the main findings in the WHO's Report on Macro-Economics on Health, is that each 10% improvement in life expectancy at birth creates a rise in economic growth of at least 0.3 to 0.4% per year.[11]

From a Canadian public health perspective, more economic evaluations on interventions addressing inequities are required to determine the cost savings and impact on economic growth.[32] Some provinces have looked at the cost of poverty, including Ontario reporting a social cost between 10 to 14 billion dollars annually. The national social cost is calculated between 24 and 30 billion dollars annually. Both Ontario and British Columbia have been able to identify 20% of health care costs directly attributable to health inequities.[6] Many studies have also been reporting cost savings as a result of changing policies and programs–or leveling up populations such as the Aboriginal population. According to the Canadian poverty report "In from the margins" examining the cost of poverty, it was cited that if all Aboriginals attained the same level of education as Non-Aboriginals in Canada, the government would save 140 billion dollars. Significant cost savings can be achieved when eliminating high school drop-outs in Canada which costs 23.8 billion dollars in health and 969 million dollars in social services annually.[6]

There is increasing evidence that the cost of doing nothing to reduce or eliminate poverty is large enough that many remedies are probably less costly. The economic and social costs of doing nothing about poverty—more than $20 billion—are more than we can afford.[6]

Understanding Models of Social Determinants of Health

There are several ways to conceptualize the DOH such as the Rainbow Model[11], the WHO's Conceptual Framework for Action on the Social Determinants of Health[33], the Ottawa Charter for Health Promotion[34] and the Population Health Promotion Model[35]. The following section will describe each model in more detail.

Rainbow Model

The multilevel Rainbow model is widely used and well-known across many sectors to identify the full range of health determinants. In this model, determinants are categorized based on their level of influence. In addition, the rainbow model highlights the interactions between layers and between various determinants of health as shown in Figure 1.

Figure 1. *The Main Determinants of Health[12]*

Dahlgren and Whiteside describe their Rainbow model in the following excerpt:

> *In the centre of the figure, individuals possess age, sex and characteristics that influence their health and that are largely fixed. Surrounding them, however, are influences that are theoretically modifiable by policy. First, there are personal behaviour factors, such as smoking habits and physical activity. Second, individuals interact with their peers and immediate community and are influenced by them, which is represented in the second layer. Next, a person's ability to maintain their health (in the third layer) is influenced by their living and working conditions, food supply and access to essential goods and services. Finally, as mediator of population health, economic, cultural and environmental influences prevail in the overall society.[12]*

The authors identify that comprehensive strategies should be used to address the determinants that cross all layers because the relationships are closely interlinked. For example, analyses of upstream unhealthy economic and SDOH need to be linked to downstream causes of certain diseases and health problems. Conversely, downstream DOH, such as unhealthy lifestyles, should be seen in the context of their upstream influences.[12]

Using the social determinant of housing as an example each layer of factors will be described below:

General socio-economic, cultural, and environmental conditions (Layer 4)
A sudden increase in community property values excludes people with less income from the housing market and puts pressure on affordable rental housing, often located near high traffic corridors or industrial sites.

Living and working conditions (Layer 3)
More people live in unaffordable, unstable and unsafe housing conditions.

Social and community networks (Layer 2)
Individuals in unstable/transient housing situations lack the trust and social support of neighbours.

Individual lifestyle factors (Layer 1)
Stressors associated with unaffordable, unsafe and unstable housing conditions contribute to rates of unhealthy behaviours such as smoking and alcohol use.[36]

The Report on the State of Public Health in Canada Addressing Health Inequalities 2008, identifies the health status based on PHAC's 12 determinants of health, referencing the Rainbow Model.[22]

Conceptual Framework for Action on the Social Determinants of Health

The World Health Organization's Commission on the Social Determinants of Health (CSDOH)[23] created the *Conceptual Framework for Action on SDOH* (Figure 5) which describes relationships among individual and structural factors.[33] A key aim of the framework is to highlight the difference between levels of causation, distinguishing between the mechanisms by which social hierarchies are created, and the conditions of daily life which result in the hierarchies. The key aim of the CSDOH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants, but must include policies specifically crafted to tackle underlying structural determinants - the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups.[23] In other words, the conceptual framework requires sectors such as public health to work towards policies that level up the population who are worse off to that of the groups who are better off. For example, while developing opportunities to improve food skills among vulnerable populations, the need to influence policy designs of neighborhoods to allow better access to healthy foods is required.

Figure 5.   *Commission on Social Determinants of Health (CSDH) Conceptual Framework*[37]

Source: Amended from Solar & Irwin, 2007
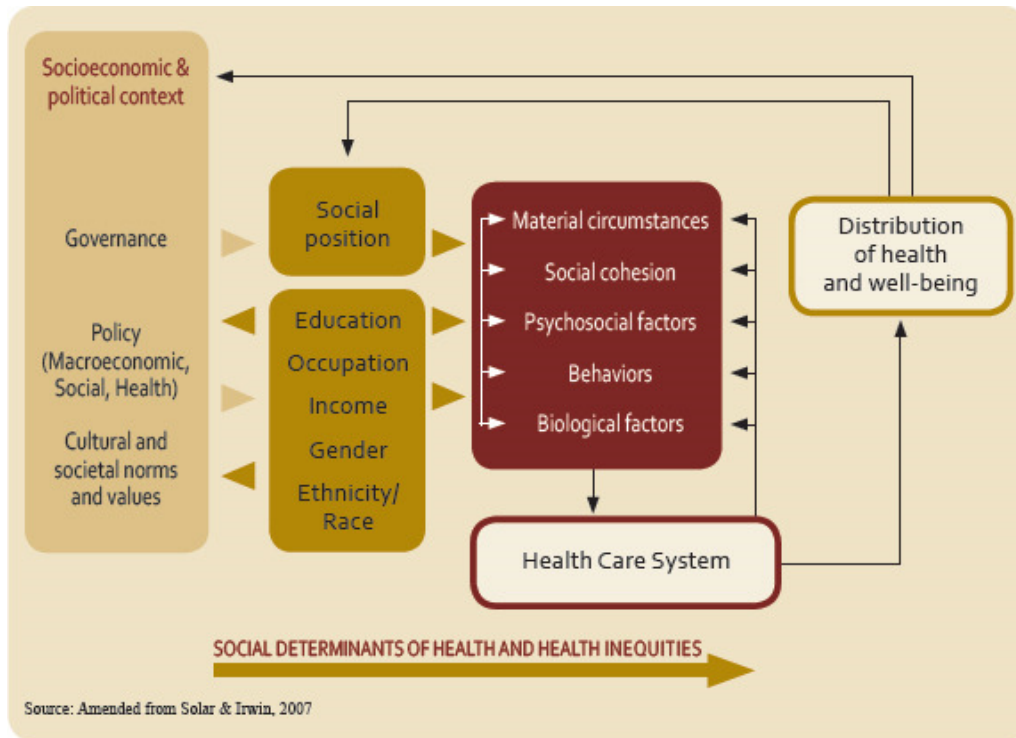
There are three elements in this framework. These elements are policy directions for action.

1. The first element focuses on socio-economic and political mechanisms that produce, organize and maintain social hierarchies. These mechanisms include the labour market, the educational system, political institutions and other mechanisms that shape cultural and societal values.

2. The second element is the structural determinants and socio-economic positions. The key structural determinants include:

    •   Social position

    •   Education

    •   Occupation

    •   Income

    •   Gender

    •   Race/ethnicity.

Socio-economic positions determine access to power, prestige and resources. The role of social positions generates health inequities.

3. The third element is the intermediary determinants such as material and psycho-social circumstances, behavioural and/or biological factors and the health system.

    - Material circumstances include factors such as:
        - housing and neighbourhood quality,
        - consumption potential (e.g. the financial means to buy healthy food, warm clothing, etc.)
        - the physical work environment.

    - Psycho-social circumstances include:
        - psycho-social stressors,
        - stressful living circumstances and relationships
        - social support and coping styles (or the lack thereof).

    - Behavioural and biological factors include:
        - nutrition,
        - physical activity,
        - tobacco consumption and alcohol consumption.

These factors are distributed differently among different social groups. Biological factors also include genetic factors. The health system is separate as it focuses on mediating the consequences of illness in people's lives.[23]

There are four common theories proposed in this conceptual framework to explain inequities in health across socio-economic position which are utilized depending on the sector and/or discipline:

1. The materialist/structuralist theory proposes that inadequacy in individual income levels leads to a lack of resources to cope with stressors of life and thus produces ill health.

2. The psycho-social model proposes that discrimination based on one's place in the social hierarchy causes stress which causes a neuroendocrine response that produces disease.

3. The social production of health model is based on the premise that capitalist priorities for accumulating wealth, power, prestige and material assets are achieved at the cost of the disadvantaged.

4. The eco-social theory brings together psycho-social and social production of health models, and looks at how social and physical environments interact with biology and how individuals 'embody' aspects of the contexts in which they live and work.[38]

Two models that embody public health practice and refer to the DOH are the Ottawa Charter on Health Promotion[34] and the Population Health Promotion Model.[35]

The Ottawa Charter on Health Promotion

The Ottawa Charter on Health Promotion (Figure 6) took a comprehensive view of health determinants, referring to them as prerequisites for health. It defined the fundamental prerequisites for health as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. It also recognized that access to these prerequisites cannot be ensured by the health sector alone. Rather, coordinated action is required among all concerned, including governments (health and other social and economic sectors) non-governmental organizations, industry and the media.[39]

Figure 6.   *The Ottawa Charter on Health Promotion[34]*
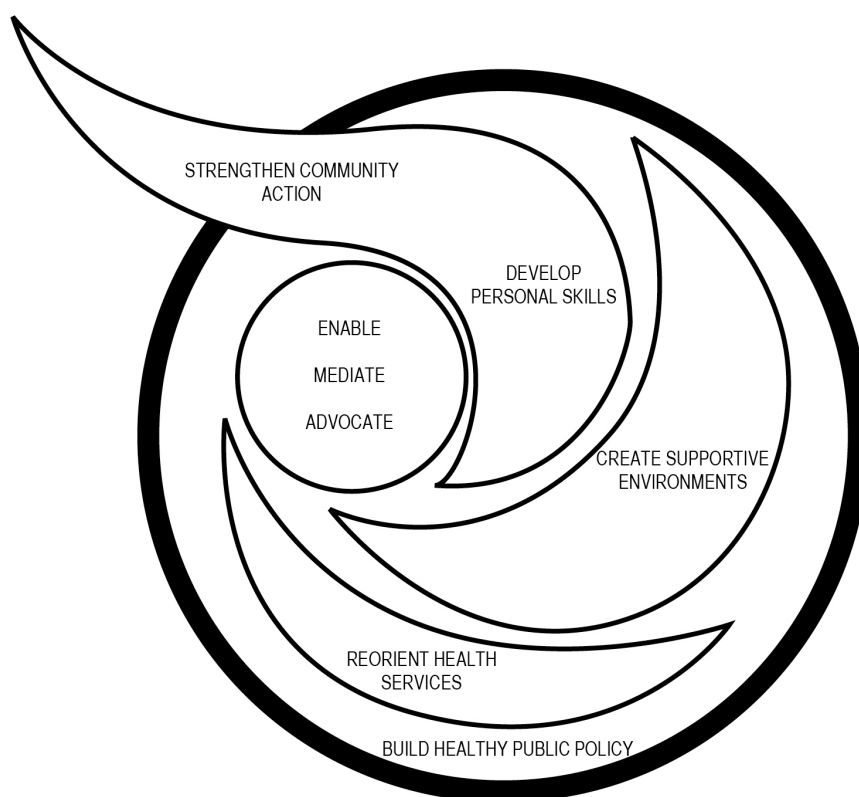
The Population Health Promotion Model

The Population Health Promotion Model's (Figure 7) underlying assumptions addressing the DOH include:

- Policy and program decision makers agree that comprehensive action needs to be taken on all the DOH using the knowledge gained from research and practice.

- It is the role of health organizations to analyze the full range of possibilities for action, to act on those determinants that are within their jurisdiction and to influence other sectors to ensure their policies and programs has a positive impact on health. This can best be achieved by facilitating collaboration among stakeholders regarding the most appropriate activities to be undertaken by each.

- Multiple points of entry to planning and implementation are essential as well as having a need for overall coordination of activity.

- Health problems may affect certain groups more than others. However, the solution to these problems involves changing social values and structures. It is the responsibility of the society as a whole to take care of all its members.[40]

Figure 7. *Population Health Promotion Model*[35]
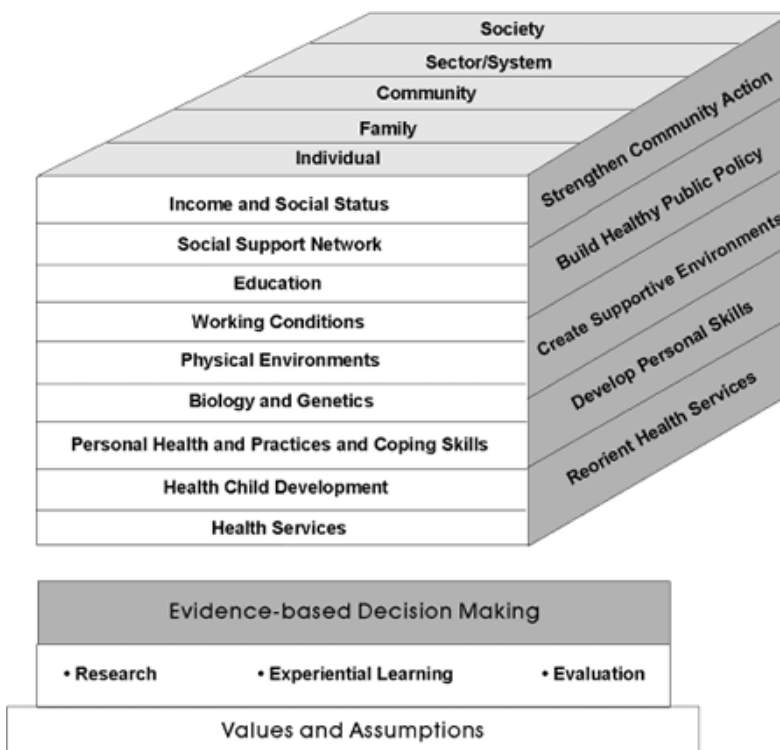
IDENTIFYING PRIORITY POPULATIONS IN SIMCOE MUSKOKA

Priority Populations are individuals and groups at a greater risk of negative health outcomes due to their social and/or economic position within society. They are those population groups at risk of socially produced health inequities.[30] The SMDHU's Strategic Direction for the DOH identifies priority populations as those "populations at risk of health inequities."[8] The Public Health Agency of Canada uses the term "disadvantaged populations" defined below.

Disadvantaged population is a term used interchangeably with priority populations. Public Health Agency of Canada uses this term and defines disadvantaged populations as those that share a characteristic associated with high risk of adverse health outcomes (e.g. Aboriginal peoples, single mothers in poverty, women, homeless people, and refugees).[41]

A key component of the requirements outlined in the OPHS is to identify and work with local priority populations. The Ontario Public Health Standards Population Health Assessment and Surveillance Protocol states the following:

"The board of health shall identify priority populations to address the **determinants of health,** by considering those with health inequities including: increased burden of illness; or increased risk for adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action".[7]

Example of Priority Population

Those at risk of homelessness are considered a priority population–at greater risk of a socially produced health inequity. For example, poor housing conditions such as mould and infestations can result in homes being declared unsafe and residents being forced to leave. The risk for homelessness increases when there is no immediate shelter available, no support of family and friends, lack of transportation and/or lack of available income to sustain them.

Identifying the Priority Population

Priority populations are identified by surveillance, epidemiological or other research studies. They are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.[7]

A broader approach to gathering information will ensure that the needs of populations that may experience exclusion from not only public health programs and services but other sectors are adequately considered and understood.[42] To determine a population that is at risk of health inequities will require collecting information that can be quantitative, qualitative, participatory and experiential.

Examples of methods and data sources to help determine priority populations

- Review of epidemiological data from:

    - Health status reports.

    - Integrated Public Health Information Systems (iPHIS); Immunization Records Information System (IRIS); Integrated Services for Children Information System (ISCIS); Oral Health Information Support System (OHISS).

    - Surveys (e.g. Canadian Community Health System (CCHS), Rapid Risk Factor Surveillance System (RRFSS) - to assess the relationship between health outcomes and the DOH factors (e.g. income and food skills; physical activity levels; education and breastfeeding rates).

    - Administrative databases (e.g. vital statistics, hospitalizations, emergency room visits).

- Use of Geographic Information Systems (GIS) to analyze and visualize neighbourhood characteristics.

- Grey literature (project/program reports, informal practice guidelines, recommended or promising practices, etc.).

- Evidence from other jurisdictions and coalitions, partners and front line staff who work with the priority population.

- Online resources.

- Consultation and community engagement findings, client surveys, photo voice.

- Key informant interviews (e.g. with local experts or staff from relevant organizations and tacit knowledge from those with lived experiences sometimes referred to as kitchen table talk or tea time). This method maximizes reach, trust and impact.

- Program evaluation results to assess who our interventions are reaching, how they are benefiting, as well as gaps in reach and benefits.

References: [42-45]

The following is a list of population groups developed by the MOHLTC which may be more or less advantaged through policy, programs, research and other initiatives:

- **Aboriginal peoples:** The Aboriginal peoples of Canada comprise the First Nations, Inuit and Métis (FNIM) peoples These distinct groups have unique heritages, languages and cultures.

- **Age-related groups:** Refers to populations whose health or equity could be specifically impacted by factors related to their age (such as the ability to vote) or developmental factors (early childhood) or physical changes (such as frail elderly) Potential groups within this category include infants, children, youth, seniors, the elderly, etc.

- **Disability:** Refers to people with physical or mental disability, infirmity, malformation or disfigurement such as blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, mental impairment (developmental or learning disability), a mental disorder, or a workplace injury or disability. This could also refer to people with a mental illness, addiction, or substance use problem.

- **Ethno-racial Communities:** An ethnic group (or ethnicity) is a group of people whose members identify with each other, through a common heritage, often consisting of a common language, a common culture (often including a shared religion) and/or an ideology that stresses common ancestry or endogamy Potential communities include racial or racialized groups, cultural minorities, immigrants, refugees, etc.

- **Francophone:** People who communicate in French as their primary official or preferred language, including new immigrant francophones, deaf communities using French or Quebec sign language (la langue des signes québécoise) (LSQ)/la langue des signes francaise (LSF), etc.

- **Homeless:** Includes marginally or under-housed people, those without a permanent address, and those without stable housing or high-quality housing, including transient people.

- **Linguistic Communities:** People uncomfortable receiving care in either English or French or who prefer a first language other than English or French, or those whose literacy level affects communication in any language.

- **Low income:** includes economically vulnerable people who are underemployed, unemployed, living on a fixed income, receiving social assistance, etc.

- **Religious/Faith Communities:** Refers to systems of religious beliefs or faith that may also include specific dietary or cultural practices.

- **Rural/remote or inner-urban populations:** Includes people facing geographic or social isolation, or living in under-serviced areas, or living in densely populated areas.

- **Sex/gender:** Sex refers to the biological and physiological characteristics that define male and female, while gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. Potential groups include female, male, women, men, transsexual, transgendered, two-spirited, etc.

- **Sexual orientation:** Sexual orientation is a personal characteristic that covers the range of human sexuality from lesbian and gay, to bisexual and heterosexual.[46]

There may be other populations that may be added over time. For example, uninsured people (people without legal status in Canada and no government health insurance), people without a family doctor, etc. Consideration must also be given to the implications of intersecting populations.

The terminology identifying population groups may or may not be preferred by members of the communities in question.[42] Therefore, it is important to establish terminology that is respectful of how the population identifies itself. For example, in Simcoe Muskoka the Aboriginal community prefers to be identified as First Nations, Métis, and Inuit (FNMI). Definitions on each population are being developed as a resource for health units by Public Health Ontario and the MOHLTC to support the use of their Health Equity Impact Assessment tool.[46] Definitions can also be provided directly by those agencies representing the particular population.

Overview of Simcoe Muskoka Statistics

Appendix D provides an overview of statistics on the DOH for Simcoe Muskoka. Where applicable, information is defined by municipality and/or county/district and compared to the provincial rate using 2006 Census data. This information will assist SMDHU staff in understanding local populations at risk of inequities. These statistics include:

- Population
  - Sex and age composition
  - Population projections and by age groups.
- Income
  - Before tax by age and sex
  - Children and youth low-income rates
  - Low income after tax by family composition
  - Low-income status of high risk groups
  - Income distribution.
- Education
  - Education levels–highest certificate, diploma or degree.
- Employment
  - Unemployment rates by highest level of education.
- Housing
  - Housing affordability
  - Housing prices
  - Rentals.
- Francophone Population

- Sex and age composition

- Population with no certificate, diploma or degree

- Income status.

- Aboriginals

    - Aboriginal population

    - Population with no certificate, diploma or degree

    - Low income.

- Immigration

    - Population with no certificate, diploma or degree

    - Income status.

BACKGROUND

In this section, the stage will be set to develop an appreciation of the political and governmental influences and mandates under which public health operates. The brief overview will assist the reader to understand the provincial, national and global influences that SMDHU experiences and, in turn, will assist in supporting recommendations within this document.

Our health is defined by the political decisions of our nation and the world. Government is influenced by transnational corporations.[21] These corporations take an "offensive approach to influence government for their benefit".[21] Hence, "politics 'over determines' the social determinants."[21] This approach results in political decision making based on priorities that conflict with the value of health and 'sustainability' for all. It is within this environment that individuals and sectors within organizations and governments need to work to address the impact of the SDOH.

Over the years there have been many Canadian documents written which emphasize the importance the DOH have on the health of an individual, family and community.

Most notably these include:

- the New Perspective on the Health of Canadians, known as the Lalonde report in 1974,[47]

- the *Ottawa Charter for Health Promotion*, a health promotion document in 1986,[34]

- the landmark Commission on the *Future of Health Care in Canada: The Romanow Commission in 2002*[48] and

- most recently, in 2010 the federal government document *Declaration on Prevention and Promotion.*[49]

Since its inception the Ottawa Charter for Health Promotion (Ottawa Charter) has guided health promotion in Canada and influenced population health efforts directed at mitigating health disparities. Much of the SDOH literature compliments the Ottawa Charter. The Ottawa Charter identifies the following fundamental conditions and resources for health; peace, shelter, education, food, income, a stable eco-system sustainable resources and social justice and equity which are reflected in the DOH.[34]

The concepts endorsed by the Ottawa Charter were further developed by Hamilton and Bhatti in the Population Health Promotion Model.[40] Utilizing the cube model they have explored population health. The "cube" illustrates the what, who, and how of population health and is supported by evidence based decision making and values and assumptions.[50] This model is relevant as we explore health inequities caused by SDOH.

What is needed now is action! The call for action is supported by many including the WHO's Commission on Social Determinants of Health, "a major thrust of the Commission is turning public-health knowledge into political action."[51] Most recently the *Rio Political Declaration on Social Determinants of Health* was adopted during the World Conference on Social Determinants of Health on October 21, 2011. *The Rio Political Declaration* states that action on the SDOH is essential to create inclusive, equitable, economically productive and healthy societies.[52]

At the national level, the *Chief Public Health Officer's Report on the State of Public Health in Canada* released in 2008, focused on the DOH and how they contribute to health inequalities. The report was written for all sectors to promote a better understanding of how to reduce the inequalities that contribute to poor health through public policy and individual and collective action.[22]

In 2010, Canada's Federal, Provincial and Territorial Ministers of Health and of Health Promotion/Healthy Living adopted the *Declaration on Prevention and Promotion,* a vision to work together to make the promotion of health and the prevention of disease, disability and injury a priority for action.[49]

Through the Declaration, Ministers recognize that actions from within and outside government are necessary to ensure conditions that determine overall health. In addition, many of the pre-conditions required for good health lie outside the health sector, and are environmental, economic, educational and community based.[49]

At a provincial level, the 2010 annual report titled *Health, Not Health Care–Changing the Conversation* by the Chief Medical Officer of Health of Ontario, Dr. Arlene King, supports the final report of the Senate Subcommittee on Population Health. "Hence we must address all of the factors that influence health and through a population health approach overcome inequities and foster well-being and productivity." [10] Dr. King states that it is time for "a different public health conversation," and time to shift our focus from health care to prevention."[53]

It is readily acknowledged that health units have a mandated role in reducing health inequities to address the avoidable and unnecessary suffering for many amongst us.[54]   However, there is some critique in the literature that states that health units need to strengthen their role.[15]

At a local level, health units in Ontario are guided by the Ontario Public Health Standards, 2008(OPHS). The Ontario Public Health Standards clearly support the above mentioned documents.

Ontario Public Health Standards

The Ontario Public Health Standards (OPHS) are guidelines for the provision of mandatory health programs and services, intended to guide boards of health to ensure the promotion of the health of the population as a whole and with community partners to reduce health inequities.[7] The standards identify specific goals related to SDOH. Addressing "determinants of health and reducing health inequities is fundamental to the work of public health units in Ontario."[7] The standards identify working with local priority populations as a key component. It is recognized that this work is best accomplished by working with community partners.

Foundational Principles

The foundational principles outlined in the OPHS are the pillars on which the foundational and program standards and protocols are based. The four foundational principles identified are needs, impact, capacity, and partnership and collaboration.[7]

These identified principles are meant to be used by boards of health to guide the assessment, planning, delivery, management and evaluation of public health programs and services as they consider community needs, public health capacity and resources required.[7] The four principles will be explored in relation to public health involvement in addressing health inequities.

1. Need

2. Impact

3. Capacity

4. Partnership and Collaboration

1. NEED

What are our communities' health needs?

Determinants of health, health status, incidence of disease and injury, health assessment and surveillance are some of the key data that is required to determine community needs. In addition, goals and targets need to be established as well as health indicators.[53;7;55]

The development of SDOH health indicators is a strategy that has yet to be fully implemented. Health indicators are measures of health and of the factors that affect health.[55] Indicators will

have to reflect true measurement of health inequities and will have to be reflective at a local, provincial or national level. For example, measuring health status is more accurate than economic measurements such as the Gross National Product (GNP) to determine if social policies are effective.[51] There is a need to "focus on the causes of the causes," a term by Geoffrey Rose cited by Marmot, which refers to the "social conditions that give rise to high risk of non-communicable disease whether acting through unhealthy behaviours or through the effects of impossibly stressful lives".[51] The data collected has to be with an upstream perspective.[15] Ultimately the collection of indicator data will allow for accurate analysis that will guide decision makers, along with the support of their communities, to move everyone up the social gradient to better health-leveling up.

2. IMPACT

Can we impact on the health inequities within our communities?

There is no doubt that the SDOH have an enormous impact on the overall health and diseases of us all.[54] It is also well established that health units can play a significant role in impacting those SDOH.[56;57] The foundational principle of impact requires public health units to examine the influence or change created by the services or programs offered. Health units are asked to consider evidence of effectiveness, compatibility, barriers, performance measures and any unintended consequences of the programs and services they offer.[7] There is a need for health units to develop a systematic approach to be able to articulate changes created by their services or programs that have reduced health inequities. To adhere to this foundational principle, public health units must be able to acknowledge the impact of the SDOH and strive to include broader societal changes that reduce health disparities and inequities by coordinating and aligning programs and services with those of other partners.[7]

3. CAPACITY

Are we able to do the work required to decrease health inequities in our communities?

Capacity includes a wide range of areas: organizational structures and process, workforce planning, development and maintenance of information and knowledge systems, and financial resources.[7] Capacity is achieved not from large financial resources but rather conducting the work differently, developing a supportive infrastructure within the agency and creating the space for action.[20] Assessing the capacity and resources required of the public health unit to meet the standards is a responsibility of the local board of health.[20] Social determinants of health have been specifically identified as a focus in the OPHS[7] therefore, the measurement of resources is key to successful implementation of SDOH services and programs.

As previously stated, the National Collaborating Centre for Determinants of Health (NCCDH)[2] outlines six strategies of a capacity building framework to assist health units to meet the four roles in relation to DOH which will be discussed at length later in this document.

4. PARTNERSHIP AND COLLABORATION

How do we work with others in our communities outside of the health sector?

The final principle for consideration is the principle of developing partnerships. The Ottawa Charter maintains that health promotion is not just the responsibility of the health sector.[34] When considering partnerships in relation to DOH, the importance of a supportive environment and engaging community throughout the process are fundamental to achieving success in reducing health inequities.[7] Each community will need to consider how to measure health. Currently economic factors such as average income and GNP are frequently utilized to determine economic well-being.[51] Many purport that these economic measurements of well-being do not provide a true reflection of health.[27;51] Many sectors and policy makers do not appreciate that the health of the population is the most critical factor to measure effectiveness of social arrangements.[51]

Another key factor is the development of relationships to enable collaboration across government, different sectors and communities.[55] We must be mindful of the skill set required to work within the community, and not assume that it exists within the health unit workforce.[2] For example, when working with various community groups and sectors, the recommendation from the Community Immigrant Retention strategy is to embrace a welcoming community attitude and an inclusive work environment both internally and externally.[58] By creating strong alliances and partnerships that recognize mutual interest and shared targets, "relationships will be dynamic in which community partners see our resources as their assets and we will view the community's assets as our greatest resource." [55;59]

Public Health Agency of Canada

The Public Health Agency of Canada (PHAC) has developed core competencies to build effective public health practices.[60] PHAC's core competencies can assist in the organization and improvement of the public health unit's workforce.[60] The core competencies not only reflect the skills required to implement the OPHS but also support the four public health roles outlined by NCCDH to address SDOH.[2] Core competencies identify the following attitudes and values that form the context within which the competencies are practiced: equity, social justice, sustainable development, recognition of the importance of the health of the community as well as the individual, and respect for diversity, self-determination, empowerment and community participation.[60]

The above overview sets the stage for an in-depth exploration of the four public health roles required to address health inequities as outlined by NCCDH.

PUBLIC HEALTH ROLES

It is imperative that public health units are confident in their roles and how to address health inequities since many of the DOH are intertwined, complex and can be viewed as outside public health's mandate.[2] Decreasing health disparities caused by SDOH requires involvement from

many sectors who work more directly on specific determinants.[20] Just as importantly we need to be certain about what falls outside of our public health mandate; we do not directly provide service to our communities related to income, education, housing, or child care hence we do face limitations when addressing health inequities caused by SDOH.

Another area for concern is the potential to inadvertently increase the gap, by contributing to an increase in health inequities.[2] The implementation of services and programs can increase the disparity between different groups within a community when health units operate without consideration of the DOH.

Even though public health has historically worked on health inequities, there is the sense today that this is new or extra work[2] and this notion needs to be challenged . In fact, throughout its history, public health has impacted on SDOH and improved the health of communities worldwide. The most common examples cited are routine immunization and safe water systems.

Within Simcoe Muskoka many examples can be found where the health unit is having a positive impact on SDOH and population health. Some examples are: the Healthy Babies Healthy Children, the mobile dental clinic, and participation on various community groups such as Poverty Reduction of Muskoka Planning Team (PROMPT); The Resilience Collaborative; Food Partners Alliance of Simcoe County; the Simcoe County Alliance To End Homelessness; Child, Youth and Family Services Coalition of Simcoe County and their subcommittee , the Basic Needs Task Group.

In an attempt to strengthen public health practice, the NCCDH has completed an environmental scan to guide health units in accomplishing their mandate related to the SDOH. The framework proposed by NCCDH outlines four specific roles for health units and six capacity building strategies that will advance the four public health roles.[2]

The framework consisting of public health roles and capacity building strategies are represented in the diagram below (Figure 2) created by the SMDHU's SDOH Steering Committee:

Figure 2. *Public Health Roles and Strategies*
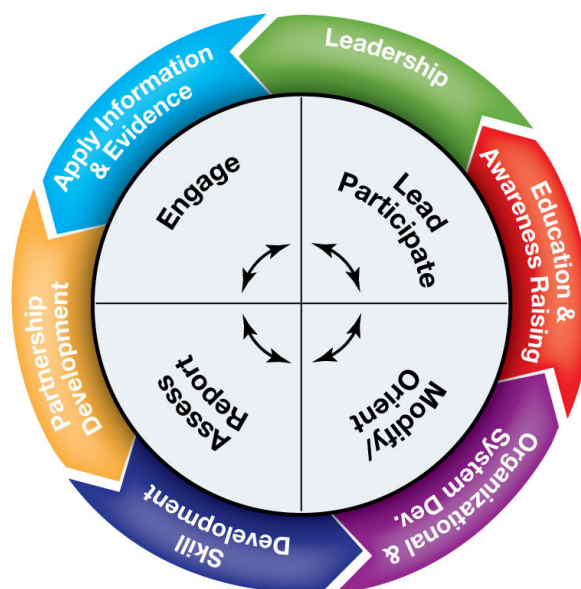
[Figure 2](#) illustrates the relationship between the four roles and six strategies. The four roles are not linear in application but revolve around each other and are supported by all six strategies depending on the needs.

The four key public health roles NCCDH has outlined are:

1. Assess and report on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities/inequities.

2. Modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations.

3. Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs.

4. Lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in the health determinants /inequities.[2]

The six capacity building strategies that support the four roles NCCDH has outlined are:

1. Leadership

2. Develop/apply information and evidence

3. Education and awareness raising

4. Organizational and system development

5. Skill development

6. [Partnership development](#).[2]

The expert reference group consisting of key informants and focus group, that were selected as part of the methodology of NCCDH's environmental scan, was in agreement on the four roles for public health.[2] The four roles will be discussed separately as outlined by the NCCDH document; however, this is not meant to indicate that there is a linear sequential order to the implementation of the roles. In fact, the four roles along with the six strategies work in a synergistically and interwoven manner.

Further support for the four roles is identified in the most recent WHO document addressing health inequities outlined by the Rio Declaration.[52] The five areas for action are as follows:

1. To adopt better governance for health and development.

2.   Promote participation in policy-making and implementation.

3. To further reorient the health sector towards reducing health inequities.

4.   To strengthen global governance and collaboration.

5.   To monitor progress and increase accountability.[52]

Health units in Ontario are also striving to articulate health unit's roles in relation to addressing the SDOH. The Sudbury District Health Unit (SDHU) outlines 10 Promising Practices[61] as the foundation for articulating their roles. They are:

1. Targeting with universalism

2. Purposeful reporting

3. Social marketing

4. Health equity target setting

5. Equity-focused health impact assessment

6. Competencies/organizational standards

7. Contribution to evidence base

8. Early childhood development

9. Community engagement

10. Inter-sectoral action.

The SMDHU SDOH Steering Committee has reviewed both the four roles outlined by NCCDH and the 10 Promising Practices by SDHU and concluded that the four roles outlined do accurately reflect the health unit's mandate. In addition, the SDHU 10 Promising Practices help

to further elaborate on the four roles described by NCCDH. The 10 Promising Practices will be discussed in this section under the headings of the four roles.

Before a more detailed exploration of the health unit's roles in addressing health inequities is provided it is important to acknowledge the documented criticism of inherent barriers found within health units. Within the NCCDH Environmental Scan it is documented that these barriers have impeded the capacity of health units to address SDOH.[2] These barriers must be addressed in order to assist a paradigm shift towards a health inequity perspective.[2] Barriers identified include:

- Preoccupation by public health with behaviour and lifestyle approaches.

- Lack of skills related to community development, engagement, and mobilization.

- Bureaucratic and controlling nature of health units.[2]

It is no longer acceptable to focus solely on risk factors, behaviour and lifestyle approaches or to place the burden of achieving health on the individual. Focusing only on behavioural and lifestyle approaches is seen as one of the greatest barriers to addressing DOH.[15] It is incumbent upon health units to assess current processes and approaches to program planning and implementation and the skills of their workforce to determine if these barriers exist within their practice.

The following section will describe in detail the four roles outlined by the NCCDH and address Sudbury District Health Unit's (SDHU) 10 Promising Practices.

 Assess and report on the health of populations describing the existence and impact of health inequalities and inequities and, effective strategies to address those inequalities.

The role of assessing and reporting is a precursor to the implementation of the other three roles.[2] Public health units are uniquely positioned to fill this role through health status reports, statistical data analysis, community consultations and program evaluations.[44]

This role is reflected in two of the 10 Promising Practices; purposeful reporting and contribution to evidence base practice. The promising practice of purposeful reporting is strongly recommended by the WHO as a means to lead to action.[62]

With a deeper understanding of the SDOH the health unit will be able to identify and compile data required to determine more specifically the existence of health inequities within communities. Gathering the data is what is needed to start the conversation and will be the basis for future evaluations.

The second promising practice contributes to evidence base practice and will require solid evaluations in order to draw a link between action and results. Within the literature, there is consensus regarding the limited amount of evaluative data.[12;57] Until such time when public

health has a wealth of research studies at its disposal, health units will need to consider various sources of data. This current situation stresses even more profoundly the importance of engaging the population impacted by the SDOH as a valuable and critical source of information to guide action.

Another realization that has been noted in the literature is that improving surveillance and population health assessment data will necessitate enhanced relationships with agencies in domains such as housing, education, social and economic development and planning.[18] Ideally, dissemination of evaluative data and experiences will be shared with others at the provincial, national and global levels.

Another aspect to this role is the development of health indicators that will enable understanding of what is happening and what is working or not.[55] Clear measurable outcomes are necessary for all to understand public health's work but more importantly to reduce health inequities, especially for those most impacted. Dr. Arlene King, the Chief Medical Officer of Health for Ontario, identifies a need to settle on a finite list of indicators that will paint us a picture of how healthy we are and identify causes of health inequities.[53]

Because many support this goal expressed by Dr. King, opportunities have begun to present themselves within this province to assist in the creation of these indicators. The alPHa/OPHA Health Equity Working Group has begun to create indicators for health units to utilize for evaluation purposes of the requirements set out in the OPHS.

Below are some SMDHU examples to illustrate the application of the role of assess and report. They are as follows:

    a. Release of a 2012 SMDHU Alcohol Health Status Report–*Focus on Health STATS*–identifying people of low socio-economic status (SES) are more vulnerable to alcohol related harm and residents of high income are more likely to drink heavily and drink above the low-risk drinking guidelines.[63]

    b. Providing evidence for the development of Simcoe County Food Charter and to ensure populations at risk are included in the consultative process.

Modify/orient public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations.

Some activities reflected in this role are engaging stakeholders in designing and delivering tailored programs, and modifying the mode of delivery of interventions and removing barriers.[44] The role of modify/orient is further supported by the ongoing effort of the alPHa/OPHA Access, Equity and Social Justice Work Group to develop indicators that reflect the ability of health units to meet the needs of priority populations.[18]

Currently health units participation in many SDOH strategies to modify interventions for priority populations.[64] However, these same health units identified the need for support to address the SDOH in the area of policy advocacy and staff skill development.[64]

Health units can be further assisted to determine health inequities by two newly created documents; the Health Equity Impact Assessment tool (HEIA) by MOHLTC and the Public Health Unit (PHU) Supplement by PHO.[42] The HEIA tool and PHU Supplement will enable decision making which supports the positive elements of a program and minimizes negative aspects as identified through a health equity lens.[42] Integration of the tool and supplement will require the tool to be embedded within the technical system of the health unit and will require staff education, training and support to implement it.

The role of modify/orient is supported by the promising practice of health equity target setting. Health equity targets will assist evaluation of strategies and in the allocation of resources. The Simcoe Muskoka District Health Unit has begun to implement this promising practice with the development of outcomes and indicators related to the SMDHU Strategic Plan 2012–2016.

The public health role of modify/orient public health interventions is further supported by the promising practice of targeting within universalism. The World Health Organization recommends targeting those who experience disparities within a universal framework.[62] As a health unit we are committed to providing universal health care but recognize that certain populations at certain times will require targeted approaches to level up.[11] As an agency, how we balance targeted and universal approaches will be a marker of our success.

We would be remiss if childhood was not identified as a focus in the discussion of targeting within universalism. Healthy early childhood development has very long-term implications. In the Early Years Study 3, Dr. Fraser Mustard established the importance and long-term benefits for all by providing resources to children.[65] By addressing "inequalities early in the life course, it is possible to help young Canadians achieve optimal health during their developmental years, diminish and/or reverse unhealthy living practices, mitigate any risky behaviours and ease the transition from one life stage to the next, ultimately promoting positive lifelong health".[39] A more in-depth consideration is required for specific child populations. For example the social determinants play a major role in disadvantaging Aboriginal children.[66]

A Canadian example of this focus is Quebec's Child Care Reform. Camil Bouchard asked Quebecers when introducing the Child Care Reform in 1992 to meet the needs of young children and youth with equity, generosity and compassion.[65] Emulating those same characteristics will have a lifetime impact on the health of the children of Simcoe Muskoka.

In reviewing the literature on childhood and DOH data, the concept that health inequities exist as a gradient is stressed. Children from low-income families do face more barriers, but the vulnerability gap between children from poor families and children from moderate-income families is as great as the gap between children living in moderate-income families and those who are affluent.[65] The concept of gradient must not be lost when we focus on health equities.

An example of a universal strategy that could address social gradient is the Enhanced 18-Month Well-Baby visit in hopes of assessing all children.[67] This example illustrates universalism since the service is being provided for all 18-month old babies. If strategies are put in place to remove barriers that impede access to this service for specific groups or populations this would be targeting within universalism.

Below are some SMDHU examples to illustrate the application of the role of modify/ orient. They are as follows:

a. Providing an annual universal influenza clinic at a local aboriginal reserve.

b. Offering financial subsidy for non-agency community members from the priority populations to attend two local conferences addressing food security and built environment.

c. Offering pre/postnatal education, and tobacco cessation supports, to pregnant/postnatal/breastfeeding women with children up to age six and their household contacts who are of low income. This includes accessing free Nicotine Replacement Therapy in collaboration with Family Health Service's programs, CPNP/CAPC community partner and the tobacco program team.

d. Providing low-cost or no-cost treatment and preparation services for low-income populations to eliminate bed bug infestations.

e. Providing mobile dental services through Healthy Smiles Ontario program for those who face financial and transportation barriers.

③ Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs.

Public health units engage in community and multi-sectoral collaboration in addressing the health needs of populations through services and programs.[2] Some activities that reflect collaboration include participation in networks of service providers and community groups to improve service and create supportive settings for the targeted groups.[44] Being able to develop strong trusting relationships with community members from various sectors is critical since many solutions lie outside the direct control of the health sector.[44] Even though engagement is identified as a unique role, the ability to engage is embedded in the success of the three other roles.[2]

The role of engaging is supported by the promising practice of community engagement which is described as a cross cutting strategy that should involve communities in all aspects of programming.[62] Frohlich and Potvin elaborate further on engagement by emphasizing in particular the participation of members of vulnerable populations in problem identification, intervention development and evaluations.[68] This is further supported by the Rio Declaration statement that addressing social determinants requires transparency and giving voice to all groups and sectors involved.[52]

Most importantly working in partnership is a value identified in the SMDHU Strategic Plan 2012–2016.[8] The first step in engaging our communities is starting the conversation about what it means to be healthy, what are the barriers, and what can public health do to facilitate health for all. There is a role for all health unit staff in engaging Simcoe Muskoka communities. The health unit will need to continue making the distinction between situations when the health unit is able to engage as equal partners and when enforceable legislated mandates may require a potentially different approach.

The promising practice of social marketing is not exclusive to the public health role of engaging but has a tremendous potential to assist health units to engage their community, enable the health unit to fulfill its roles, create a more dynamic relationship between members of our community and develop a deeper understanding of the causes and impacts of SDOH. When considering the practice of social marketing programs there is a need to consider carefully the intended audience and outcomes. It has been reported that while concepts of SDOH were understood phrases like "social determinants of health" and "social factors" failed to engage the audience.[5]

Below are some SMDHU examples to illustrate the application of the role of engaging. They are as follows:

a. Participating as an active member on the Poverty Reduction of Muskoka Planning Team (PROMPT).

b. Participating on Francophone COMPASS, supporting francophone population (services provided in French) and providing outreach to French schools.

c. Participating on Housing Champions of South Georgian Bay, a multi-stakeholder team from the community and government sector working together to develop innovative approaches to provide safe affordable housing.

Lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in the health determinants /inequities.

The last role of public health is the role of lead/participate; circumstances will help to determine if participating or leading is the best approach. These roles are supported in the Ontario Public Health Annual Report in which Dr. King is advocating for a "joined-up government"[53] which is described in the *Adelaide Statement: Moving Towards a Shared Governance for Health and Well-Being.*[69] The joined-up government is a partnership between government, civil society and the private sector so that health is in all policies.[69]

Public health units can lead/participate and support other stakeholders in policy analysis, development and advocacy for improvements in health determinants/inequities.[2] Some activities that are reflected in this role are advocating for systemic changes to reduce inequities at various levels and exposing evidence of a relationship between health and SDOH.[44] Raising awareness

of the link between health and the DOH is a first step in starting a community conversation about health inequities. The Simcoe Muskoka District Health Unit staff has the ability to raise awareness within the parameters of their daily work. Collectively having a strong voice about health inequities is the first step to fulfilling this role to lead/participate in addressing health inequities.

The promising practice of inter-sectoral action supports this public health role of leading/ participating. Inter-sectoral action is defined as building strong and durable relationships between public health and other sectors.[61]

Even though many health units have experience being actively involved in their communities and assume pivotal roles on health related issues, public health units have identified requiring support for policy advocacy work in a survey by alPHa/OPHA.[18]

Another requirement when connecting with various sectors is knowing your audience. Because the SDOH are "inherently value-laden, it can be challenging to shape messages in ways that are heard and resonate with the public, policy-makers and politicians."[5] In addition the range of professions that health units will become involved with will expand to include; agricultural economists, land use planners, social policy analysts and environmentalists.[20] Health units will be required to form new relationships with an expanding roster of partners, requiring new knowledge in order to participate more fully together.[20]

The Simcoe Muskoka District Health Unit will need to identify a process to determine how and who will respond to collaborate with partners on various SDOH initiatives in an effective and timely manner.   Additionally, leadership is essential within an organization for establishing action on health determinants as a priority, allocating resources, modeling desired behaviours and overseeing implementation.[2] The Simcoe Muskoka District Health Unit has already taken a critical leadership step by endorsing DOH goal within its Strategic Plan 2012–2016.[8]

To illustrate the application of the role of lead/participate some SMDHU examples have been provided. They are as follows:

a. Participating in the review of official plans to ensure planning for safe and inclusive neighborhoods.

b. Providing support for the development of Gay Straight Alliances (GSA) in the school setting.

c. Advocating for municipalities to fluoridate community water systems.

d. Active member at various levels of Child Youth and Family Services Coalition of Simcoe County to improve the outcome for children and youth such as supporting Working Together for Kids Mental Health, Student Support Leadership Initiative, Bridges out of Poverty training, and the release of the broadsheet *A Safe, Affordable and Comfortable Place to Live* addressing local housing issues.

e. Active member of the alPHa /OPHA Health Equity Work Group which has been politically advocating by submitting a letter to government opposing budget cuts that affect low-income

families and also reviewed and submitted feedback to the Commission for the Review of Social Assistance in Ontario.

Implementation of these four key roles will drive health unit strategies further upstream to better address the root causes of health inequities. Health units will need to push the boundaries of our comfort zone and take calculated risks as we strive to meet the goal of decreasing health inequities through the integration and enhancement of the four roles of assessing and reporting, modifying/orientating public health interventions, engaging and leading/participating in our communities.

CAPACITY BUILDING STRATEGIES

Building capacity will ensure public health can address inequities within the four key roles. Community capacity building goes beyond simply providing education or technical assistance. It also involves assisting people to gain the knowledge and experience that is needed to solve problems, implement change, build effective partnerships to take action and reach sustainability.[70]

The six strategies to develop capacity to sustain the four roles were developed by NCCDH adapted from the World Health Organization European Union [70] and Australia's Capacity Building Framework [71] projects to address SDOH and improve health equity.

> In order to develop capacity, The Waterloo Region Health Unit adopted the Ottawa Charter Strategies to re-orient their staff to develop internal capacity to address the determinants of health. Strategies to create a supportive environment were implemented in order to support staff to advance healthy public policy. Policy advocacy skills were built by enhancing their knowledge and skills. Strengthening community action was about creating the most effective partnerships that could influence public policy.[20]

The six capacity building strategies are:

1. Leadership
2. Develop/apply information and evidence
3. Education and awareness raising
4. Organizational and system development
5. Skill development
6. Partnership development.[2;70]

1 **Leadership**

Public health officials can take a leadership role in building understanding about the links between health determinants and population health, and support the collaborative relationships needed at a local level to address the DOH.[10]

For public health to take action on DOH and address inequities, "local public health leadership needs to be intimately engaged in this work."[10] This is considered critical because they influence and examine the following:

- Setting the priorities.

- Allocation of resources and staff.

- How programs are planned and implemented.

- Shifting to greater community development and policy work.

- More intensive interventions with hard to reach populations.

- Engaging community partners more strategically for inter-sectoral action.

  References: [2;10;17;22;72]

The literature suggests some activities to support leadership to address inequities:

- Create synergy and buy-in within the organization through conversations at key events.

- Champion opportunities to act on DOH by stimulating discussions internally and at the regional and local level. Use existing social marketing resources to stimulate conversations such as "Let's Start a Conversation."

- Find or create opportunities for improved collaboration between the health, health promotion and health care sectors to improve health equity by identifying common goals.

- Present outcomes at a relevant conference or event.

- Approach relevant decision makers in the health sector to present information on SDOH and health equity and to discuss how to achieve more effective leadership from the health sector.[17]

2   **Develop/apply information and evidence**

Reviews of the available literature affirm a lack of available evidence of the effect of public health interventions, policies, program design, collection of data and evidence to address the DOH. Tools and techniques to address the DOH are also lacking. [23;72;73] More information is needed about the effectiveness of policies and interventions to address health inequities. The Healthy Equity Impact Assessment (HEIA) is a tool using a structured approach that provides a evidenced based solution allowing programs, policies and other interventions to proceed when the evidence base is limited.[38] Another tool mentioned in the Public Health Ontario Supplement Guide for the HEIA is a Situational Assessment which examines trends and factors providing a "snapshot of the present" to assist in planning for the future.[42] *The Population Health Assessment and Surveillance Protocol* of the Ontario Public Health Standards identifies using the following sources of information:

- Key facts, findings, trends, and recommendations from the literature.

- Data and analyses obtained from population health assessment and surveillance.

- Legal and political environments.

- Stakeholder perspectives.

- Recommendations based on past experiences, including program evaluation information.[7]

Some activities to develop/apply information and evidence from the literature can include:

- Know the information systems currently in place and how to use them.

- Analyze the information systems in place to ensure they are sufficient to tell the story.

- Identify on-line information sources with best practices on SDOH that can be of use both internally and externally.

- Contribute to or set up user friendly mechanisms (including use of social media) to communicate data and evidence to policy makers and practitioners within and outside of the health sector.

- Assess what knowledge is available to evaluate policies or practices that address SDOH and health equity.

- Implement HEIA and use of situational assessments into all planning cycles, campaigns and organizational policies.

- Support involvement with organizational networking to learn about new information and evidence that can be applied to current practices and public health interventions.

- Support engaging not only with government but non-government stakeholders who represent priority populations to exchange learning on promising practices in order to collaborate on finding better solutions.

References:[2;6;10;17;74]

3 **Education and awareness raising**

Willingness and ability to act (internally and externally) requires the ongoing processing of information and awareness-raising among public health staff, stakeholders, decision makers and the public alike in order to anticipate needs and respond more appropriately to priority populations.[10]

Some activities to support this strategy can include:

- Assess the quantity and quality of information available in the region on SDOH and health equity that has been developed for raising awareness.

- Complement the existing information developed with facts and figures that are local to the specific region; involve those decision makers and other key stakeholders by sharing a health status report with compelling stories highlighting DOH inequities to support advocacy efforts.

- Develop social marketing tools for communication materials and disseminate through various media via internet sources and radio, television, etc.

- Organize educational events to increase "Poverty Literacy."[75]

- Assess numbers of local population who understand the circumstances about inequities and health.

- Scan the number of opportunities that decision makers are taking to speak out about poverty.[17]

4 Organizational and system development

Addressing the policies, structures, procedures and practice of an organization, and managing required change will assist that organization in addressing inequities. Organizational development with an equity lens will support role modeling desired behaviour, setting up better programs, greater understanding among front line staff and demonstrating a commitment to the public.[17]

Building the capacity of an organization to address the SDOH may involve interventions in several areas of organizational functioning.   These include: strategic planning, management involvement, improving policies, procedures and resources, or adapting the organizational culture.

Some suggested activities identified in the literature and from environmental scans with other health units that support this strategy include:

- Create a baseline of the activities being done to support equity work.

- Create an action plan of the findings from the baseline analyses.

- Develop organizational performance indicators that have the potential to align provincially to measure long-term structural change.

- Ensure understanding of SDOH within the organization in order to assess if internal workplace processes and environment are negatively impacting on employees with lower incomes.

- Develop an internal centralized unit within the organization to review practices, recommend changes, support planners and management and to serve as the catalyst both internally and externally for any SDOH related staff development.

    References: [2;17;42;75]

5 Skill development

Knowledge, skills and attitudes to adopt and implement new strategies, along with approaches and techniques are required internally but potentially externally as well. The Public Health

Agency of Canada (PHAC) core competencies identify key concepts related to equity work. However, competencies to address values and attitudes for DOH equity work are critical. [17;60]

Front line staff skilled in community development, capacity building and mobilization are required. Management requires the same skills in addition to reflective practice, critical analysis and integrating equity assessments into program planning cycles. Skills to assess and report on populations are well supported through the PHAC Skills On-line programs.

Some suggested activities from the literature for skill development are:

- Organize workshops on SDOH and health equity. Draw on existing resources for the workshops from other health units.

- Reorient staff from a behaviour focus on health promotion to a determinants focus.

- Support staff to participate in Health Equity Impact Assessment and Situational Assessment training to become a resource during planning cycles and for training external partners to engage in health equity assessments.

- Support staff to participate in workshops about community collaboration and how to develop effective partnerships.

- Promote PHAC Skills On-line program to all staff.

    References: [2;17;61]

Appendix E describes some topics for professional development required for staff to develop the competencies to address health inequities.

6   **Partnership development**

This is a critically important and essential strategy involving community engagement, community development and action particularly related to advocacy and policy development to address health inequities. There is significant evidence that shows the vertical structures and "siloed" approaches within public health can hamper partnership development. This can be overcome with good communication, shared planning and commitment across the organization.[38] It is important that public health develop an inclusive practice at all levels in the planning cycle to ensure that there is shared power and control with community partners. Key DOH such as housing, education and adequate income fall within the mandates of other organizations. Yet these determinants are critical to maintain good health.[38] Not one group can accomplish the many tasks required to change the social, economic and environmental conditions that impact health. The ability of public health and other sectors to reduce health inequities therefore relies on building strong and durable partnerships with a range of other sectors and agencies (e.g. health care, social services, education, housing, labour market, environment, transport, agriculture, industry and energy).[38;61]

Although there are many potential partnerships that exist locally and regionally, it is often challenging to determine which ones to participate in and to what degree. Resources and workshops have been developed about assessing partnerships, process of engagement and developing skills for better collaboration through organizations such as the Tamarack Institute for Community Engagement, HC Link and CDC.

Some activities or approaches to establish shared and inclusive partnerships are:

- Stakeholder analysis.

- Enable other sectors to address health related issues by using a health impact assessment.

- Increase flexibility across the organization to support increase delegation with a more responsive approach.[38]

- Analyze the internal resources available for community involvement.

- Learn the best methods of engagement in different contexts.

- Build capacity internally to be able to engage with local communities to take effective action.

- Involve those with lived experiences and use their tacit knowledge for advocacy in order to make the inequities "real."

- Support the capacity of local communities by involving them in all stages of the process of development, implementation and evaluation of interventions.

- Support and promote the multiple approaches proposed by the many representatives from different sectors.

- Share information with partners that will assist in understanding the impacts that the DOH has on health status.

- Support measuring and evaluating inter-sectoral programs, partnerships or experiences.

References: [17;38;75]

RECOMMENDATIONS

In order to support Simcoe Muskoka District Health Unit (SMDHU) to address the DOH strategic goal of improving health for those populations at risk of poor health outcomes the following recommendations are required to be met. Utilizing the framework consisting of the four roles and six strategies addressed in the *Simcoe Muskoka District Health Unit's Approach to Addressing the Determinants of Health—A Health Equity Framework* document will assist the organization to develop the capacity to be fully engaged with the community in reducing health inequities. It is important that all SMDHU staff address health inequities in partnership with priority populations, health and non-health sectors and with local, regional, provincial and national partners.

Recommendation 1

The Executive Committee, Service Area Directors and program managers/supervisors will use the MOHLTC Health Equity Impact Assessment and PHO Supplement Guide as agency, service area and program policies are developed and reviewed. The SDOH Steering Committee will review the Request For Service from External Clients policy in 2012.

Recommendation 2

The Agency Management Committee will ensure cross program collaboration for DOH initiatives.

Recommendation 3

The SDOH Steering Committee will commit to creating a professional development plan for implementation beginning in 2012 to enhance knowledge and skills on content areas enhancing staff's ability to address DOH as outlined in Appendix E.

Recommendation 4

The SDOH Steering Committee will develop a proposal outlining best strategies to support health equity work beyond 2012, including utilization of the SDOH PHN funding provided by MOHLTC for Executive Committee's consideration.

Recommendation 5

The SDOH Steering Committee will identify priority populations as a whole for SMDHU, as well as develop health equity indicators based on the Strategic Directions 2012-2016 outcomes that address reducing inequities for programs and services. The Evaluation Specialist will be engaged in indicator development for inclusion in the Balanced Scorecard Performance Management Tool. The indicators will align with performance indicators created at the provincial level, when applicable.

Recommendation 6

The Executive Committee and Managers/Supervisors will use a consistent planning process, and tools, including the HEIA to determine and prioritize priority populations annually. Programs will determine best strategies reflecting the four roles and six strategies as reflected in the Capacity Building Framework by NCCDH.

Recommendation 7

Corporate Service will enhance the existing assessment and surveillance resources to systematically include health equity indicators. These health equity indicators will be updated over time as new data and indicators become available. The initial list of health equity indicators will be developed by the SDOH Steering Committee in 2012.

Recommendation 8

Managers/Supervisors will ensure that all SMDHU reports include health equity information, and that a communication and dissemination plan is developed.

Recommendation 9

Executive Committee will ensure priority will be given to the development of both internal and external DOH communication strategies reflecting a multi-faceted approach including social media.

Recommendation 10

The Directors, AMOH's, MOH, and the Board of Health will seek and engage in advanced leadership opportunities to promote health equity, including doing the following:

•   influence priority setting and allocation of resources, and

•   model desired behaviours.

CONCLUSION

The purpose of this document *Simcoe Muskoka District Health Unit Approach to Addressing the Determinants of Health - A Health Equity Framework* is to guide health unit staff as they strive to meet the Strategic Plan 2012–2016 (Appendix A) DOH goal and outcomes and future health equity endeavors. The Strategic Direction's goal of addressing the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes reflects the work of public health in Ontario.

A framework has been provided examining four key roles along with six strategies that support these four roles for public health. A list of recommendations has been developed to create a shift in the organization's culture and practice to reduce inequities and to achieve better health outcomes for all. By adopting the recommendations, the health unit will be well prepared to address the complex issues both with existing and newly formed partnerships from different sectors representing different segments of the population.

Health disparities are growing, giving rise to long lasting negative health outcomes. We echo the many voices across all sectors including those living with disparities when we say–it is time to act now!

APPENDIX A: SIMCOE MUSKOKA DISTRICT HEALTH UNIT STRATEGIC PLAN 2012–2016

Strategic Directions 2012-2016

Important Public Health Issues

Identify and address priority public health issues that require a coordinated and comprehensive agency response.

- By June, 2012 a process is developed and used to identify priority public health issues that require a coordinated and comprehensive agency response.
- An agency wide action plan to address the identified priority issue is developed and approved within one year of being identified.
- By December, 2012 a scalable business continuity plan to systematically monitor and re-align resources in order to respond to unanticipated public health issues that have the potential to disrupt programs and services is developed.

Determinants of Health

Address the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes.

- Populations at risk of health inequities, that require a coordinated and comprehensive agency response, are prioritized annually.
- Populations at risk of health inequities, that require a specific service area response, are prioritized annually.
- Within one year of a priority population being identified, a determinants of health plan for action to address the critical risk conditions to meet the priority population's public health needs is developed, approved, operationalized and tracked.

Organizational Capacity

Enhance our knowledge, skills and practices to increase our ability to respond to community needs and optimize service delivery.

- By March 2013, core competency framework(s) is adopted by SMDHU to guide the development of a human resources strategy.
- By August, 2013, a human resources strategy is identified and supporting action plan is developed, approved and operationalized.
- By December, 2014, the selected core competency framework is integrated into a comprehensive human resources performance management system within a human resources strategy.
- An action plan for SMDHU to provide tools and technologies to support program and service delivery is developed, approved and operationalized by December, 2013
- By October, 2013, an enhanced, agency-wide operational planning and monitoring system is used by all programs and services.
- An action plan, leveraging partnerships where possible, for agency-wide knowledge management and exchange that enhances SMDHU human resource capacity is developed, approved and operationalized by December, 2015.

Accountability and Performance Measurement

Demonstrate efficiency and effectiveness, and enhance systems that measure and communicate progress on our priorities, programs and services.

- By February, 2013 key performance indicators that demonstrate compliance with public health standards and progress on the strategic plan are identified at the agency, service area and program levels.
- By December 2015 the agency selects and implements electronic systems to collect and monitor data to report progress on key performance indicators.
- Progress on key performance indicators are systematically reported to SMDHU stakeholders and the public at least annually, or as required.

simcoe muskoka DISTRICT HEALTH UNIT

APPENDIX B: DETERMINANTS OF HEALTH FROM THE PUBLIC HEALTH AGENCY OF CANADA

The definitions provided by the PHAC are from 2003 and have not been modified; however, the work through the PHAC's National Collaborating Center for the Determinant's of Health will involve reviewing the definitions and the health equity data and examples. These definitions only reference the first two reports from the Chief Medical Officer of Health regarding state of public health in Canada. The eighth report titled *Report on The State of Public Health in Canada 2008 Addressing Health Inequities* is focused on inequality.

Determinants of Health from the Public Health Agency of Canada

KEY DETERMINANT – 1. Income and Social Status	
UNDERLYING PREMISES	**EVIDENCE**
Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.	There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health. Evidence from **the Second Report on the Health of Canadians** • Only 47% of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73% of Canadians in the highest income group. • Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of residence. • At each rung up the income ladder, Canadians have less sickness, longer life expectancies and improved health. • Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole. Evidence from **Investing in the Health of Canadians:** • Social status is also linked to health. A major British study of civil service employees found that, for most major categories of disease (cancer, coronary heart disease, stroke, etc.), health increased with job rank. This was true even when risk factors such as smoking, which are known to vary with social class, were taken into account. All the people in the study worked in desk jobs, and all had a good standard of living and job security, so this was not an effect that could be explained by physical risk, poverty or material deprivation. Health increased at each step up the job hierarchy. For example, those one step down from the top (doctors, lawyers, etc.) had heart disease rates four times higher than those at the top (those at levels comparable to deputy ministers). So we must conclude that something related to higher income, social position and hierarchy provides a buffer or defense against disease, or that something about lower income and status undermines defenses. • See also evidence from the report Social Disparities and Involvement in Physical Activity **PDF format** • See also evidence from the report Improving the Health of Canadians • See also **The Social Determinants of Health:** income inequality and food security • Are poor people less likely to be healthy than rich people? This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

KEY DETERMINANT – 2. Social Support Networks	
UNDERLYING PREMISES	**EVIDENCE**
Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems. In the 1996-97 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for. Similarly, in the 1994-95 National Longitudinal Survey of Children and Youth, children aged 10 and 11 reported a strong tendency toward positive social behaviour and caring for others.	Evidence from **Investing in the Health of Canadians:** Some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure. - An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates. - Another U.S. study found that low availability of emotional support and low social participation were associated with all-cause mortality. - The risk of angina pectoris decreased with increasing levels of emotional support in a study of male Israeli civil servants. - See also **The Social Determinants of Health:** social inclusion and exclusion and social economy - How do relationships with others affect people's health? This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

KEY DETERMINANT – 3. Education and Literacy	
UNDERLYING PREMISES	**EVIDENCE**
Health status improves with level of education. Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. It also improves people's ability to access and understand information to help keep them healthy.	Evidence from the **Second Report on the Health of Canadians:** - Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy. - People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods. - In the 1996-97 National Population Health Survey (NPHS), only 19% of respondents with less than a high school education rated their health as "excellent" compared with 30% of university graduates. - Evidence from **Investing in the Health of Canadians:** - The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven work days per year due to illness, injury or disability, while those with university education lose fewer than four days per year. - See also evidence from the report: How Does Literacy Affect the Health of Canadians? - See also **The Social Determinants of Health:** education - How does education affect health? This question was prepared by the Canadian Council on Social Development.

KEY DETERMINANT – 4. Employment / Working Conditions	
UNDERLYING PREMISES	**EVIDENCE**
Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.	Evidence from the **Second Report on the Health of Canadians:** - Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job. - Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-

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being.
- Participation in the wage economy, however, is only part of the picture. Many Canadians (especially women) spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is bound to suffer. Between 1991 and 1995, the proportion of Canadian workers who were "very satisfied" with their work declined, and was more pronounced among female workers, dropping from 58% to 49%. Reported levels of work stress followed the same pattern. In the 1996-97 NPHS, more women reported high work stress levels than men in every age category. Women aged 20 to 24 were almost three times more likely to report high work stress than the average Canadian worker.

Evidence from **Investing in the Health of Canadians:**
- A major review done for the WHO found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities.
- See also **The Social Determinants of Health:** employment and job security and working conditions

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KEY DETERMINANT – 5. Social Environments

UNDERLYING PREMISES	EVIDENCE
The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. The array of values and norms of a society influence in varying ways the health and well- being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. A healthy lifestyle can be thought of as a broad description of people's behaviour in three inter-related dimensions: individuals; individuals within their social environments (eg. family, peers, community, and workplace); the relation between individuals and their social environment. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community (ie. shared) issue. Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health. In 1996-97: • Thirty-one percent of adult Canadians reported volunteering with not-for-profit organizations in 1996-97, a 40% increase in the number of volunteers since 1987. • One in two Canadians reported being involved in a community organization. • Eighty-eight percent of Canadians made	Evidence from the **Second Report on the Health of Canadians** • In the U.S. high levels of trust and group membership were found to be associated with reduced mortality rates. • Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24% of all assaults against children; among very young children, the proportion was much higher. • Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80% of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend. • Since peaking in 1991, the national crime rate declined 19% by 1997. However, this national rate is still more than double what it was three decades ago.

donations, either financial or in-kind, to charitable and not-for-profit organizations.	

KEY DETERMINANT – 6. Physical Environments

UNDERLYING PREMISES	EVIDENCE
The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.	Evidence from the **Second Report on the Health of Canadians** • The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13% of boys and 11% of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 1996-97. • Children and outdoor workers may be especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts Evidence from **Investing in the Health of Canadians:** • Air pollution, including exposure to second hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined. • See also **The Social Determinants of Health:** housing What affects health more: germs and viruses, or the environment? This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

KEY DETERMINANT – 7. Personal Health Practices and Coping Skills

UNDERLYING PREMISES	EVIDENCE
Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health. Definitions of lifestyle include not only individual choices, but also the influence of social, economic and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions	Evidence from **the Second Report on the Health of Canadians** • In Canada, smoking is estimated to be responsible for at least one-quarter of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole. • Multiple risk-taking behaviours, including such hazardous combinations as alcohol and drug use with driving, alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men. • Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 1996-97 from 22% to 34% among men and from 14% to 23% among women. Evidence from **Investing in the Health of Canadians:** • Coping skills, which seem to be acquired primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the

and other adverse health events. However, there is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.	events, challenges and stress they encounter in their day to day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles. • See also evidence from the report Social Disparities and Involvement in Physical Activity **PDF format** • See also evidence from the report Improving the Health of Canadians (2004)

KEY DETERMINANT – 8. Healthy Child Development	
UNDERLYING PREMISES	**EVIDENCE**
New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other DOH affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.	Evidence from the **Second Report on the Health of Canadians** • Experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health into adulthood. • Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 1996-97 National Population Health Survey, about 36% of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy. • A loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life. • Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death. Evidence from **Investing in the Health of Canadians:** • A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play. • See also evidence from the report Improving the Health of Canadians (2004) • See also **The Social Determinants of Health:** early childhood education and care

KEY DETERMINANT – 9. Biology and Genetic Endowment	
UNDERLYING PREMISES	**EVIDENCE**
The basic biology and organic makeup of the human body are a fundamental DOH.	Evidence from the **Second Report on the Health of Canadians** • Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the

Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.	investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime. • Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.

KEY DETERMINANT – 10. Health Services

UNDERLYING PREMISES	EVIDENCE
Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention	Evidence from the **Second Report on the Health of Canadians** • Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained. • There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services. • Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counseling and prescription drugs.

KEY DETERMINANT – 11. Gender

UNDERLYING PREMISES	EVIDENCE
Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.	Evidence from the **Second Report on the Health of Canadians** • Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34. • While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence. • While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb. • See also articles on Rural, remote and northern women - where you live matters to your health and How being Black and female affects your health

KEY DETERMINANT – 12. Culture

UNDERLYING PREMISES	EVIDENCE
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization,	Evidence from the **Second Report on the Health of Canadians** • Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole and the

stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.	prevalence of major chronic diseases, including diabetes, heart problems, cancer hypertension and arthritis/rheumatism, is significantly higher in Aboriginal communities and appears to be increasing. • In a comparison of ethnic groups, the highest rate of suicide occurred among the Inuit, at 70 per 100,000, compared with 29 per 100,000 for the Dene and 15 per 100,000 for all other ethnic groups, comprised primarily of non-Aboriginal persons. • The 1996-97 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian born peers, even though far more of the former lived in low-income households. The study suggests that "poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty's blows; the hopelessness of majority-culture poverty accentuates its potency." • See also evidence from the report Improving the Health of Canadians (2004)

APPENDIX C: TOOLS AND RESOURCES

The following is a list of tools and resources to support further understanding of the framework. These resources include key documents on the topic of SDOH and will provide examples of good practice towards addressing inequities. Resources will be in the form of literature, websites, videos, list serves/webinars and books.

Literature

Social Determinants of Health: The Canadian Facts by Mikkonen and Raphael (2010).

Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health by the Commission on Social Determinants of Health World Health Organization (2008) http://www.who.int/social_determinants/thecommission/en/

A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice) by Solar and Irwin World Health Organization (2010) http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

Concepts and Principles for Tacking Social Inequities in Health: Levelling up Part 1 by Dahlgren and Whitehead World Health Organization Europe (2006)http://www.enothe.eu/cop/docs/concepts_and_principles.pdf

Levelling up (part 2): a Discussion Paper on European Strategies for Tackling Social Inequities in Health by Dahlgren and Whitehead World Health Organization Europe (2006) http://www.who.int/social_determinants/resources/leveling_up_part2.pdf

Urban Physical Environments and Health Inequalities Factors Influencing Health by Canadian Institute for Health Information (2012) https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1586

Ontario's Women's Health Equity Report Volume 2 by Beirman Project for **O**ntario **W**omen's Health **E**vidence-Based **R**eport Power Study and Ministry of Health and Long Term Care (2010) http://www.powerstudy.ca/

Early Years Study 3 by McCain, Fraser, McCuaig (2011) http://earlyyearsstudy.ca/

Activities to Address the Social Determinants of Health in Ontario Local Public Health Units by the Joint OPHA/alPHa Working Group on Social Determinants of Health (2010) http://www.opha.on.ca/resources/docs/Survey_Report-SDOHinOntarioHealthUnits-20Dec10.pdf

Promoting Health Equity A Resource to Help Communities Address Social Determinants of Health Workbook by Brennan, Baker, Metzler, Centers for Disease Control and Prevention; (2008) *http://www.cdc.gov/nccdphp/dach/chhep/pdf/SDOHworkbook.pdf*

Communicating the Social Determinants of Health Daghofer Well Spring Strategies (2011) http://www.cphaknowledgecentre.ca/uploads/user_323950617288/SDH%20Scoping%20Paper%20-%20FINAL%20with%20EX%20SUMM%20-%2025April2011.pdf

Capacity Building and Awareness Raising Action to Address the SDOH and Improve Equity by EuroHealthNet, and the International Union on Health Promotion and Education for Public Health Programs(2009): http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Menu-for-CB-Actions_1.pdf

Focus on Health Stats Alcohol-Related Harm in Simcoe Muskoka by Simcoe Muskoka District Health Unit (2012) http://www.simcoemuskokahealthstats.org/Libraries/Focus_Reports/AlcoholFocusReportFinal2012.sflb.ashx

Charter Broadsheet Number Two A Safe, Affordable and Comfortable Place to Live Child Youth Family Coalition of Simcoe Countyhttp://www.simcoecountycoalition.ca/Libraries/Council/Broadsheet_2-ENGLISH-WEB-Final.sflb.ashx

Charter Broadsheet Number Three The Making of a Charter for Simcoe County Children and Youth Child Youth Family Coalition of Simcoe County http://fpa.simcoe.ca/ws_cos/groups/public/@pub/@fpa/documents/web_content/wscos_008355.pdf

Ottawa Charter for Action to Achieve Health for All International Conference on Health Promotion World Health Organization (1986) http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

Websites

- **World Health Organization Social Determinants of Health**
  http://www.who.int/social_determinants/en/
- **Public Health Agency of Canada What Determines Health** http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php
- **National Collaborating Center for Determinants of Health** http://www.nccdh.ca/

- **National Collaborating Center on Methods and Tools** http://www.nccmt.ca/index-eng.html

- **The Canadian Center for Policy Alternatives: The Growing Gap**
  http://www.policyalternatives.ca/projects/growing-gap
- **Ministry of Health Long term Care Health Equity Impact Assessment**
  http://www.health.gov.on.ca/en/pro/programs/heia/
- **Public Health Ontario** http://www.oahpp.ca/
- **Ontario Public Health Association Access, Equity and Social Justice Workgroup**
  http://www.opha.on.ca/our_voice/workgroups/access_equity.shtml
- **Registered Nursing Association Knowledge Depot Social Determinants of Health**
  http://www.rnaoknowledgedepot.ca/promoting_health/social_determinants.asp
- **Robert Wood Johnson Foundation** - **A New Way to Talk About the Social Determinants of Health** http://www.rwjf.org/vulnerablepopulations/product.jsp?id=66428
- **HC Link Resources Partnership Development:**
  http://www.hclinkontario.ca/index.php/resources/44-resources-partnership-development

- **Tamarack Institute for Community Engagement** http://tamarackcommunity.ca/index.php

- **Sudbury District Health Unit Health Equity**
  http://www.sdhu.com/content/healthy_living/folder.asp?folder=3225&lang=0
- **Hamilton Code Red BORN Project** http://www.thespec.com/topic/codered

- **Kingston Community Poverty Reduction Roundtable Deprivation Index Reports**
  http://www.kingstonpovertyreduction.ca/news.html

- **Simcoe County Alliance to End Homelessness** http://www.endhomelessness.ca/

- **Redefine Rebuild Reconnect Changing our Picture of Health, Population Health Working Group Nova Scotia** http://www.changingourpictureofhealth.ca/

- **European Portal for Action on Health Inequalities** http://www.health-inequalities.eu/HEALTHEQUITY/EN/home/

- **Wellesley Institute Health Equity Portal:** http://www.wellesleyinstitute.com/our-work/healthcare/healthequity/

- **SPENT – interactive website:** http://playspent.org/

Campaigns

- Better Health is Worth 0.5% http://www.healthiestprovince.ca/#!
- Put Food in the Budget http://putfoodinthebudget.ca/
- Doctors for Fair Taxation http://doctorsforfairtaxation.ca/
- Occupy Wall Street http://www.davidsuzuki.org/blogs/science-matters/2011/10/occupy-wall-street-reflects-increasing-frustration/?gclid=CK-zitr2vrACFWkCQAods1KLog
- The Robin Hood Tax http://robinhoodtax.org.uk/

Videos/Webinars/Podcasts

Unnatural Causes Is inequality Making us Sick? By NACCHO www.unnaturalcauses.org

Sick People or Sick Societies CBC podcast (2008) http://www.vivelecanada.ca/article/235929840-sick-people-or-sick-societies

Better health is a community effort (Saint John, NB) http://www.youtube.com/watch?v=Je_Vuw6dwUs

Let's Start a conversation Videos http://www.youtube.com/watch?v=Gqla3a3rM6Q

IN Focus: Seeking Shelter http://www.rogerstv.com/page.aspx?rid=23&lid=237&gid=70410

Civilized to Death Part 1 APTN on Aboriginals http://aptn.ca/pages/news/2012/01/23/civilized-to-death-part-1/

Civilized to Death Part 2 APTN on Aboriginals http://aptn.ca/pages/news/2012/01/23/civilized-to-death-part-2/

Taxes The Gift We Give Each Other – Canadian Center for Policy Alternatives
http://www.policyalternatives.ca/newsroom/updates/new-video-taxes-gift-we-give-each-other

Sir Michael Marmot Closing the Gap: Building a healthier and more vibrant Toronto – 2012 Charles
Hasting Lecture on Public Health http://www.marsdd.com/videos/entries/closing-the-gap-building-a-
healthier-and-more-vibrant-toronto-2012-charles-hasting-lecture-on-public-health

Hans Rosling shows the best stats ever seen Ted Talks:
http://www.ted.com/talks/hans_rosling_shows_the_best_stats_you_ve_ever_seen.html

Richard Wilkinson How Economic Inequality Harms Society Ted Talks:
http://www.ted.com/talks/lang/en/richard_wilkinson.html

The Lorenz Curve and the Gini Coefficient: Income Inequality in an Economy
http://www.youtube.com/watch?v=AQWN_DqcHG4

On Line Courses

- **Skills Enhancement for Public Health**: Skills On Line http://www.phac-aspc.gc.ca/php-
psp/ccph-cesp/index-eng.php

- **The Roots of Health Inequity**: A web based course for the public health workforce by NACCHO
2012 http://rootsofhealthinequity.org/

On Line Networks

- **Health Equity Clicks** Community Forum NCCDH: http://nccdh.ca/connect/
- **Social Determinants of Health** at York University list serve:
https://listserv.yorku.ca/archives/sdoh.html
- **Health As If Everybody Counted** Blog by Ted Schrecker CHNET Works http://www.chnet-
works.ca/index.php?option=com_easyblog&view=blogger&layout=listings&id=6753&Itemid=50&l
ang=en

Books

- **The Spirit Level: Why Equality is Better for Everyone** by Richard Wilkinson and Kate Pickett
(2012)
- **Social Determinants of Health Canadian Perspectives**, 2nd Edition by Dennis Raphael (2009)
- **Tackling Health Inequities Through Public Health Practice: A Handbook For Action** by the
National Association of County and City Officials (NACCHO)(2006). Also available On-line.
- **Bridges out of Poverty Strategies for Professionals and Communities** by Ruby Payne, Philip
DeVol, Terie Dreussi Smith (2006): http://www.bridgesoutofpoverty.com/

APPENDIX D: OVERVIEW OF SIMCOE MUSKOKA STATISTICS

Population

According to the Canadian Census, the population of Simcoe Muskoka was 504,110 in 2011. The population grew by 5%, from 479,767 in 2006.

The largest portion of the population lives in the City of Barrie (135,711) followed by Orillia (30,586) and the southern municipalities of Simcoe County – Innisfil (33,079), Bradford West Gwillimbury (28,077) and New Tecumseth (30,234).

Population Count
Simcoe Muskoka, 2011

Sources: Statistics Canada, 2011 Census
Land Information Ontario, 2010

Population Count
- 210 - 3,284
- 3,285 - 13,734
- 13,735 - 20,078
- 20,079 - 33,079
- 33,080 - 135,711
- Federal Jurisdiction

Kilometres
0 5 10   20   30   40
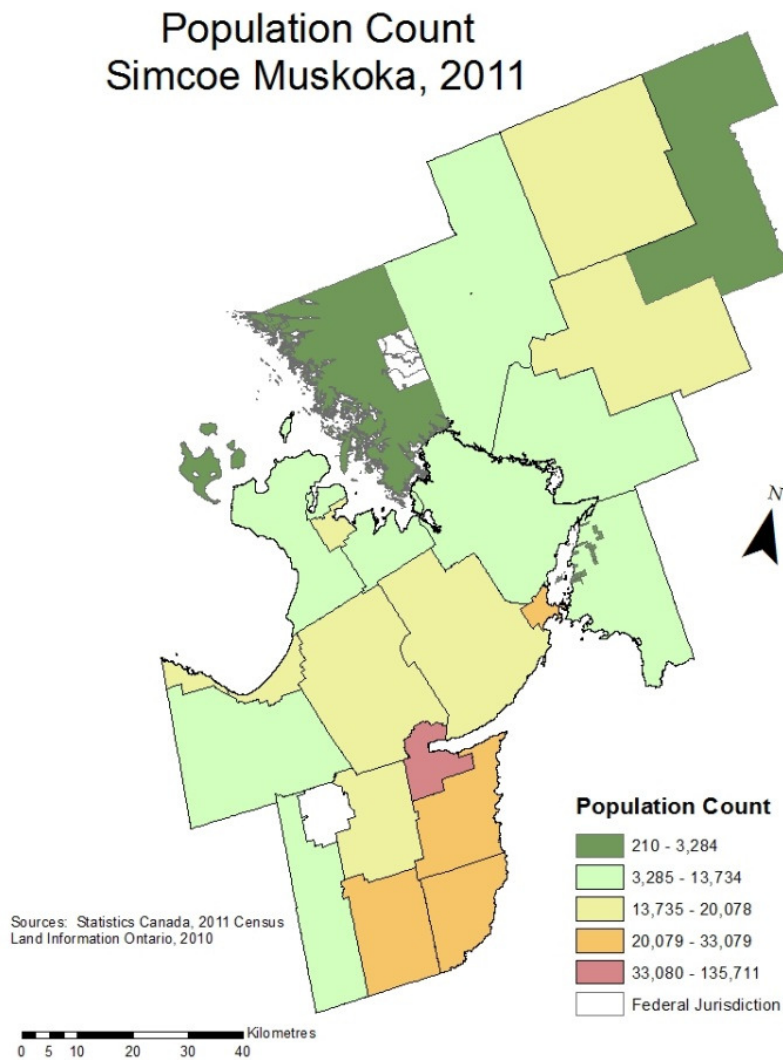
The population pyramid is a useful tool for illustrating a population's age distribution.

Population Pyramid, 2006, Simcoe Muskoka and Ontario
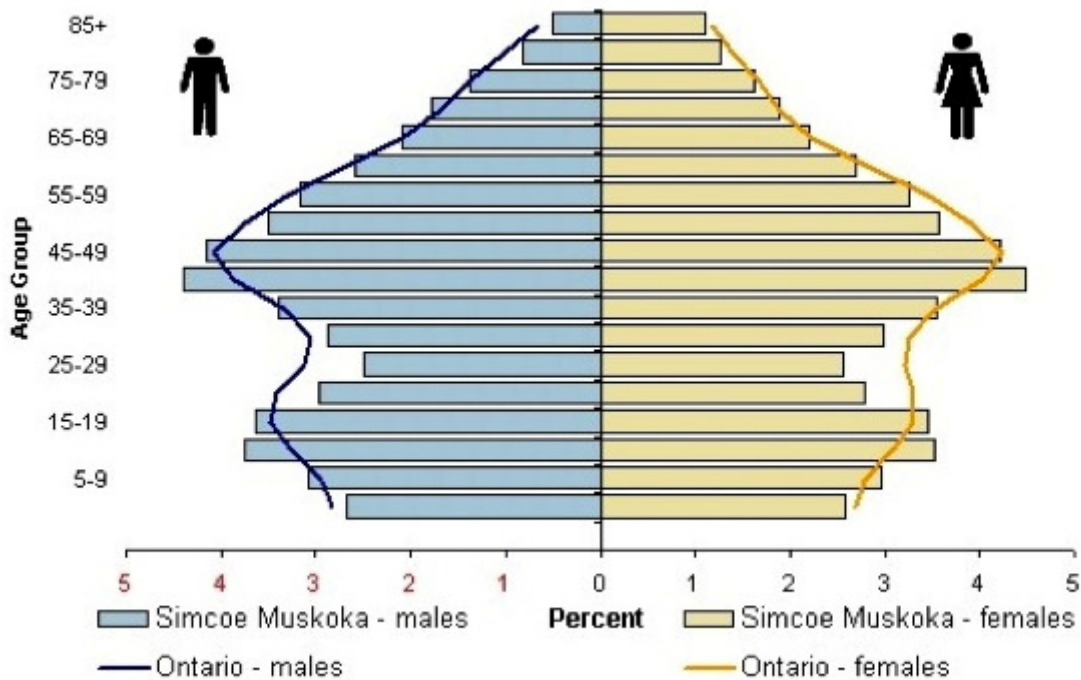
Data Source: Statistics Canada, 2006 Census

The age-sex distribution of the 2006 Simcoe Muskoka population was consistent with that of Ontario. However, in Simcoe Muskoka young adults ages 20 to 34 years represented a smaller proportion of the overall population as compared to that of the province. As a whole, Simcoe Muskoka's population is younger than the provincial average; Children and youth five to 19 years of age contributed a higher percentage to Simcoe Muskoka's total population than was evident at the provincial level.

In Simcoe Muskoka, there is considerable variation in the age distribution (see Table 1). Municipalities in the north west areas of Simcoe County, such as Collingwood, Wasaga Beach, Penetanguishene and Midland as well as Muskoka District's municipalities have a higher proportion of their population 65 years and older. The more southern municipalities in Simcoe County tend to have higher proportions of persons under 19 years of age. In comparison, Muskoka's median age (45.3 years) is more than five years older than Simcoe County's median age (39.8 years).

Table 1. Population Demographics of Municipalities and First Nations
Simcoe Muskoka and Ontario, 2006

Region	2006 Population	Population Change '01-06	Median Age	Population under 15	Population over 65
Ontario	*12,160,282*	*6.60%*	*39*	*18.20%*	*13.60%*
Simcoe County	*422,204*	*12.00%*	*39.8*	*19.00%*	*14.00%*
District of Muskoka	*57,563*	*8.40%*	*45.3*	*15.30%*	*19.80%*
Adjala-Tosorontio	10,695	6.10%	39.7	20.30%	9.90%
Barrie	128,430	23.80%	35.4	21.30%	10.90%
Bracebridge	15,652	13.80%	44.5	15.90%	18.70%
Bradford West Gwillimbury	24,039	8.10%	36.7	20.80%	8.70%
Christian Island	584	13.40%	27.7	30.80%	2.60%
Clearview	14,088	2.10%	41.2	19.50%	14.80%
Collingwood	17,290	7.80%	44.4	15.60%	20.60%
Essa	16,901	0.60%	36.2	21.20%	7.70%
Georgian Bay	2,340	17.50%	49.3	13.00%	23.70%
Gravenhurst	11,046	1.30%	46.8	13.60%	21.90%
Huntsville	18,280	5.40%	43.4	16.50%	18.30%
Innisfil	31,175	8.80%	40.3	19.40%	13.60%
Lake of Bays	3,570	23.10%	50.7	12.20%	23.20%
Midland	16,300	0.50%	44.4	15.60%	15.60%
Mnjikaning First Nation	846	41.70%	32.3	29.00%	5.90%
Moose Point	208	12%	-	31.00%	5%
Muskoka Lakes	6,467	7.00%	47.4	15.20%	20.20%
New Tecumseth	27,701	6.00%	40	19.50%	14.80%
Orillia	30,259	3.90%	42.7	16.50%	19.20%
Oro-Medonte	20,301	9.40%	42.5	17.80%	13.30%
Penetanguishene	9,354	12.50%	42.9	15.40%	17.50%
Ramara	9,427	9.40%	45.9	15.40%	20.30%
Severn	12,030	8.00%	44.3	16.60%	16.60%
Springwater	17,456	8.40%	40.8	19.80%	11.90%
Tay	9,748	6.40%	43	17.30%	14.60%
Tiny	10,784	19.40%	46.9	14.40%	19.00%
Wahta Mohawk Territory	-	-	-	-	-
Wasaga Beach	15,029	21.00%	48.8	14.20%	24.90%

Data Source: Statistics Canada, Census 2001; Statistics Canada, Census 2006
Regions are identified according to the Standard Geographical Classification (SGC) by Statistics Canada.
Data was not collected or were suppressed by Statistics Canada for cells marked with a -

The First Nations communities in Simcoe County, by comparison, are the youngest. Christian Island has a median age of 27.7 and only 2.6 % of the population is over age 65 while Mnjikaning First Nation's median age is 32.3 with 5.9 % over the age of 65. [14]

The population of the SMDHU is projected to continue growing, both in Simcoe County and the District of Muskoka. From 2012 to 2036, the population of Simcoe Muskoka will increase 41%, from 532,208 to 751,452. More growth is expected in Simcoe County (44%), but Muskoka's population will also increase by 23%.

Population growth in Simcoe County is expected to exceed provincial growth. From 2012 to 2036, Ontario's population will grow 31%, from 13,532,864 in 2012 to 17,748.818 in 2036.

Population Projections
Simcoe Muskoka, Simcoe County and Muskoka District, 2012 and 2036

Legend: ■ 2012   ■ 2036

District	2012	2036	Increase
Muskoka District	62,177	76,744	23% increase
Simcoe County	470,031	674,708	44% increase
Simcoe Muskoka	532,208	751,452	41% increase

Source: Population Projecttions, intelliHEALTH ONTARIO, MOHLTC, Extracted January 2012.
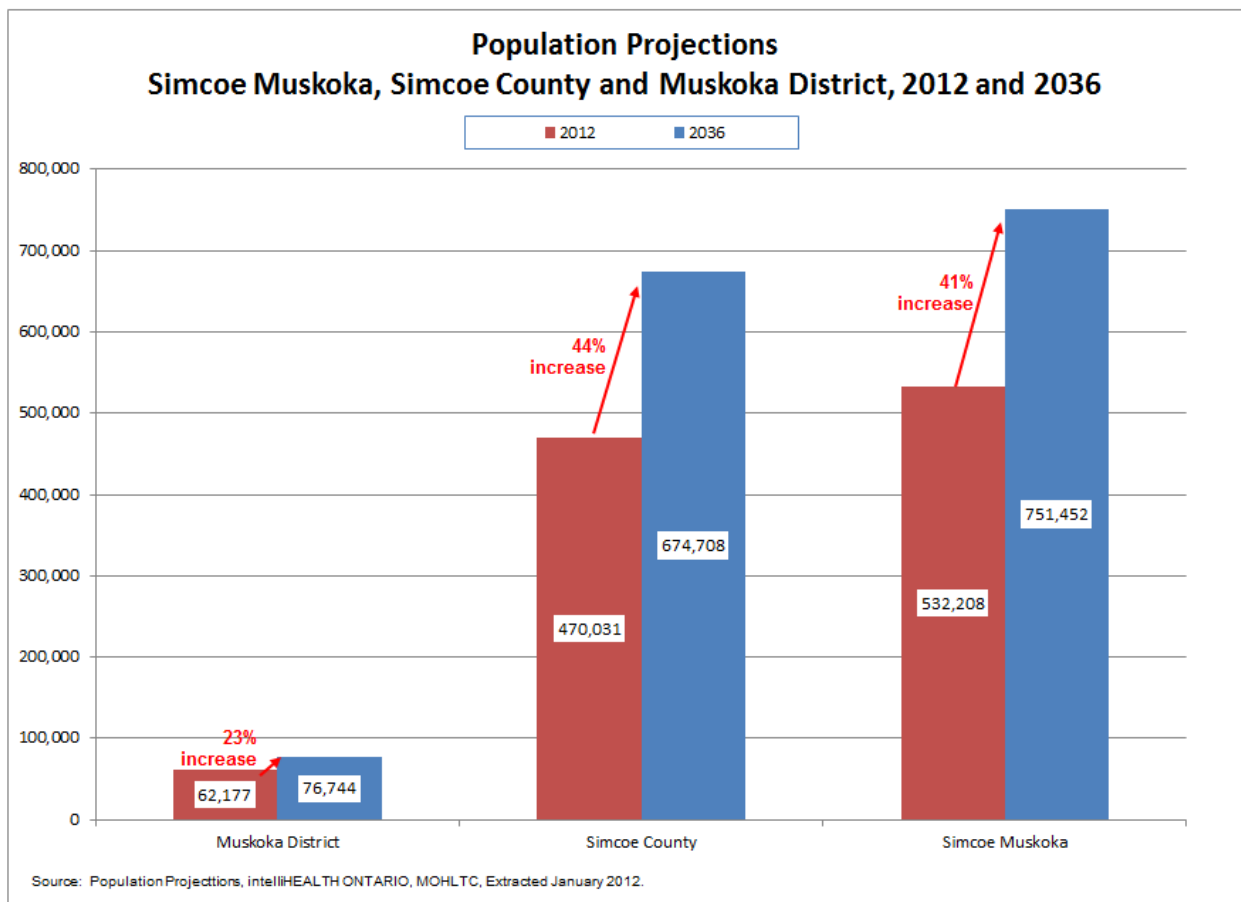
The population will grow at various rates, depending on the age group in question. Although all age groups will experience increases in their populations, the largest growth will occur in the 65+ age group, from 86,358 in 2012 to 203,672 in 2036, a 136% increase. By 2036, the 65+ population will be nearly as large as the 20 to 44 year population.

**Population Projections by Age Group
Simcoe Muskoka, 2012 to 2036**

Legend: 0 to 9 | 10 to 19 | 20 to 44 | 45 to 64 | 65+

*Source: Population Projecttions, intelliHEALTH ONTARIO, MOHLTC
Extracted January 2012.*
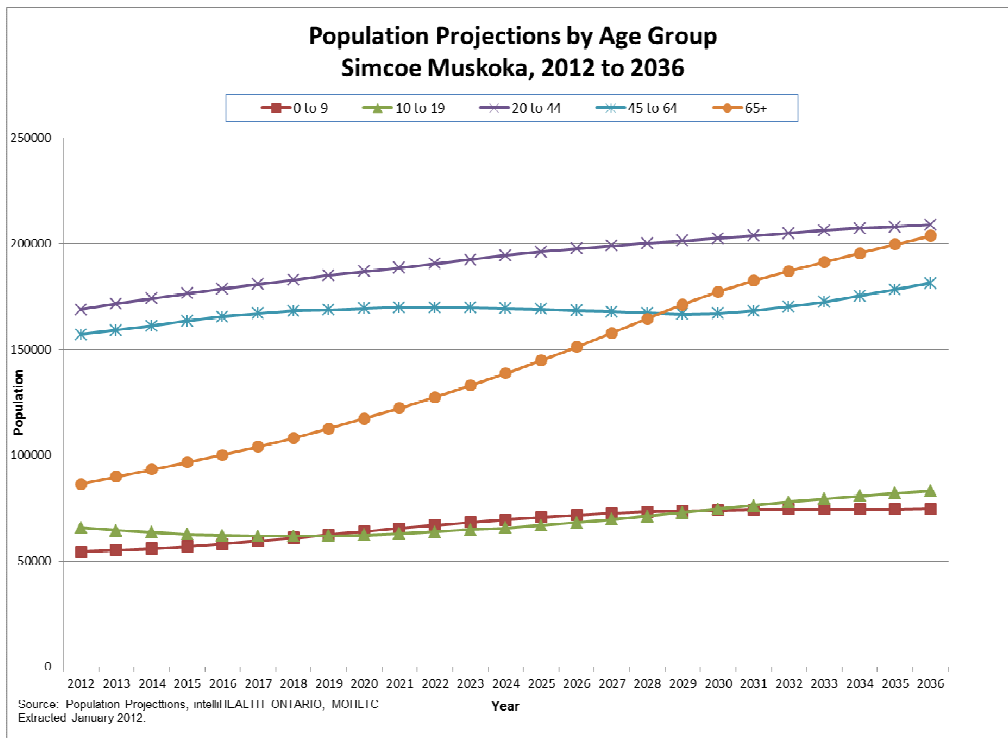
In comparison to the Ontario senior population which will also experience a similar growth in its 65+ population, the Simcoe Muskoka 65+ population will constitute a larger proportion of its total population, 27% compared to 23% of Ontario's total population in 2036.

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**Ages 65+ as a Proportion of the Total Population
Simcoe Muskoka and Ontario, 2012 to 2036**

Source: Population Projections, intelliHEALTH ONTARIO, MOHLTC
Extracted January 2012
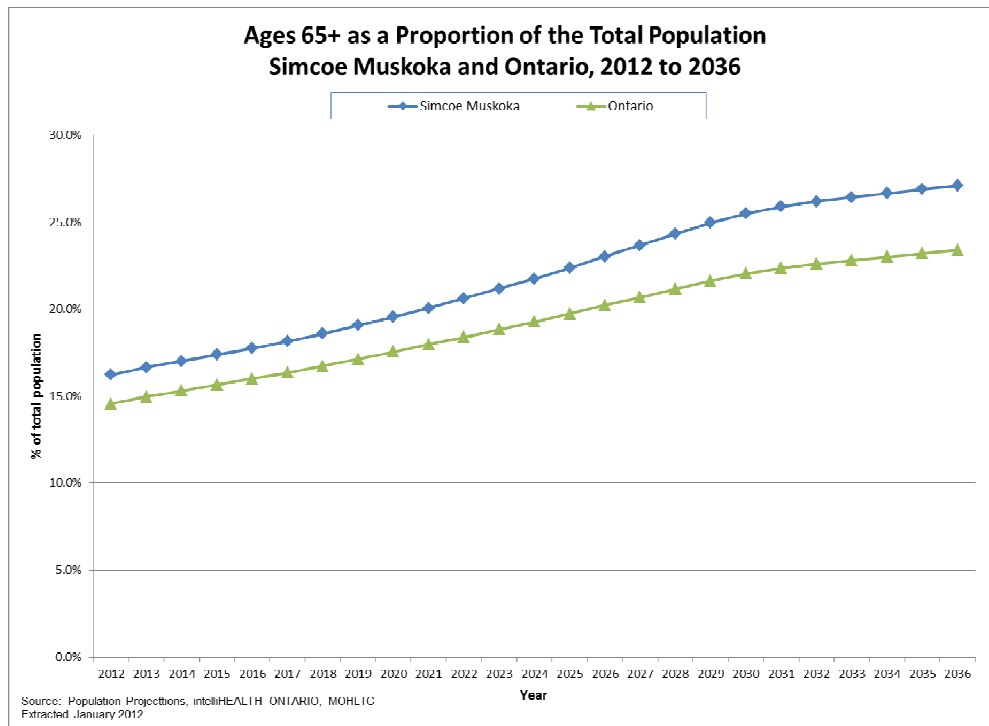
Income

Although there is no official measure of poverty in Canada, the Statistics Canada measure of low income cut offs (LICOs) is probably the best known. Virtually all of the statistics used by other national measures of poverty in Canada come from Statistics Canada's annual survey of incomes. There is a strong relationship between socio-economic status and health outcomes.

According to the 2006 Census, among the 42,760 low income persons in Simcoe Muskoka, 22% were children under 15 years of age, 17% youth ages 15 to 24, 52% were ages 25 to 64 years and 10% were seniors. Women accounted for 56% of all low income persons and 74% of low income seniors.

Before-tax low income rates were higher for children, youth and older women and are lowest for senior men.

Before-Tax Low Income Rate by Age and Sex
Simcoe Muskoka, 2005

Source: Statistics Canada, 2006 Census.
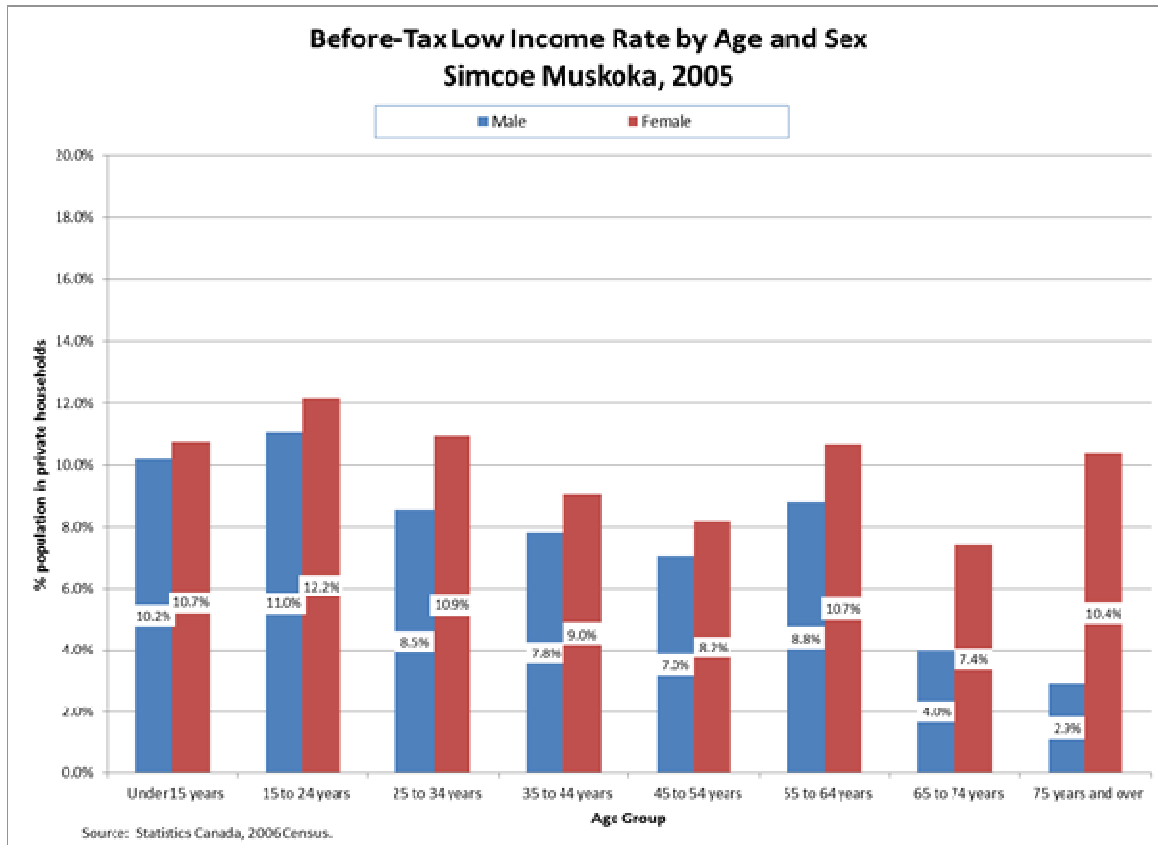
Although child low income rates are lower in Simcoe Muskoka compared to Ontario, there is still one in every 10 children, ages 0 to 18 years living below the before tax low-income cut-offs in our jurisdiction.

Children and Youth Low Income Rates
Ontario and Simcoe Muskoka, 2005

Source: Statistics Canada, 2006 Census.
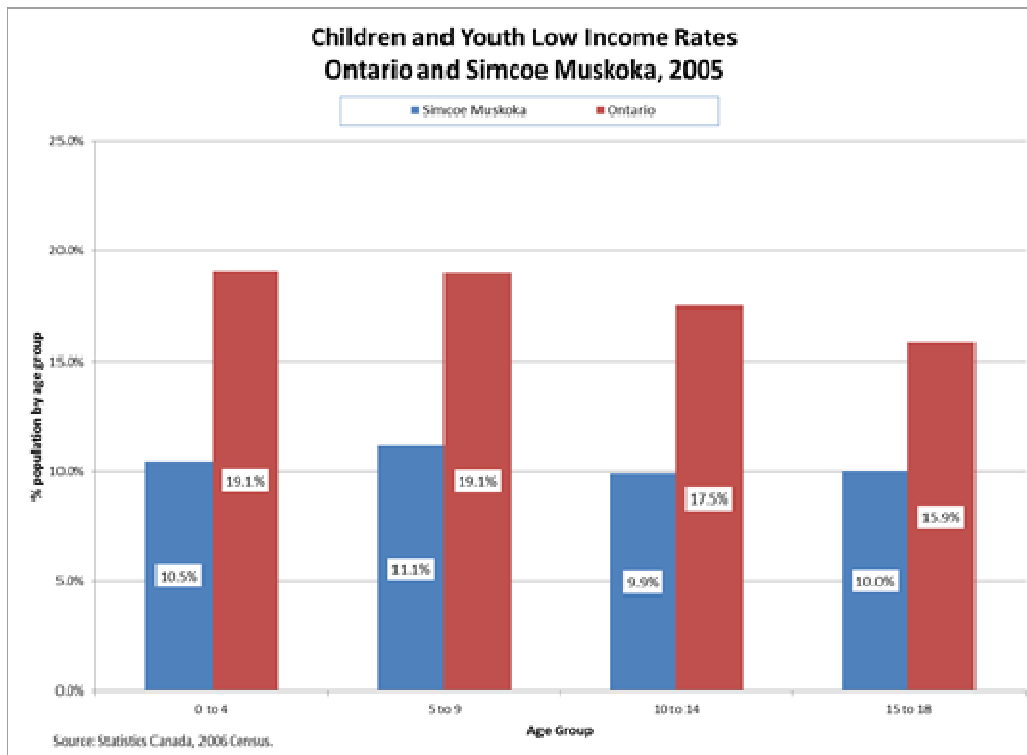
The prevalence of low income economic families in Simcoe County was 5% (after taxes). For persons 15 years and over not in economic families, the prevalence of low income was 19%. Among persons in private households, the prevalence of low income was 7%. The prevalence of low income for male lone-parent families in Simcoe County was 9% and 18% for female lone-parent families.

According to the 2006 Census, in 2005, the prevalence of low income (after taxes) economic families in Muskoka District was 4%. For persons 15 years and over not in economic families the prevalence of low income was 15%. Among persons in private households, the prevalence of low income was 5%. The prevalence of low income for male lone parent families in Muskoka District was 16% and 11% for female lone parent families.

Except for male lone-parent families, the prevalence of low income across all family types was higher for Ontario as a whole when compared to Simcoe County and Muskoka District levels. In SMDHU's jurisdiction, Simcoe County had a higher prevalence of low income than Muskoka District, except for male lone-parent families.

After-tax income: Refers to total income minus federal, provincial and territorial income taxes paid for calendar year 2005.

Before-tax income: Income levels at which families or persons not in economic families spend 20% more than average of their before tax income on food, shelter and clothing.

Low income cut-offs (LICOs): Are income thresholds, determined by analyzing family expenditure data, below which families will devote a larger share of income to the necessities of food, shelter and clothing than the average family would. To reflect differences in the costs of necessities among different community and family sizes, LICOs are defined for five categories of community size and seven of family size.

The low income after-tax cut-offs (LICO-AT): Are set at after-tax income levels, differentiated by size of family and area of residence, where families spend 20 percentage points more of their after-tax income than the average family on food, shelter and clothing.

(Statistics Canada, 2006 Census)

Low Income After-Tax by Family Composition
Ontario, Simcoe County and Muskoka District, 2005

Source: Statistics Canada, 2006 Census.
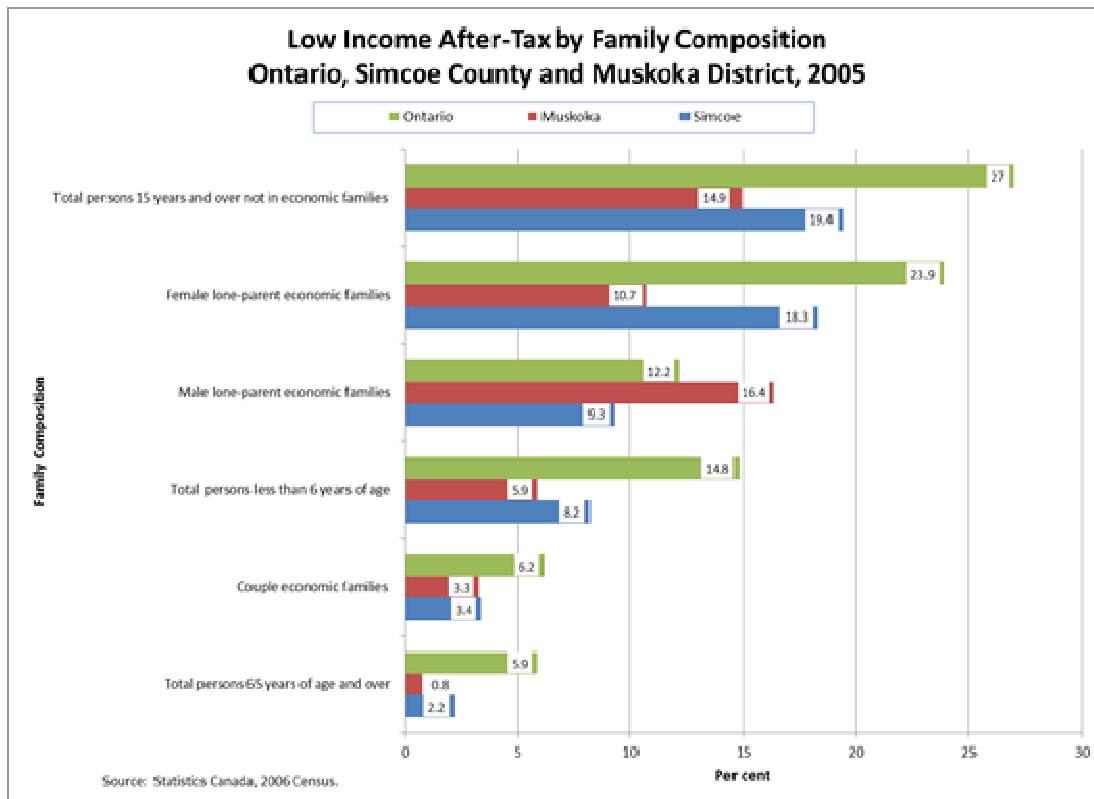
Refer to the table below for more detailed information about variations in low-income families by municipality. A comparison to Ontario is also featured, outlining those municipalities that are faring better or worse than the provincial percentages.

	Prevalence of Low Income After-Tax (%) by Family Composition, 2005									
	Total economic families	Couple economic families	Male lone-parent economic families	Female lone-parent economic families	Total persons 15 years and over not in economic families	Males 15 years and over not in economic families	Females 15 years and over not in economic families	Total persons in private households	Total persons less than 6 years of age	Total persons 65 years of age and over
Simcoe	**5.2**	**3.4**	**9.3**	**18.3**	**19.4**	**19.4**	**19.4**	**6.6**	**8.2**	**2.2**
Adjala-Tosorontio	3.8	2.6	0	19.5	11.1	7.9	18	3.6	3.5	0
Barrie	6.6	3.9	5.4	23.7	23.4	22.2	24.4	8.4	9.3	3.1
Bradford West Gwillimbury	3.2	2.4	6.1	11	11.3	8.4	14.2	3.7	6.2	1.5
Christian Island*										
Clearview	4.8	3.2	26.1	14.7	14.8	8.9	20	5.5	4.7	1.3
Collingwood	5.9	3.6	11.1	16.7	13.5	16.2	11.7	7.2	10.6	0.6
Essa	3	2.8	9.5	7	11.3	10.8	13.3	3.2	4	0
Innisfil	5.4	4.2	10	16.7	15.7	14.2	17.4	6.5	6.7	2.6
Midland	8.6	4.2	8.1	28.5	26.9	29.8	25.1	11.1	18.5	4.1
Mnjikaning First Nation*										
Moose Point*										
New Tecumseth	3.4	2.3	4.8	13.4	12.3	12.6	12.5	4	5.1	1.2
Orillia	7.1	4.2	21.7	18.2	26.7	31.9	23	10	11.9	3.4
Oro-Medonte	2.8	2.8	0	2.9	14.3	16.7	11.2	4	4.7	0.7
Penetanguishene	6.4	4.7	0	15.9	28	26.6	28	8.7	14.2	3.1
Ramara	3.6	3	22.2	6.8	10.9	11.8	7.9	4.4	0	0
Severn	4.2	3.7	0	10.3	15.7	20.6	11	5.4	3.4	1
Springwater	2.3	1.9	15.8	3.1	16	20	10.9	3.3	2.5	0.7
Tay	4	2.8	16.7	13.8	15.8	13.1	18.3	5.6	15.7	2.9
Tiny	5	3.4	14.3	22.7	11.1	12.2	8.6	5.7	17.4	2.2
Wasaga Beach	3.9	3	0	12.9	14	16	12.3	5.2	7.9	1.2
Muskoka	**4.3**	**3.3**	**16.4**	**10.7**	**14.9**	**17.9**	**12.1**	**5.4**	**5.9**	**0.8**
Bracebridge	3.7	3.1	10	7.1	14.5	16.8	12.7	4.4	3.2	0
Georgian Bay	6.3	6.2	0	0	17.1	27.8	5.9	6.7	0	0
Gravenhurst	5.2	3.2	26.7	15.8	17.6	23.2	12.9	7.3	15.8	1.4
Huntsville	3.5	2.4	16	11.2	16.1	16.9	15.4	4.8	3.2	1.2
Lake of Bays	5.8	5.2	0	28.6	8.2	13.3	3.8	6.2	0	0
Muskoka Lakes	5.2	4.2	50	6.7	9.5	12.8	7.1	5.1	0	0
Ontario	**8.6**	**6.2**	**12.2**	**23.9**	**27**	**27.3**	**26.8**	**11.1**	**14.8**	**5.9**
*Reserves excluded from calculations										

Cells coloured in grey →Highest prevalence in each column.　　　Numbers coloured in red →Higher than Ontario.

According to the 2006 Census:

- Nine per cent of all private households in Simcoe Muskoka are classified as low income (before taxes).

- Although the percentages of low income groups are below the provincial levels, there is still room for improvement:

  - 14% aboriginal population below low income cut-offs.

  - 17% visible minorities.

  - 14% of those with activity limitations.

  - 9% of all immigrants.

  - 21% of recent immigrants (immigrating to Canada between 2001 and 2006).

Low Income Status (Before Taxes) of High Risk Groups, Ontario and Simcoe Muskoka, 2005

Legend: ■ Simcoe Muskoka ■ Ontario

Group	Simcoe Muskoka	Ontario
Aboriginal Identity	13.5%	24.3%
Visible Minority	17.0%	26.4%
With Activity Limitations	13.5%	19.7%
Total Immigrants	8.8%	20.3%
Recent Immigrants	21.4%	39.8%
Total Private Households	9.1%	14.7%

Y-axis: % total population

Source: 2005 Census, Statistics Canada.

An important indicator that can be derived from Census household income data is the Gini Concentration Ratio or the Gini Coefficient of Income Disparity (Lorenz, 1905). The Gini Coefficient is often associated with a Lorenz Curve that visually displays disparity in income distribution. The Lorenz Curve shows the percentage of income received (y-axis) by the cumulative percentage of households (x-axis). If income was equally distributed and every household had the same income, the Lorenz Curve would follow the reference diagonal line

exactly. The extent to which the Lorenz curve diverges from the diagonal illustrates the degree of inequality of income distribution. If household incomes were exactly equally distributed between households (totally equal distribution), the Gini Coefficient would equal zero; if all the income was owned by one household (totally unequal distribution), the Gini Coefficient would equal one.

The Gini Coefficient of Income Disparity is estimated for Ontario and Simcoe Muskoka using the household income of private household categories derived from the 2006 Census. Simcoe Muskoka's Gini Coefficient (0.3255) is lower than Ontario's Gini Coefficient (0.3394), suggesting that when compared to Ontario, income is more equally distributed among Simcoe Muskoka households. Income distribution amongst private households is illustrated in the Lorenz Curve and the difference between Simcoe Muskoka and Ontario is visible.

Lorenz Curve of Income Disparity
Ontario and Simcoe Muskoka, 2006

Source: 2006 Census, Statistics Canada.
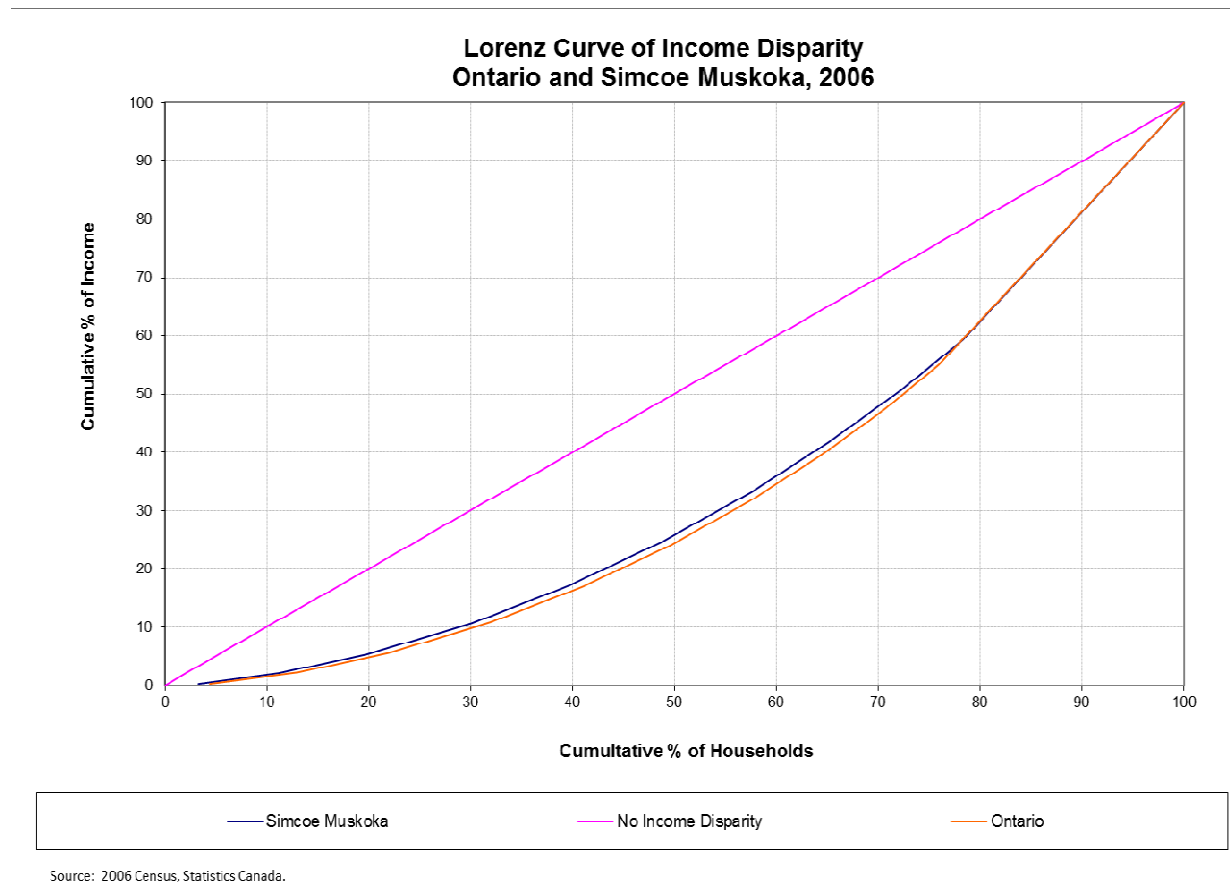
Education

According to the 2006 Census, nearly six out of every 10 adults aged 25 to 44 years in Simcoe Muskoka had completed some form of postsecondary education. They accounted for 60% of the 127,120 persons in this age group.

Twelve per cent or 15,560 people aged 25 to 44 years had not obtained a certificate, diploma or degree, 28% (35,950) had a high school certificate or equivalent.

The proportion of those without a certificate, diploma or degree varies by municipality. Georgian Bay (29%), Gravenhurst (23%), Christian Island (18%), Midland (16%) and Orillia (16%) have the highest percentages of their populations aged 25 to 44 years that have not obtained a certificate, diploma, or degree.

Highest certificate, diploma or degree refers to the highest certificate, diploma or degree completed based on a hierarchy which is generally related to the amount of time spent 'in-class.' For post-secondary completers, a university education is considered to be a higher level of schooling than a college education, while a college education is considered to be a higher level of education than in the trades. Although some trades requirements may take as long or longer to complete than a given college or university program, the majority of time is spent in on-the-job paid training and less time is spent in the classroom.

No certificate, diploma or degree refers to people who have not obtained any type of certificate, diploma or degree, including people with less than high school.

High school certificate or equivalent includes persons who have graduated from a secondary school or equivalent and excludes persons with a post-secondary certificate, diploma or degree. Examples of post-secondary institutions include community colleges, institutes of technology, CEGEPs, private trade schools, private business colleges, schools of nursing and universities.

Post-secondary certificate, diploma or degree includes those who have completed an apprenticeship or trades certificate or diploma; college, CEGEP or other non-university certificate, or diploma; and university certificate, diploma or degree.

(Statistics Canada, 2006 Census)

Refer to the table below for more detailed information about variations in educational attainment by municipality. A comparison to Ontario is also featured, outlining those municipalities that are faring better or worse than the provincial percentages.

	Education Levels - Highest Certificate, Diploma or Degree, Ages 25 to 44 Years, 2006					
	Total Population	No certificate, diploma or degree	% No certificate, diploma or degree	High school certificate or equivalent	% High school certificate or equivalent	Postsecondary certificate, diploma or degree	% Postsecondary certificate, diploma or degree
Simcoe County	**114520**	**13785**	**12.0%**	**32440**	**28.3%**	**68290**	**59.6%**
Adjala-Tosorontio	2940	320	10.9%	935	31.8%	1,675	57.0%
Barrie	40410	4490	11.1%	11040	27.3%	24,880	61.6%
Bradford West Gwillimbury	7285	980	13.5%	1940	26.6%	4,365	59.9%
Christian Island	170	30	17.6%	40	23.5%	90	52.9%
Clearview	3445	410	11.9%	1040	30.2%	1,995	57.9%
Collingwood	3970	510	12.8%	1195	30.1%	2,260	56.9%
Essa	5265	500	9.5%	1705	32.4%	3,060	58.1%
Innisfil	8695	1265	14.5%	2435	28.0%	4,985	57.3%
Midland	3650	570	15.6%	1095	30.0%	1,980	54.2%
Mnjikaning First Nation	260	40	15.4%	50	19.2%	185	71.2%
New Tecumseth	7480	860	11.5%	2390	32.0%	4,250	56.8%
Orillia	7215	1125	15.6%	2130	29.5%	3,950	54.7%
Oro-Medonte	4820	315	6.5%	1245	25.8%	3,255	67.5%
Penetanguishene	2065	280	13.6%	555	26.9%	1,230	59.6%
Ramara	2155	330	15.3%	605	28.1%	1,215	56.4%
Severn	2725	360	13.2%	845	31.0%	1,515	55.6%
Springwater	4185	350	8.4%	930	22.2%	2,900	69.3%
Tay	2415	355	14.7%	760	31.5%	1,290	53.4%
Tiny	2270	300	13.2%	655	28.9%	1,320	58.1%
Wasaga Beach	3080	405	13.1%	835	27.1%	1,840	59.7%
Muskoka District	**12600**	**1775**	**14.1%**	**3510**	**27.9%**	**7,320**	**58.1%**
Bracebridge	3525	405	11.5%	945	26.8%	2,180	61.8%
Georgian Bay	480	140	29.2%	180	37.5%	160	33.3%
Gravenhurst	2260	525	23.2%	535	23.7%	1,195	52.9%
Huntsville	4345	465	10.7%	1175	27.0%	2,710	62.4%
Lake of Bays	645	65	10.1%	190	29.5%	390	60.5%
Muskoka Lakes	1275	145	11.4%	475	37.3%	660	51.8%
Ontario	**3437150**	**332515**	**9.7%**	**827555**	**24.1%**	**2277080**	**66.2%**

Cells coloured in grey → Highest prevalence in each column.   Numbers coloured in red → Higher than Ontario.

Educational Attainment, Ages 25 to 44 years
Ontario, Simcoe County, Muskoka District and Municipalities, 2006

■ No certificate, diploma, degree   ■ High school certificate or equivalent   ■ Post-secondary certificate, diploma or degree

Source: Statistics Canada, 2006 Census.

% population ages 25-44

Unemployment

According to the 2006 Census, 261,225 people 15 years of age and older living in the service area of the Simcoe Muskoka District Health Unit were in the labour force. Among them, 6% or 14,655 were unemployed, an increase from 2001's rate of 5%. The unemployment rate for those aged 15 to 24 years was the highest of all age groups – 13% of this group was unemployed at the time of the 2006 Census, up from 11% in 2001. More women than men were unemployed, and this difference was consistent across all age groups.

In 2006, the unemployment rate varied by municipalities and townships. In Simcoe County, the highest unemployment rates (among those ages 15+) were in Christian Island (23%) and Mnjikaning First Nation (13%), while the highest in Muskoka District Municipality was in Moose Point (11%).

Prevalence of unemployment varies by highest level of education attained. In both Simcoe County and the District of Muskoka, the population ages 15+ with no certificate, diploma or degree have the highest unemployment rate (9.4% and 6.5% respectively) while those with a university certificate, diploma or degree have the lowest unemployment rates (3.9% and 2.9% respectively). Across all educational levels, Simcoe County experiences higher unemployment rates compared to Muskoka District's labour force.

Unemployment rate: proportion of the population 15 years and over unemployed relative to the total non-institutional population 15 years and over in the labour force in the week prior to Census Day.

(Statistics Canada, 2006 Census)

**Unemployment Rate by Highest Level of Education
Simcoe County & Muskoka District, 2006**

■ Simcoe County ■ Muskoka District

% labour force ages 15+

Education Level	Simcoe County	Muskoka District
No certificate, diploma or degree	9.4	6.5
High school certificate or equivalent	6.1	4.7
Apprenticeship or trades certificate or diploma	4.6	4.3
College, CEGEP or other non university certificate or diploma	4.5	4.3
University certificate, diploma or degree	3.9	2.9
Total Population Ages 15+	5.7	4.6

Source: 2006 Census, Statistics Canada.

Housing

In 2006, 46,345 Simcoe Muskoka households spent 30% or more of their income on shelter. This group represented 26% of all households. One-third (32.7%) of the households that spent 30% or more of their income on shelter were renters. Households that owned their home with a mortgage accounted for 58%, while those without a mortgage accounted for the remainder. The proportion of homeowners spending more than 30% of their income on shelter costs varies by municipalities and townships. One-third of all private households in Collingwood (33%) and more than one-quarter of all Georgian Bay households (26%) report spending in excess of 30% of their income on housing.

According to Statistics Canada, not all households spending 30% or more of incomes on shelter costs are necessarily experiencing housing affordability problems. This is particularly true of households with high incomes. There are also other households who choose to spend more on shelter than on other goods. Nevertheless, the allocation of 30% or more of a household's income to housing expenses provides a useful benchmark for assessing trends in housing affordability.

Housing Affordability
Ontario, Simcoe County, Muskoka District and Municipalities, 2006

Legend: ■ Spending More than 30% income   ■ Spending Less than 30% income

Y-axis label: Geographic Location

Categories (top to bottom): Essa, Springwater, Lake of Bays, Tiny, Muskoka Lakes, Oro-Medonte, Tay, New Tecumseth, Bracebridge, Bradford West Gwillimbury, Clearview, Muskoka, Huntsville, Innisfil, Adjala-Tosorontio, Ramara, Wasaga Beach, Severn, Gravenhurst, Georgian Bay, Simcoe, Ontario, Penetanguishene, Barrie, Midland, Orillia, Collingwood

X-axis: 0.0%, 10.0%, 20.0%, 30.0%, 40.0%, 50.0%, 60.0%, 70.0%, 80.0%, 90.0%, 100.0%

X-axis label: Per cent of private households

Source: Statistics Canada, 2006 Census.

According to the Canada Mortgage and Housing Corporation (CMHC), housing prices in the Census Metropolitan Area (CMA) of Barrie have been increasing. The average price of an existing home in the Barrie CMA hovered in the $282,000 to $294,000 range in 2011. Despite both employment growth and low mortgage rates, economic uncertainty means homebuyers in late 2011 were cautious and focused on homes with lower price tags.[76]
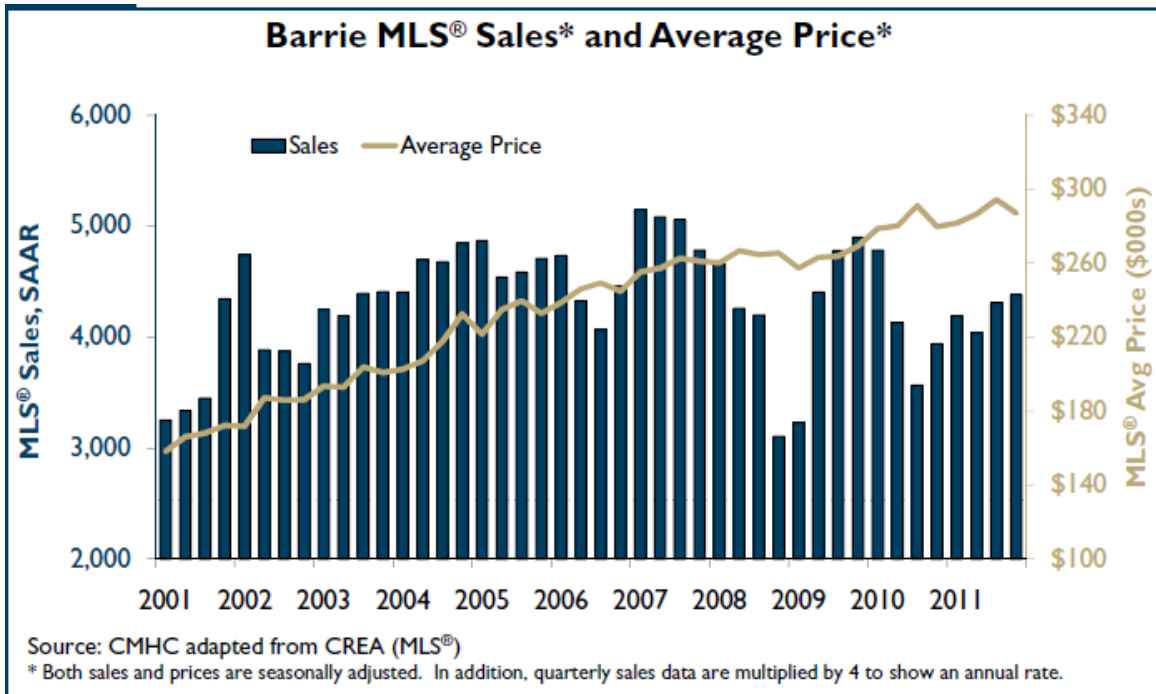

Barrie MLS® Sales* and Average Price*

Source: CMHC adapted from CREA (MLS®)
* Both sales and prices are seasonally adjusted. In addition, quarterly sales data are multiplied by 4 to show an annual rate.

Table 5: MLS® Residential Activity for Barrie Fourth Quarter 2011									
		Number of Sales[1]	Yr/Yr[2] (%)	Sales SA[1]	Number of New Listings[1]	New Listings SA[1]	Sales-to-New Listings SA[2]	Average Price[1] ($)	Yr/Yr[2] (%)	Average Price[1] ($) SA
2010	January	204	58.1	374	600	642	58.3	270,340	4.1	278,087
	February	278	35.6	357	663	708	50.4	278,336	14.9	282,900
	March	468	49.5	448	972	784	57.1	273,148	6.4	275,950
	April	541	31.3	390	957	697	56.0	282,252	12.8	286,458
	May	439	-13.1	329	853	676	48.7	284,392	4.1	273,952
	June	461	-19.4	324	767	650	49.8	285,476	5.5	279,134
	July	309	-31.2	273	645	628	43.5	267,768	0.6	261,091
	August	330	-16.2	302	588	612	49.3	294,954	12.1	290,934
	September	332	-21.3	323	669	660	48.9	316,167	17.2	316,405
	October	277	-28.8	328	580	641	51.2	270,906	1.0	275,842
	November	273	-17.0	306	454	650	47.1	272,261	3.1	278,189
	December	193	-6.8	350	260	662	52.9	277,454	5.9	284,615
2011	January	197	-3.4	353	577	624	56.6	274,821	1.7	281,538
	February	284	2.2	358	614	649	55.2	273,042	-1.9	278,978
	March	379	-19.0	337	808	622	54.2	282,997	3.6	284,500
	April	427	-21.1	342	842	642	53.3	288,409	2.2	290,816
	May	449	2.3	308	815	619	49.8	285,610	0.4	280,697
	June	501	8.7	359	750	648	55.4	291,073	2.0	287,750
	July	380	23.0	352	653	646	54.5	303,739	13.4	295,507
	August	401	21.5	362	655	648	55.9	299,921	1.7	291,914
	September	387	16.6	364	655	648	56.2	292,153	-7.6	295,650
	October	312	12.6	363	607	667	54.4	274,686	1.4	280,019
	November	321	17.6	375	459	636	59.0	280,581	3.1	288,545
	December	190	-1.6	357	241	626	57.0	290,769	4.8	292,478
	Q4 2010	743	-19.7		1,294			273,105	2.9	
	Q4 2011	823	10.8		1,307			280,698	2.8	
	YTD 2010	4,105	-5.1		8,008			281,966	6.8	
	YTD 2011	4,228	3.0		7,676			287,588	2.0	

According to the CMHC, Barrie CMA's rental vacancy rate declined from 3.4% in October 2010 to 1.7% in October 2011. In comparison, Ontario vacancy rates declined to 2.2% in October 2011, down from 2.9% in the fall of 2010. It is expected that with the market remaining fairly tight, the average rent in Barrie CMA will increase significantly in 2012. The factors driving the vacancy rate lower include:

- Strong movement of renters to homeownership which exerted upward pressure on the rate.

- Demographic situation in Barrie. There was strong increase in the number of people aged between 20 and 24 who are more likely to rent.

- Stronger employment among those aged 15 to 24 in Barrie this past year further induced household formation, increasing demand for rental.

- Enrolment at the local community college has expanded, resulting in increases in student rentals.

  No new units were added to the rental stock in the past year.[77]

Barrie CMA: Includes the municipalities of Barrie, Springwater and Innisfil.

Census Metropolitan Area (CMA) and Census Agglomeration Area (CA): Formed by one or more adjacent municipalities centred on a large urban area (known as the urban core). The census population count of the urban core is at least 10,000 to form a CA and 100,000 to form a CMA. To be included in the CA or CMA, other adjacent municipalities must have a high degree of integration with the central urban area, as measured by commuting flows derived from census place of work data.

(Canada Mortgage and Housing Corporation)

For the most part, average rents across Simcoe Muskoka are less expensive than the provincial averages. The Barrie CMA is the one exception – rent for one bedroom apartments ($884) is higher than the average Ontario rent ($866).

Average Rent for Simcoe County and Muskoka District Private Apartments* by Bedroom Type Sources: Rental data: CMHC, Ontario Rental Market Report, Fall 2011 Population data: 2006 Census, Statistics Canada					
		Average Rents (Oct 2011)			
	Population (2006 Census)	Bachelor	1 bdrm	2 bdrm	3 bdrm+
Barrie CMA	177061	$681	$884	$1,001	$1,126
Collingwood CA	17290	$672	$751	$868	$844
Midland CA	35402	$530	$687	$795	$919
Orillia CA	40532	$610	$769	$873	$951
Bradford W. Gwillimbury (Zone 31) - New Tec & BWG Census Tracts 480-482; 483-485 = CSDs	51740	$673	$838	$977	$1,102
Huntsville Town	18280	$582	$749	$912	$1,016
Bracebridge Town	15652	**	$761	$855	**
Gravenhurst Town	11046	**	$710	$903	**
Simcoe Muskoka District estimate^	367003	**$649.84**	**$822.34**	**$943.73**	**$1,059.74**
Ontario		$741	$866	$1,002	$1,234
* average rent for Simcoe Muskoka District are estimates only. Does not include all areas. ** data suppressed to protect confidentiality or data not statistically reliable. Therefore, avg rent calculation for Bachelor and 3 bdrm+ to be interpreted with caution since over-represented by Simcoe County jurisdictions. ^ average rent for bachelor and 3 bedroom+ are over-represented by Simcoe County rental and population data. Barrie CMA comprised of Barrie City, Innisfil Town and Springwater Township.					

Francophone Population

The French Language Services Act (FLSA) guarantees the right to services in French from the provincial government in government offices in designated areas of the province. Across Ontario, there are currently 25 designated areas under the FLSA.[78] Three census subdivisions in the County of Simcoe are considered designated areas – Essa, Penetanguishene and Tiny.
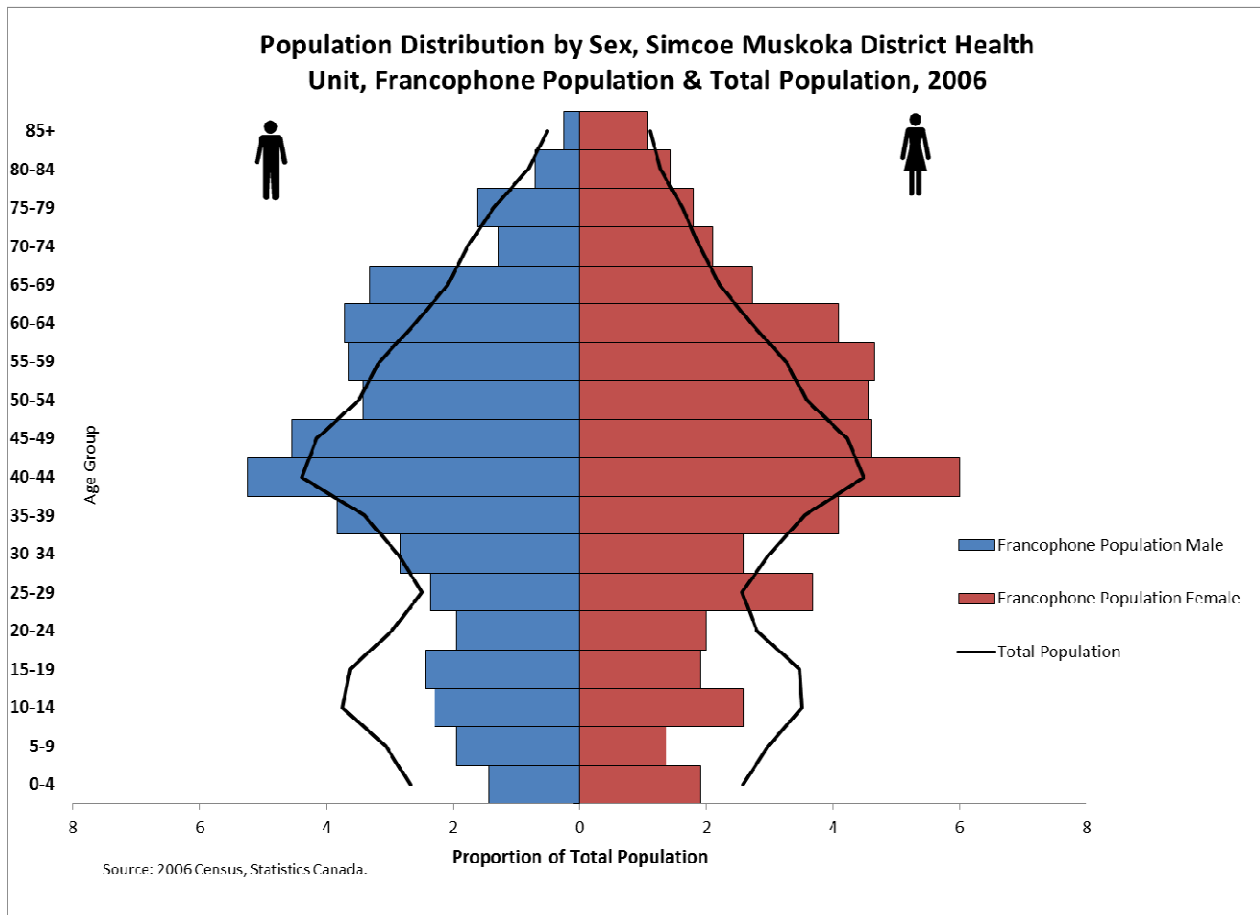
According to the 2006 Census, 29% (3,980) of Simcoe Muskoka's 13,555 Francophones live in Essa, Penetanguishene and Tiny.

Overall the Francophone population makes up 3% of Simcoe Muskoka's total population but this can be as high as one in eight in Tiny (13%) and in Penetanguishene (13%).

Francophone: derived from the following Census language variables; (a) first official language, (b) mother tongue, and (c) home language. Basically if French came up for an individual as part of any of the three (first official language, mother tongue, or home language) then they were counted as Francophone and included in the target group.

(Community Social Data Strategy, 2006 Census Target Group Profile)

In terms of the age and sex structure, there are proportionately more Francophones in each age category 35 and over and proportionately fewer in each category under 35 years of age when compared to the overall Simcoe Muskoka population. The population pyramid below also shows that there are more women than men in all age groups 70 and older – for both the Francophone community and the total population.

Population Distribution by Sex, Simcoe Muskoka District Health Unit, Francophone Population & Total Population, 2006

Source: 2006 Census, Statistics Canada.

In 2006, more working-age Francophones (25 to 64 years) reported not having a certificate, diploma or degree compared to the total 25 to 64-year population (17.1% compared to 15.5%).

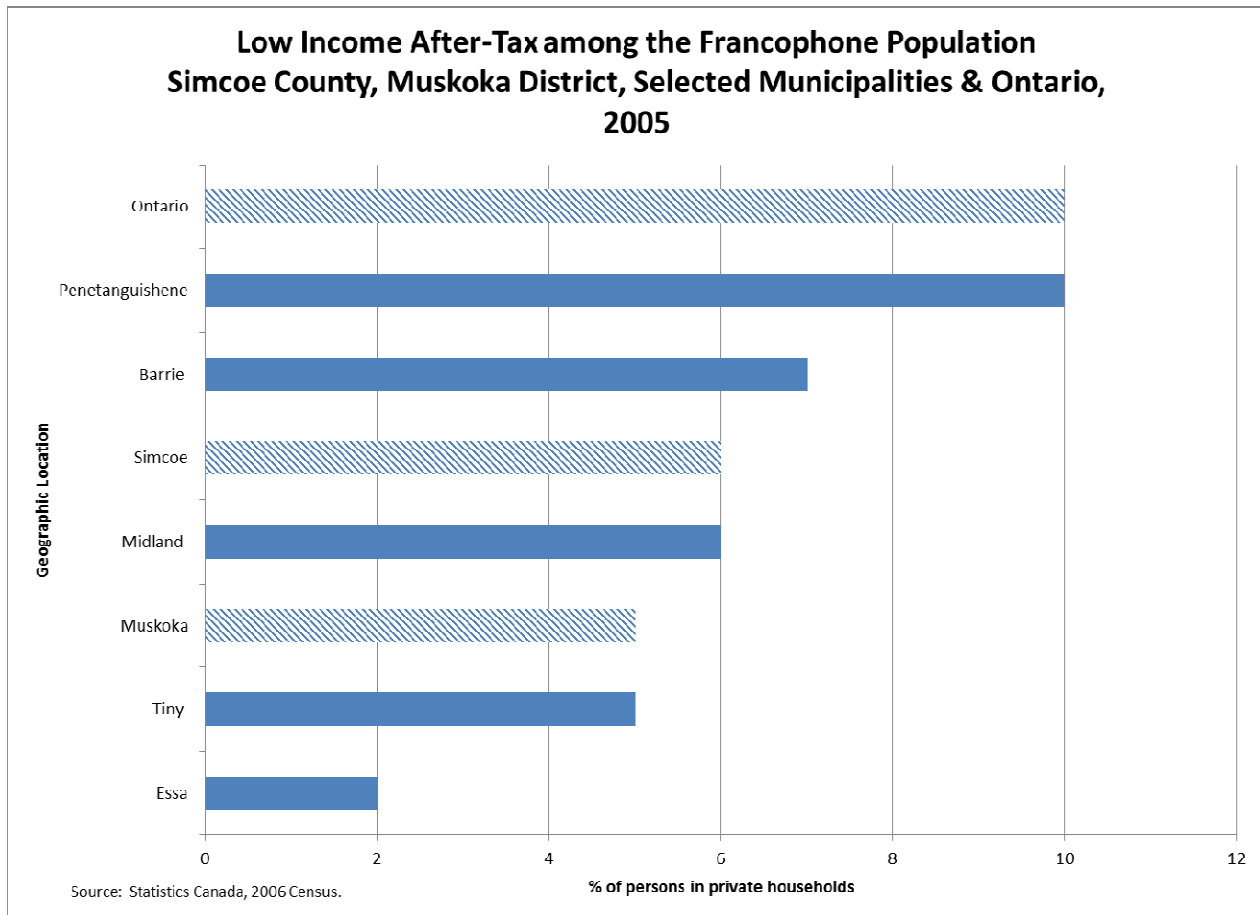The proportion of Francophones without a certificate, diploma or degree varies from municipality to municipality. One-third of Francophones living in Midland do not have a certificate, diploma or degree compared to 7% in Essa.

Francophone Population with No Certificate, Diploma or Degree Simcoe County, Muskoka District, Selected Municipalities & Ontario, 2006

Source: Statistics Canada, 2006 Census.

% of population ages 25 to 64 years
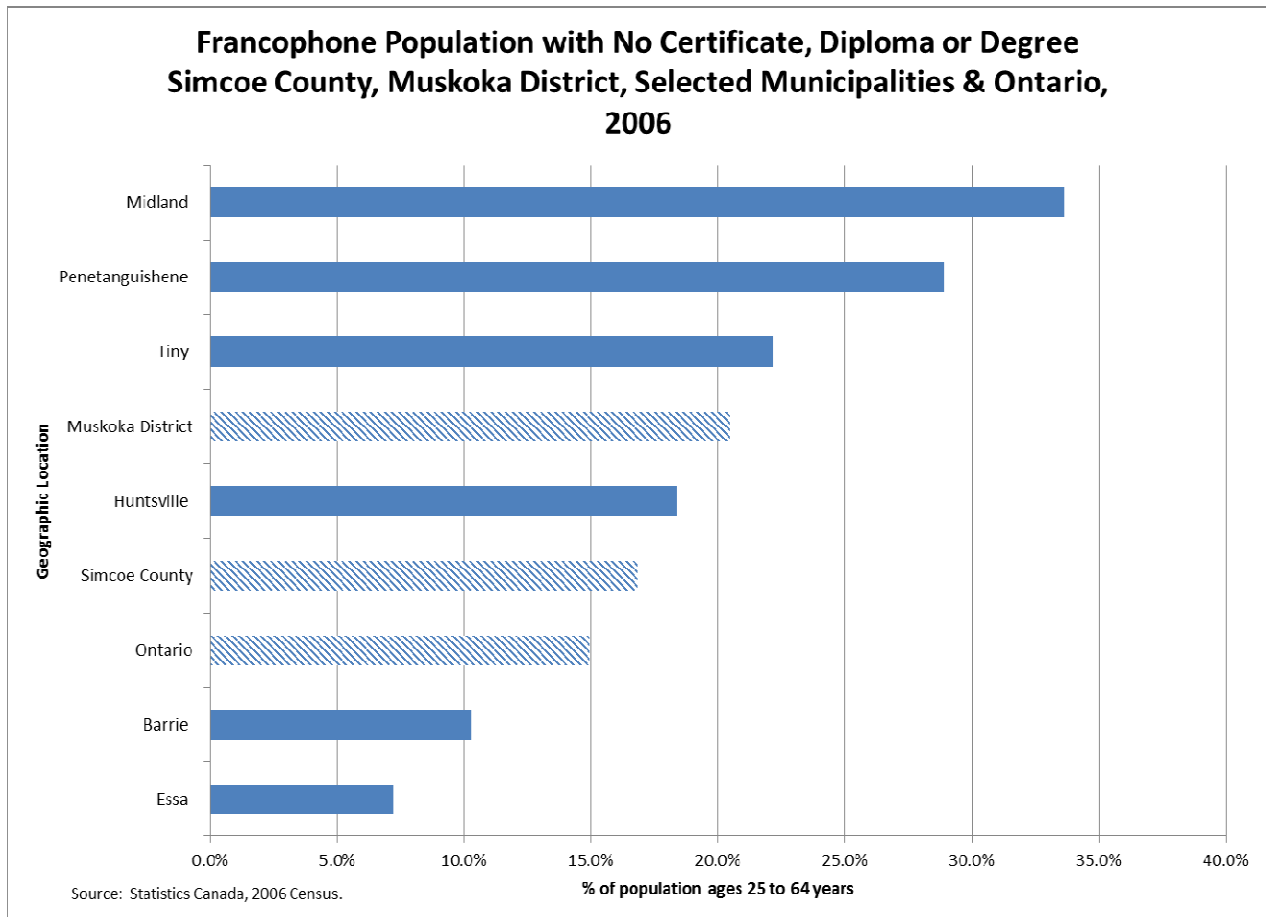
In Ontario, one in ten Francophones was living below the after-tax low-income cut-off in 2006. Overall, the proportion of Simcoe Muskoka Francophones living below the low-income cut-off is lower than the provincial rate (6% in Simcoe County and 5% in Muskoka District).

In the municipalities of Barrie and Penetanguishene, there were proportionately more Francophones living below the low-income cut-off than in the overall population – 7% in Barrie and 10% in Penetanguishene.

**Low Income After-Tax among the Francophone Population
Simcoe County, Muskoka District, Selected Municipalities & Ontario,
2005**

Source: Statistics Canada, 2006 Census.

% of persons in private households

Geographic Location

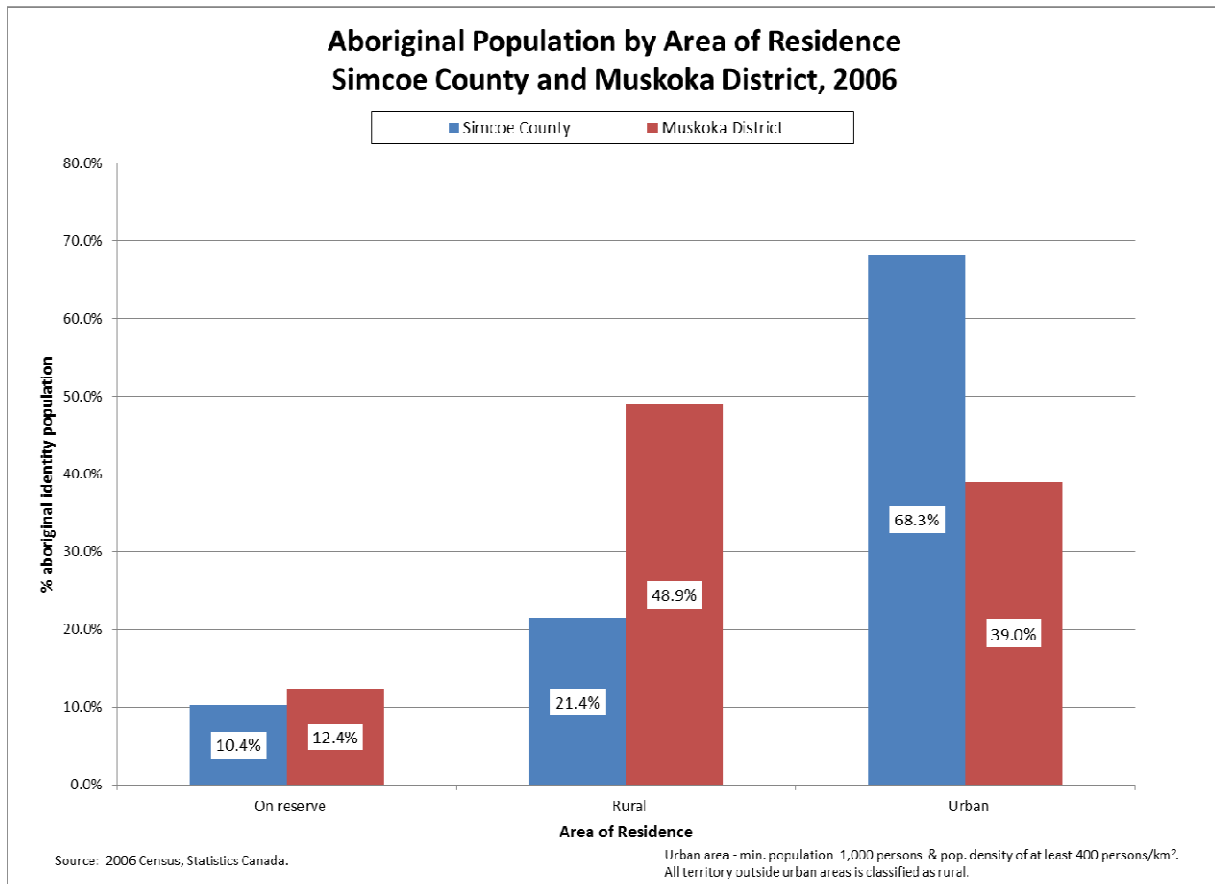| Location	Value
Ontario	10
Penetanguishene	10
Barrie	7
Simcoe	6
Midland	6
Muskoka	5
Tiny	5
Essa	2

Aboriginal Population

In 2006, 3% of the Simcoe Muskoka population, or 14,450 people, identified themselves as
Aboriginal people, with 3% in Simcoe County and 3% in Muskoka District. In Simcoe County,
there was a higher proportion of the population who identified themselves as Aboriginal in the
northwest area compared to the rest of the county: Penetanguishene (15%), Tay (10%),
Midland (9%) and Tiny (8%). In the Muskoka District, 11% of the population in Georgian Bay
identified themselves as Aboriginal, which was the highest proportion in Muskoka.

The majority of the Aboriginal population lives off-reserve. In Simcoe County, more than two-
thirds of Aboriginals live in urban areas whereas in Muskoka, nearly half of all Aboriginals live in
rural areas.

Aboriginal Identity: Refers to those persons who reported identifying with at least one Aboriginal group, that is,
North American Indian, Métis or Inuit (Eskimo), and/or those who reported being a Treaty Indian or a Registered
Indian, as defined by the Indian Act of Canada and/or who reported they were members of an Indian band or First
Nation.

Urban area: Minimum population 1,000 persons and population density of at least 400 persons/km2.

Rural area: All territory outside urban areas.

(Statistics Canada, 2006 Census)

Aboriginal Population by Area of Residence
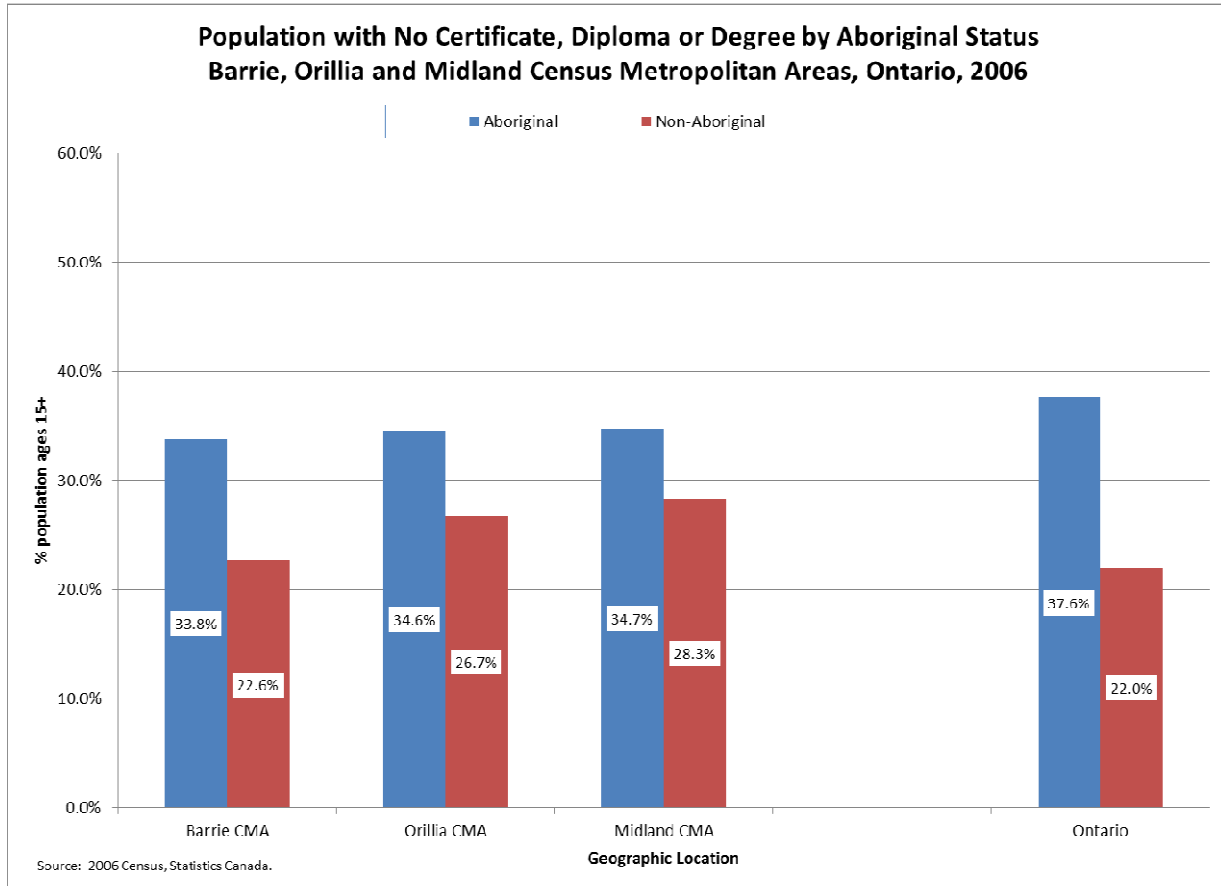## Simcoe County and Muskoka District, 2006

Source: 2006 Census, Statistics Canada.

Urban area - min. population 1,000 persons & pop. density of at least 400 persons/km².
All territory outside urban areas is classified as rural.

Area of Residence, Aboriginal Population
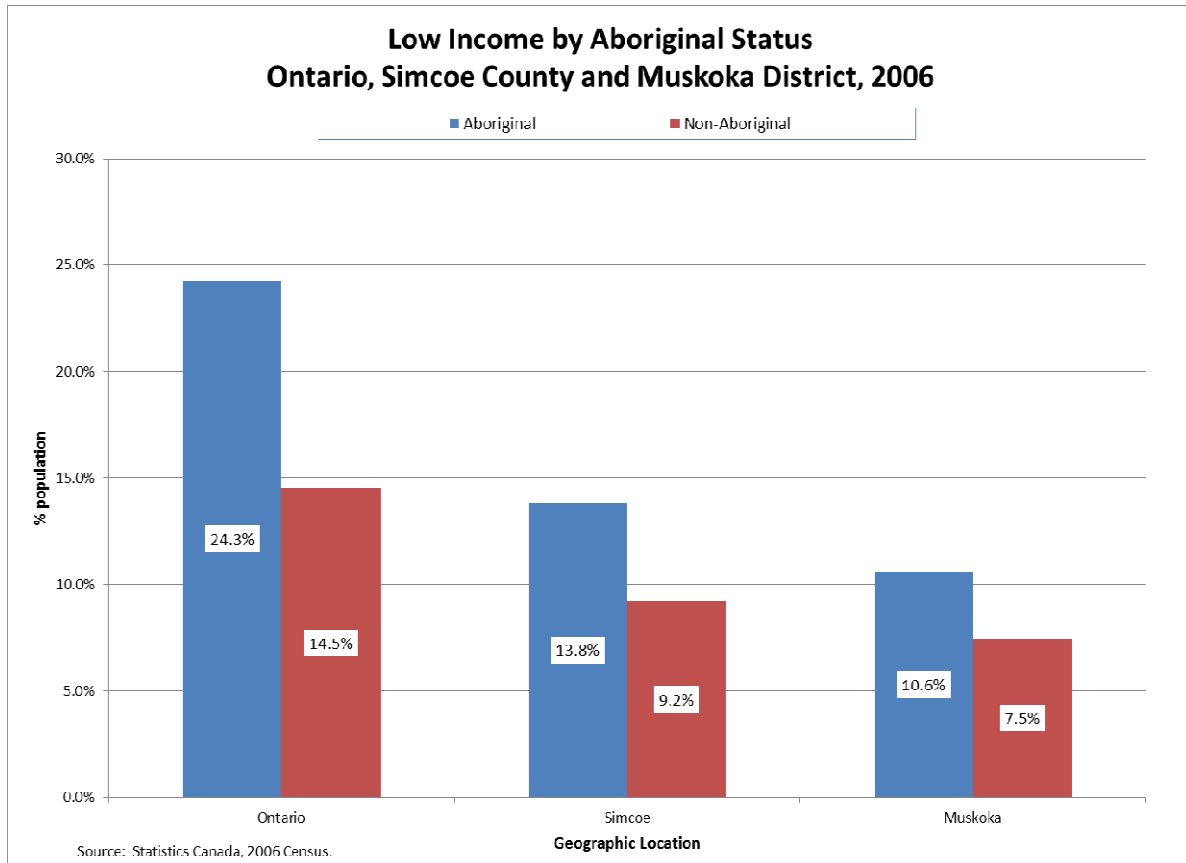## Ontario, Simcoe County, Muskoka District and Municipalities, 2006
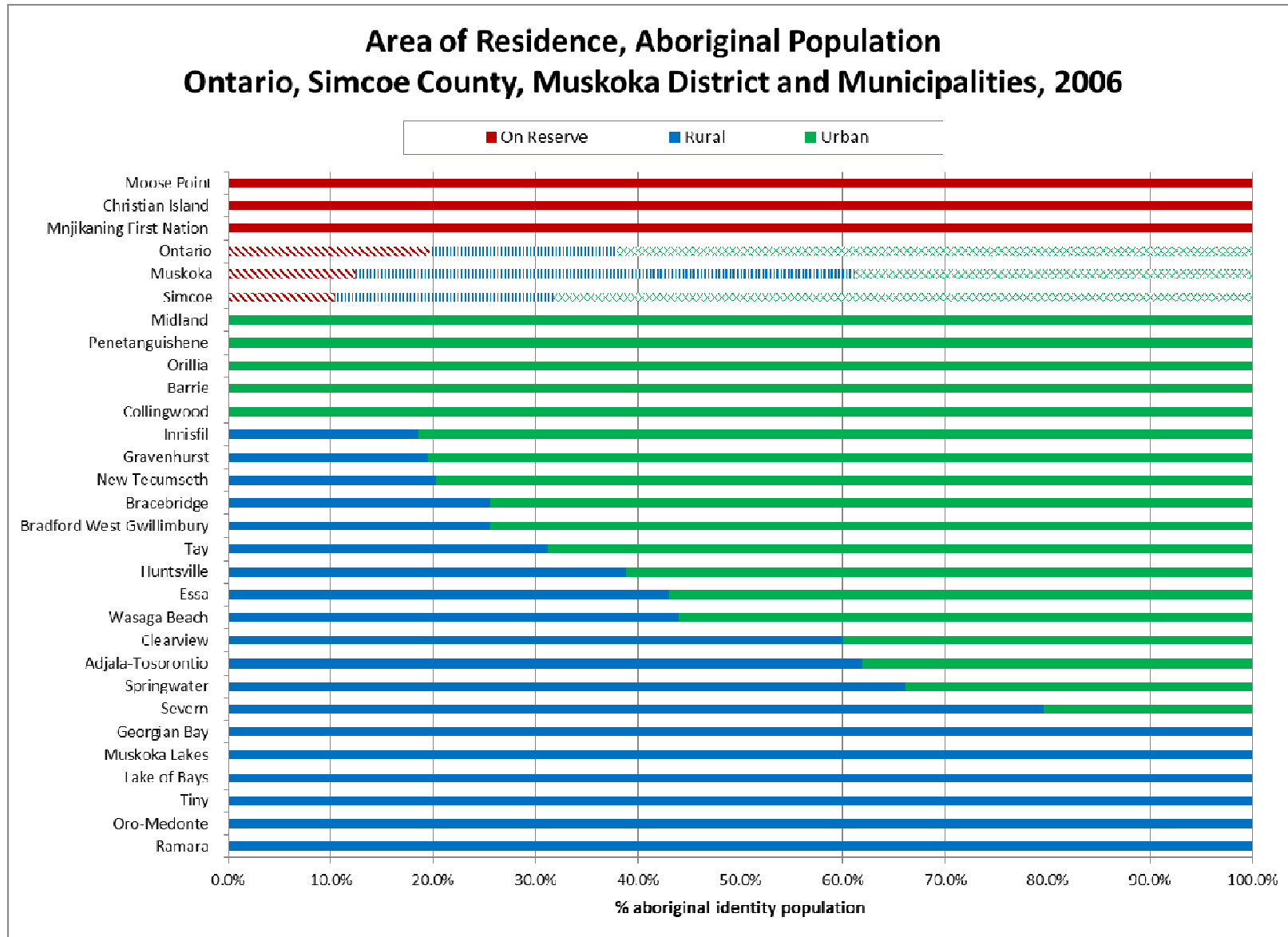
The prevalence of low education (without a certificate, diploma or degree) is higher among the Aboriginal population living in the Barrie, Orillia and Midland CMAs, compared to the non-Aboriginal population. More than one-third of the population identifying as Aboriginal report not having a certificate, diploma or degree.

Population with No Certificate, Diploma or Degree by Aboriginal Status
Barrie, Orillia and Midland Census Metropolitan Areas, Ontario, 2006

Source: 2006 Census, Statistics Canada.

The prevalence of low income is also higher among the Aboriginal population. Fourteen per cent of the Aboriginal population (1,740) living in Simcoe Muskoka are classified as low income compared to 9% of the non-Aboriginal population. A higher percentage of Aboriginals in Simcoe County are living below the low income cut-offs compared to those living in Muskoka District.

**Low Income by Aboriginal Status
Ontario, Simcoe County and Muskoka District, 2006**

■ Aboriginal   ■ Non-Aboriginal

Ontario: 24.3% (Aboriginal), 14.5% (Non-Aboriginal)
Simcoe: 13.8% (Aboriginal), 9.2% (Non-Aboriginal)
Muskoka: 10.6% (Aboriginal), 7.5% (Non-Aboriginal)

Y-axis: % population (0.0% to 30.0%)
X-axis: Geographic Location

Source: Statistics Canada, 2006 Census.

Immigration

The service area of the SMDHU was home to 56,080 new immigrants in 2006, representing 12% of the total population, an increase of 18% from 2001 but lower than the provincial average of 28%. Immigration numbers vary by municipality and township. The highest proportions of immigrants were found in Bradford West Gwillimbury (20%) and Wasaga Beach (20%) within Simcoe County, while Lake of Bays (10%) and Georgian Bay (10%) were home to the highest proportion of immigrants in the District of Muskoka. The fastest immigrant growth occurred in Midland, where the number increased more than 3.5 times from 410 in 2001 to 1,450 new Canadians in 2006.

The majority of the immigrants residing in Simcoe Muskoka came from Northern Europe (18,395), the United Kingdom (16,885) and Western Europe (9,515). Only 15% of the immigrant population 15 years of age and older were first generation immigrants. Thirty-two per cent of all immigrants came to Canada before 1961 and 7% (3,705) were recent newcomers arriving between 2001 and 2006 (compared to 17% in Ontario).
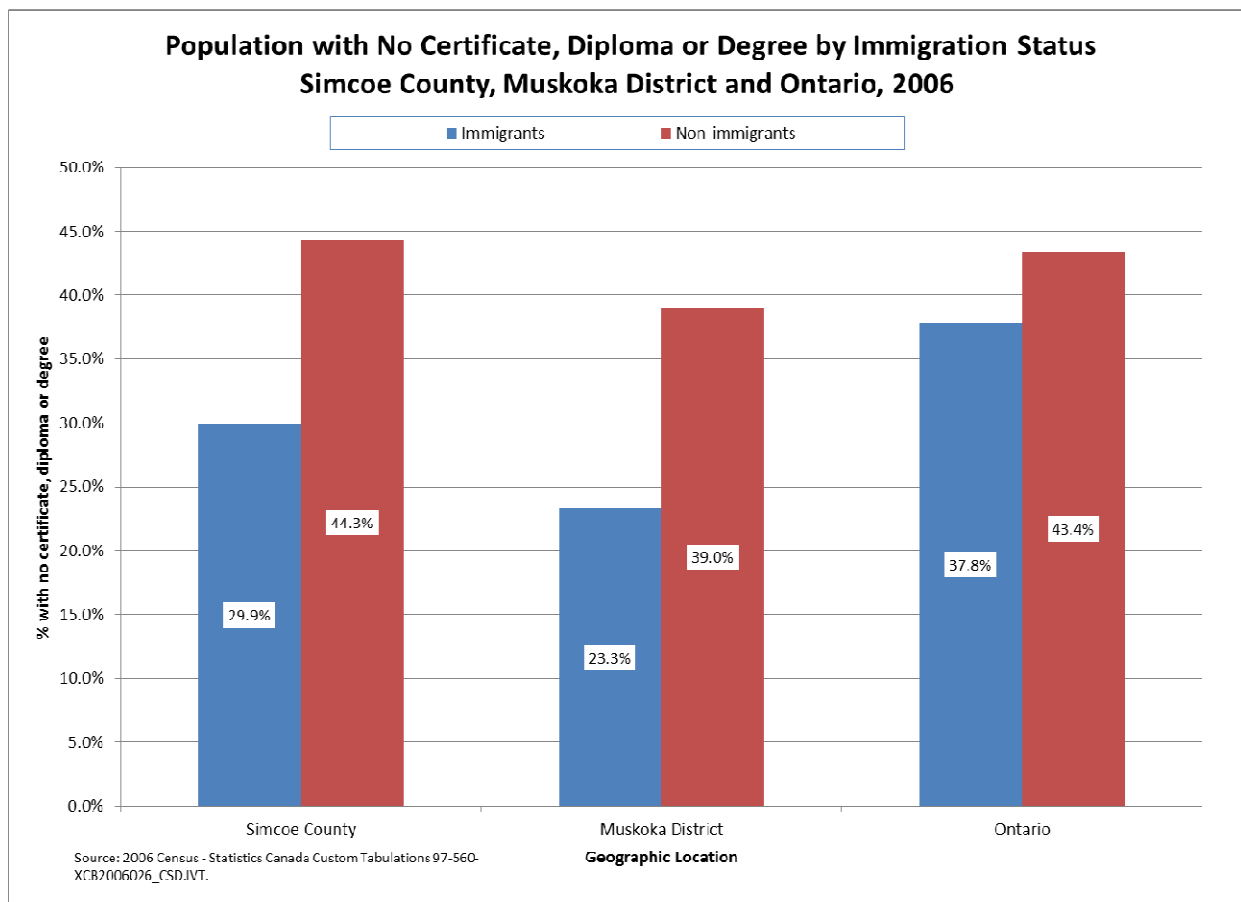
Immigrant Population: The per cent of landed immigrants relative to the total non-institutional population.

First Generation Immigrant: Persons born outside Canada. For the most part, these are people who are now, or have ever been, landed immigrants in Canada. Also includes a small number of people born outside Canada to parents who are Canadian citizens by birth. Also includes people who are non-permanent residents (defined as people from another country in Canada on Work or Study Permits or as refugee claimants, and any family members living with them in Canada).

Recent immigrant: Persons who immigrated to Canada between 2001 and Census Day, May 16, 2006.

(Statistics Canada, 2006 Census)

In terms of educational attainment, the immigrant population in Simcoe Muskoka is faring better in comparison to the non-immigrant population. In Simcoe County, 30% of immigrants report not having a certificate, diploma or degree while 44% of the non-immigrant population fall into this category. In Muskoka District, 23% of all immigrants do not have a certificate, diploma or degree in comparison to nearly four in every 10 non-immigrants.

Population with No Certificate, Diploma or Degree by Immigration Status Simcoe County, Muskoka District and Ontario, 2006

Source: 2006 Census - Statistics Canada Custom Tabulations 97-560-XCB2006026_CSD.IVT.

While recent arrivals are relatively well educated, they face a variety of barriers that may impede their entry into the labour market and many find themselves in low paid employment. It may take from 10 to 15 years before new arrivals reach employment income levels comparable to the

Canadian born population.[79] In comparison to other 'high risk' groups residing in Simcoe Muskoka, recent immigrants report the highest percentage of individuals earning below the low income cut-offs–more than one in every five recent immigrants (21%) are classified as low income, representing 785 individuals.

In comparison to Ontario, the proportion of Simcoe Muskoka's total immigrant population considered low income (9%) is much lower than in the province as a whole (20%). The same applies to recent immigrants, where 21% live below the low income cut-offs, compared to 40% across the province.

Low Income Status (Before Taxes) of High Risk Groups, Ontario and Simcoe Muskoka, 2005

Source: 2006 Census, Statistics Canada.

APPENDIX E: PROFESSIONAL DEVELOPMENT

The staff development plan is required in order to allocate resources and provide opportunities for staff to develop the capacity to meet the DOH outcomes in the 2012 – 2016 strategic plan and beyond. The plan will include opportunities for staff to increase capacity to address the factors that create health inequities and to work with populations at risk of health inequities.

Professional development is required to develop competencies to address DOH. Ontario Public Health Standards state Boards of Health shall ensure a competent and diverse public health workforce by providing ongoing staff development and skill building related to SDOH public health competencies.[7] A more detailed description of staff development and skill building is offered by many sources in the literature.[80-84]

Recommendation 3 states, "The SDOH Steering Committee will commit to creating a professional development plan for implementation beginning in 2012 to enhance knowledge and skills on content areas to enhance staff's ability to address determinants of health as outlined in Appendix E."

The staff professional development plan beginning in 2012 to enhance knowledge and skills will include the following:

1. Bridges out of Poverty – full day workshop on cultural sensitivity training about poverty.

2. Health Equity Impact Assessment – a decision support tool which assists in providing equitable delivery of programs, service, policy etc.

3. Let's Start a Conversation- an engagement tool to encourage greater understanding about the SDOH influence on health.

The staff professional development plan for beyond 2012 can include topics from the following list:

- SDOH influence on health and well-being

- Community development

- Collaborative leadership

- Cultural sensitivity training for various priority populations including the culture of poverty

- Collection and analysis of surveillance and epidemiological data and reporting

- Policy advocacy and understanding of political and economic systems

- Early childhood development

- The Health Equity Impact Assessment Tool

- Media advocacy

- Social Media

- Collaborative Governance Framework by Tamarack Institute for Community Engagement; and Partnership Models by HC Link

- Broad public health perspective and its influence on priority populations

APPENDIX F: LIST OF ACRONYMS

alPHa	Association of Local Public Health Agencies
APHEO	Association of Public Health Epidemiologists in Ontario
CDC	Centers for Disease Control and Prevention
CSDOH	Commission on the Social Determinants of Health
DOH	Determinants of Health
FNMI	First Nations Métis Inuit
GNP	Gross National Product
HEIA	Health Equity Impact Assessment
MOHLTC	Ministry of Health and Long-Term Care
NCCDH	National Collaborating Centre for Determinants of Health
OPHA	Ontario Public Health Association
OPHS	Ontario Public Health Standards
PHAC	Public Health Agency of Canada
PHO	Public Health Ontario
SDHU	Sudbury District Health Unit
SDOH	Social Determinants of Health
SMDHU	Simcoe Muskoka District Health Unit
WHO	World Health Organization

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