
Delivery mechanisms of prevention and health promotion for socioeconomically vulnerable populations: an exploratory study



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Delivery mechanisms of prevention and health promotion for socioeconomically vulnerable populations: an exploratory study

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ACKNOWLEDGEMENTS

This report was made possible through the financial support of the Institut National de Prévention et d'Éducation pour la Santé (INPES).

Deep gratitude is owed to our respondents for their detailed and thoughtful responses, and their openness to further dialogue. Any lingering inaccuracies in this report are the author's own.

We wish to thank the members of the advisory committee for its valuable guidance and support: Jocelyne Boudot, National Institute for Prevention and Health Education (INPES); Connie Clement, Scientific Director, National Collaborating Centre for Determinants of Health, St. Francis Xavier University, Antigonish, Nova Scotia, Canada; Pascale Echard-Bezault, National Institute for Prevention and Health Education (INPES); Ginette Lafontaine, Quebec, Canada, Francophone International Network of Health Promotion (REFIPS); Marie-Claude Lamarre, Executive Director, International Union for Health Promotion and Education (IUHPE); Lisandra Lannes, Quebec, Canada, Francophone International Network of Health Promotion (REFIPS); Louise Potvin, University of Montreal, Canada; Marilyn Rice, IUHPE Global Working Group on Social Determinants of Health, USA; and Sylvie Stachenko, University of Alberta, Canada.

Lisandra Lannes (REFIPS) and Marie-Claude Lamarre (IUHPE) are additionally thanked for their attentive editing and proofreading of the French translation of this report.

EXECUTIVE SUMMARY

Introduction

The reduction of health inequities has become the preoccupation of many governments, be they on the national, subnational or local level. While the need to act has been widely acknowledged, how, concretely, to choose, fund, and deploy initiatives and means that tackle social inequalities in health from a prevention and health promotion perspective remains uncharted territory. Each country has adopted its own strategies and entry points. Furthermore, countries have different visions of how to conceptualize social issues and define populations, such as the notion of *précarité* in France, a concept that translates poorly in different languages or cultures where concepts of disadvantage, vulnerability and poverty are more common.

The French National Institute for Prevention and Health Education (INPES) has a major role in prevention and health promotion in France and can therefore inform the approaches that are implemented. It is therefore highly useful for the institute to learn what delivery mechanisms other countries have developed, so that France may take inspiration from international experiences to improve its own practices, both in terms of effectiveness and its alignment with strategic objectives to reduce social inequalities in health.

Objective

The objective of this exploratory study/scoping analysis was to explore what policies and means (human, material and financial) other countries deploy to address the needs of socioeconomically vulnerable people via prevention and health promotion. An additional objective was to provide examples of structural policies that tackle social inequalities in health.

Methods

Supported by an advisory committee, a questionnaire was developed and sent by email to 22 respondents in 9 countries, with an invitation to participate in the study. Out of this total, 6 respondents from 5 countries (Australia, Canada, Finland, Spain and Switzerland) submitted complete responses. Semi-structured interviews were conducted with 6 respondents from two countries, Australia and Canada. It is important to note that a very high proportion of Canadian responded positively to our invitation, whereas we were unable to recruit respondents from the Netherlands, the United Kingdom, Sweden or Norway.

Once the responses were collected, they were analyzed thematically using a deductive-inductive process.

Results

We found that countries tended not to specifically target the socioeconomically vulnerable, and that there is a wide variety of target populations (the disadvantaged, the working poor, low-income families, etc.) that overlap more or less with the French vision of people in precarity.

Strategies to improve the health of these populations are situated within the context of universal efforts to improve overall population health while aiming for greater improvement among those in the greatest need; based on this gradient, targeting within universalism or proportionate universalism was more prevalent where there was an explicit mandate to tackle health inequities and/or structural (historical, economic, and political) facilitators were in place. The kinds of interventions prioritized by these strategies varied but respondents emphasized

action on the social determinants of health (poverty reduction and housing) as well as a life-course approach (antenatal and early childhood interventions). These actions are financed through different mechanisms, such as co-financing with multiple levels of government or sectors, public funding of NGOs and public-private partnerships. One success factor that was highlighted by our respondents was the development of funding mechanisms that bring organizations together to coordinate and cooperate, rather than bringing them into competition.

Regarding the decisionmaking process within these fund allocation mechanisms, an approach based on local health and socioeconomic surveillance data and on the academic literature to build an evidence base, complemented by multisectoral stakeholder consultations, emerged as a promising practice. Structural support for this process is a prerequisite for concerted and integrated action, and two informants at the regional level illustrated how organizational transformation made it possible for health promotion to have a clear mandate to involve agents from different sectors in their work on social determinants of health. This structural support was also perceived to be a success factor for evaluating interventions, either via built-in funding, a university partnership or other means. Finally, while almost every country had a mechanism in place to disseminate successful interventions and to pool knowledge, finding effective ways to sustain individual interventions that resist changes in the political climate

remains a real challenge, for which a participative approach and constant advocacy are potential solutions.

Conclusion

The responses provided by our informants illustrate a range of practices, mechanisms and tools which we were able to only superficially explore. Nevertheless, a sense of common priorities and values did emerge. An approach focused on the social determinants of health is perceived as a promising way of addressing the needs of socioeconomically vulnerable people while improving the gradient and population health as a whole, and that this approach is within the jurisdiction of health promotion. Furthermore, our informants highlighted the need for those working in prevention and health promotion to coordinate and collaborate with partners from other sectors through formal structures. Lastly, one essential asset is the capacity for municipalities or regions to autonomously manage the implementation of national public health priorities in order to remain responsive to the local context, as well as to retain responsibility for action at the operational level by proposing knowledge-sharing opportunities for professionals at local and regional levels. The richness and diversity of the concrete practices shared in this report offer several avenues of action that public health professionals in France could draw inspiration from and adapt, so that France may chart its own course to health equity.

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1. BACKGROUND

The reduction of health inequities has become the preoccupation of many governments, be they on the national, subnational or local level. While the need to act has been widely acknowledged, lesser known (and even lesser proven) are effective methods to do so (Bambra et al., 2010). In addition to and amplifying this lack of actionable knowledge is the uncharted territory of how, concretely, to choose, fund, and deploy initiatives and means that tackle social inequalities in health from a prevention and health promotion perspective.

Each country has adopted its own delivery mechanisms and entry points in this respect. To name a few, they may differ in the extent to which these mechanisms are proactive (in that they emerge from an explicit strategy and rely upon a fully developed framework) or reactive (in that they emerge to meet sudden demands and as such are expedient but have little to no strategy or framework). Further, they may differ in the values underlying their strategies, the intervention or policy approaches espoused by strategies, how resources are mobilized, the extent to which strategies determine what is actually implemented, and relatedly, what accountability exists for the strategy as well as for the programs, interventions, or policies that are implemented in its wake. Lastly, they may differ in the impact their approach has on population health as a whole, on the health of the socioeconomically vulnerable and on health

inequities.

In addition to this, different countries have different lenses through which they conceptualize social issues. France has a particular lens on *la précarité*, literally “precariousness”, a concept that is defined by the French government as “the absence of one or more of the securities that allow people and families to fulfill their basic responsibilities and to enjoy their fundamental rights” (translated by the author). We translate “les personnes précaires” henceforth as socioeconomically vulnerable populations. Five categories of the socioeconomically vulnerable have been historically defined by the French national statistics agency (INSEE): the unemployed, those receiving the country’s basic social allowance, those on a state-assisted work contract, the homeless, and young people aged 16-25 who are out of school and looking for work (Moulin et al, 2005 citing 1992 arrêté). This definition, largely dependent on the use of social protections, has since evolved into a more general definition of people who are experiencing **an accumulation of unstable life circumstances** that generate difficulties, thereby threatening the social links that bring support and recognition in the different social spheres of one’s life: family, the working world, one’s neighborhood, and friends (Chauvin & Estecahandy, 2010). This concept has been prevalent both in the way the country describes

¹ Such as being a family member, a citizen, an employee, etc.

social inequalities in health within its borders and in the approaches and mechanisms it has adopted and implemented in order to reduce said inequalities.

The French National Institute for Prevention and Health Education (INPES)² is a government agency tasked with the implementation of prevention, health education and health promotion policies in the framework of the French Ministry of Health's priorities. It is also a major funder of prevention and health promotion initiatives in France. INPES would like to use its position to address the needs of socioeconomically vulnerable populations to tackle health inequities but needs guidance on how to decide what to

fund and how to make sure its funded actions are effective and sustainable. The institute has asked the IUHPE to gather international examples that could support this process.

The objective of this environmental scan/scoping study was to explore different countries' approaches to funding and deploying initiatives and means (human, material, financial) that address socioeconomically vulnerable populations (*personnes précaires*) through a prevention and health promotion perspective. An additional objective was to provide examples of structural policies that reduce health inequities.

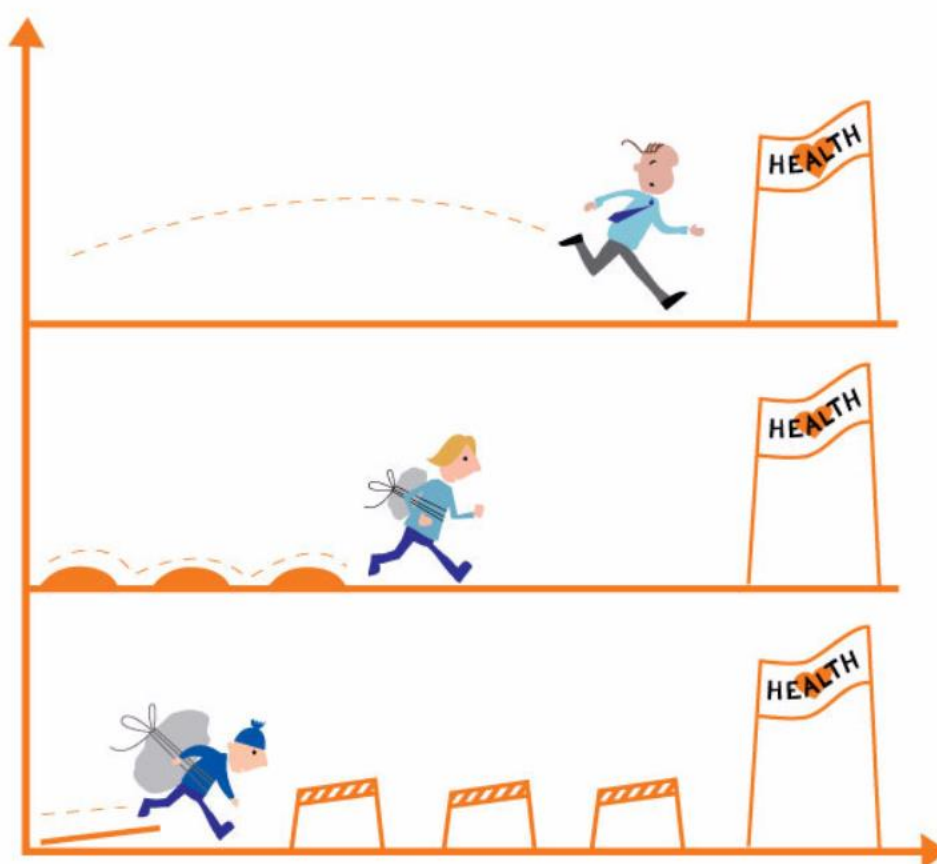


FIGURE 1. SOCIAL INEQUALITIES IN HEALTH. (SOURCE: NORWEGIAN MINISTRY OF HEALTH AND CARE SERVICES, 2007).

² As of May 1, 2016, the INPES has merged into a new agency, Santé publique France (Public Health France). INPES is retained throughout as the funder of the study.

2. METHODS

In order to provide a wide variety of responses that could be of relevance to the French context, we first identified ‘developed’ countries that, based on our experience within the IUHPE network, we knew had promising mechanisms, practices or policies. Additionally, within the larger countries a mix of levels—regional, provincial/state, and national/federal—was sought. Beyond the jurisdictions, we also included agencies and foundations.

An advisory committee was formed, tasked with guiding the development of the questionnaire, generating ideas of potential informants and more generally providing guidance and approval of the different parts of the project. The committee convened four times by telephone through the course of the project. Members were chosen and invited based on their expertise in the field of health promotion and tackling health inequities. The members of the committee are presented on page 4.

The initial list of possible informants was built by brainstorming and recommendation, first of experts from within our network and experts suggested by our advisory committee. They were chosen for their level of expertise within the selected jurisdiction as well as familiarity with other contexts internationally. Negative responses from this list of informants were asked to recommend others in their country who could also be invited.

The questionnaire sent to informants, available in Appendix 1 in English (p.39) and Appendix 2 in French (p.41), is structured in the following manner: questions concerning the context, in terms of leadership and governance, of the country; questions about how decisions on program/service/initiative funding and deployment are made, and on what level(s); a question mechanisms of program deployment on each level; questions regarding intersectoral action, accountability and sustainability; and finally, an opportunity for respondents to highlight successes and innovations not mentioned earlier in the questionnaire.

The questionnaire was sent by email to 22 informants in 9 countries, with an invitation to participate in the study. Of these, 6 informants from 5 countries (Australia, Canada, Finland, Spain, and Switzerland) returned full responses, and one responded with an email containing information and documentation without completing the questionnaire. We also offered the chance to respond via interview instead of questionnaire to those who either responded that they did not have the time to complete the questionnaire, or responded late in the project period. We ended up conducting semi-structured interviews with 6 informants from two countries (Australia and Canada). Appendix 3 (p. 43) provides a complete list of informants contacted. It is important to note that a very high proportion of Canadian informants responded positively to

our invitation, while we were unsuccessful recruiting informants in the Netherlands, the UK, Sweden and Norway.

Questionnaire and interview responses were pooled. The contents were analyzed thematically through an inductive process. The themes closely correlated to the questions asked in the questionnaire, with additional themes emerging. The results first present the different governmental strategies that drive efforts to reduce health inequities in different countries or provinces. Next, different funding mechanisms

are presented. Following that, we explore the types of interventions highlighted by our informants. We then present some examples of rules for allocation of resources. Lastly, we show the different approaches taken by jurisdictions to ensure accountability and sustainability, as well as knowledge pooling mechanisms. For each, we first analyze the general tendencies, with examples to illustrate the diversity of approaches. Then, boxes are presented to delve more deeply into specific examples that appear particularly innovative, impactful, or that could be of special interest to France.

3. RESULTS

In conducting our interviews and reviewing the completed questionnaires, an immediate observation was that the majority of informants, though asked specifically about prevention and health promotion actions for socioeconomically vulnerable people, rarely answered in these terms. Instead, responses seemed to concentrate on actions addressing the social determinants of health. Indeed, informants tended to reframe our questions to reflect the paradigm under which they were working and as a result, very few talked about interventions targeting only the socioeconomically vulnerable. When this did emerge, it was in the context of proportionate universalism³. In the latter case, universal interventions or policies are intensified or tailored to different levels of socioeconomic

status in order to “level up” in health through the entire social gradient. Throughout, jurisdictions tended to see action on the social determinants of health as a necessary step towards tackling health inequities, and that the needs of the socioeconomically vulnerable could not be properly addressed without effectively working on the social determinants.

Informants also infused the entirety of the questionnaire with information regarding intersectoral action. It is at once the value, structure and technique that emerge time and time again as critical to effective action. In light of this, examples have been woven throughout instead of being confined to a separate section.

3.1 STRATEGIES TO TACKLE HEALTH AND SOCIAL INEQUITIES

Countries, provinces, states and territories differ in the degree to which their governmental strategies explicitly mention the reduction of health inequities. They also differ in the origin and leadership of the strategy. Ministries of Health are often the authors of said strategies but not exclusively, as Quebec’s Anti-Poverty and Social Exclusion Law and the Finnish Government Programme show. Additionally, the strategy may or may not mention specific priority

populations that are to be given special consideration when designing programs to implement the strategy.

Since the 1980s, successive Finnish governments have produced numerous strategies and policy papers around tackling inequalities in health. The most important of these is the Government Programme, a policy paper that sets the priorities for the national

³ Participants also discussed targeting within universalism, a related concept that is more common in North America.

government's four-year term. Finland's current Government Programme (2011-2015) includes social inequalities as a priority area as well as social cohesion (<http://valtioneuvosto.fi/hallitus/hallitusohjelma/en.jsp>). In the health sector, the "Health 2015" strategy, launched in 2001 by the Ministry of Health and Social Affairs and based on the Health for All programme of the WHO, aims to improve the health of Finns with a cross-cutting aim "to reduce inequality and increase the welfare and relative status of those population groups in the weakest position". This document goes further by explicitly aiming for a 20% reduction in employment-, education-, and gender

-related health inequalities by 2015. As part of the implementation of this objective of Health 2015, a National Action Plan to Reduce Health Inequalities was executed from 2008 to 2011 (Ministry of Social Affairs and Health, 2008).

The plan focused on (1) policy measures on the social determinants of health (income security, education, housing and unemployment), (2) targeting within universal behavior change measures (tailoring or intensifying interventions for disadvantaged groups), and (3) improving access to and quality of universal health and social services. Its implementation required the cooperation of all sectors, not just health.⁴ Today,

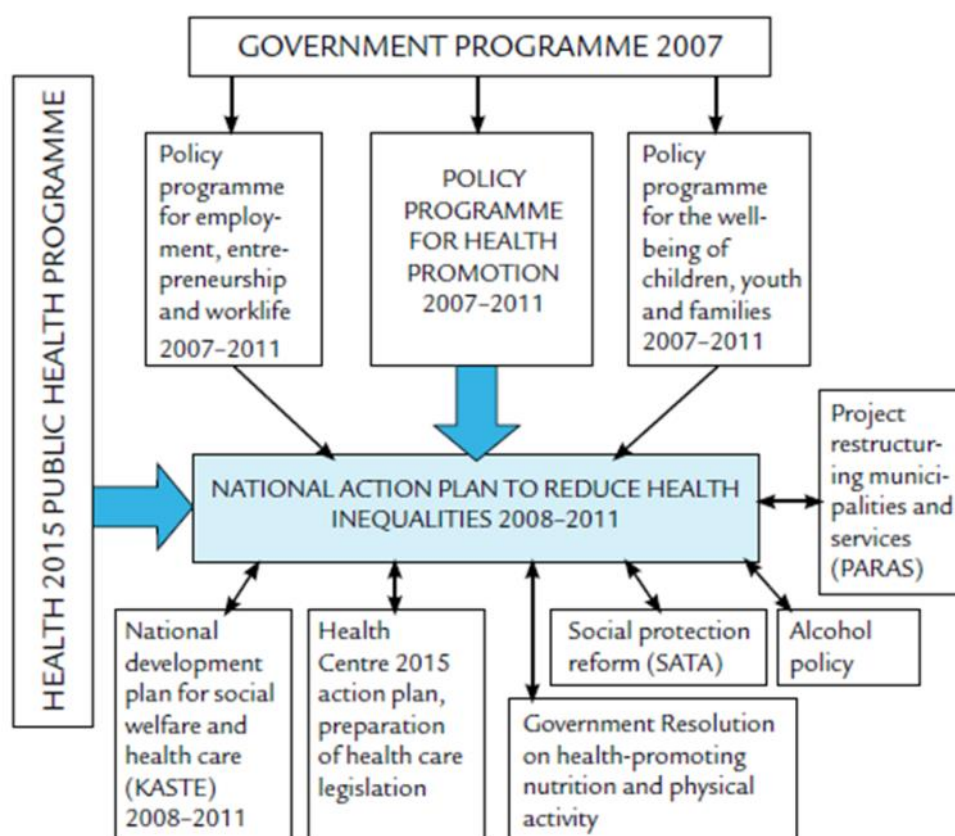


FIGURE 2. LINKS OF THE FINNISH NATIONAL ACTION PLAN TO REDUCE HEALTH INEQUALITIES TO OTHER PLANS AND PROGRAMS. SOURCE: MINISTRY OF SOCIAL AFFAIRS AND HEALTH (2008)

⁴ It is important to note that while the action plan achieved many positive outcomes, as of yet an improvement in health inequities is yet to be observed (<http://www.thl.fi/en-US/web/kaventaja-en/national-programmes>). It is encouraging that through this plan, tackling inequalities gained public and intersectoral acceptance as a societal goal.

the strategy “Socially Sustainable Finland 2020” aims to create a socially sustainable country by reducing health gaps, providing adequate social protection, attaining longer working careers through well-being at work and achieving a balanced economy and social development (see Box 1).

In the province of Quebec, Canada, health and social inequities are brought to the fore via three different strategies. The Public Health Law of 2001 created the National Public Health Program⁵ and it addresses inequalities by requiring the Minister of Health to prioritize those programs that act on the determinants of health, particularly those that have an impact on health inequalities. A second pertinent national strategy came not from the health sector but from the Ministry of Labour in 2002. The Anti-Poverty and Social Exclusion Law (author’s translation) has among its aims the reduction of inequalities that threaten social cohesion. Third and lastly, Article 54 is a law requiring consultation with the Ministry of Health for any policy, law or regulation that could carry a health impact.

Also in Canada, the province of British Columbia (BC) has launched a “Guiding Framework for Public Health” (2013). This strategy establishes a long-term vision for the province’s public health system. It specifically outlines public health’s role in health equity, emphasizing the need for universal initiatives that have added scale or

intensity for vulnerable populations. The strategy capitalizes on the province’s Core Public Health Functions, an evidence-based framework that provides the key set of public health programs and strategies that regional health authorities should implement. The framework has an equity lens that cuts across all programs and strategies.

In Australia, the state of Victoria has developed and launched its first Public Health and Wellbeing Plan (2011-2015). The plan, issued by the Ministry of Health, establishes objectives and policy priorities for the promotion and protection of public health and wellbeing as well as the development and delivery of public health interventions. One of the state’s nine strategic directions for prevention, as identified in the plan, is to “tailor interventions for priority populations to reduce disparities in health outcomes” (State of Victoria Department of Health, 2011). Additionally, and of special relevance to us, the objective of strengthening the prevention system includes a finance and resource allocation ‘building block’ where the vision of what a good funding model looks like is outlined: “Funding models should enhance partnerships and collaboration between government and the community sector, as well as removing impediments to achieving good outcomes. Funding models should support population-based interventions that are integrated and improve population-level health and wellbeing.”

⁵ Programs, strategies, and plans that cover the whole of Canada are referred to as “federal” in this report. On the provincial level, the word “provincial” is used with the exception of Quebec, where the word “national” is used.

Box 1: SOCIALLY SUSTAINABLE FINLAND 2020

Finland's Ministry of Social Affairs and Health released this comprehensive strategy in 2011. Socially Sustainable Finland 2020 distinguishes itself from other strategies presented in this report precisely through its focus on sustainability. It integrates emerging challenges of demographic shift; changing economic, environmental and technological realities; and cross-border mobility and multiculturalism into how social services and health/wellbeing promotion efforts are oriented. Its three pillars or "strategic choices" as they are termed in the document, are the following:

1. A strong foundation for welfare
 - Health and welfare in all policies
 - Longer working careers through wellbeing at work
 - Balancing the various areas of life
 - Sustainable social protection financing
2. Access to welfare for all
 - Reduce differentials in welfare and health
 - Customer-oriented services
 - New service structures and operating practices
 - Strong sense of social inclusion
3. A healthy and safe living environment
 - Strengthen the viability of the environment
 - Ensure that society can continue to function under exceptional circumstances

With regards to health inequities, the strategy places intersectoral cooperation in the forefront. It also presents an upcoming action plan to improve the social status of low-income people. The strategy also emphasizes that in addition to universal "social welfare and health care services intended for all, measures will be

targeted at vulnerable population groups such as low-income elderly people."

The strategy also outlines how these priorities will be translated into action, "putting policies into practice":

- ◇ "Cooperation secures welfare": implementing intersectoral collaboration through binding legislation, funding mechanisms, and informational guidance.
- ◇ "Active influence in international cooperation": working to make sure Finland's health and social concerns are represented in EU policymaking in all sectors.
- ◇ "Knowledge-based decision-making": using health status monitoring and creating a network of expert institutes to improve the evidence base for decision making.
- ◇ "Effective communication": developing new, networked communication models and reinforcing cooperation for improved communication.

(Ministry of Social Affairs and Health, 2010)

The National Development Plan for Social Welfare and Health Care, also known as the Kaste Programme, is one way through which the Ministry of Social Affairs and Health operationalizes the above strategy, even though the first iteration of the program existed before the strategy (http://www.stm.fi/en/strategies_and_programmes/kaste). This four-year guidance tool aims to reduce inequalities in wellbeing and health and ensure that social welfare and health care structures and services are organized in a client-oriented and economically sustainable way (see Figure 3 on the next page).

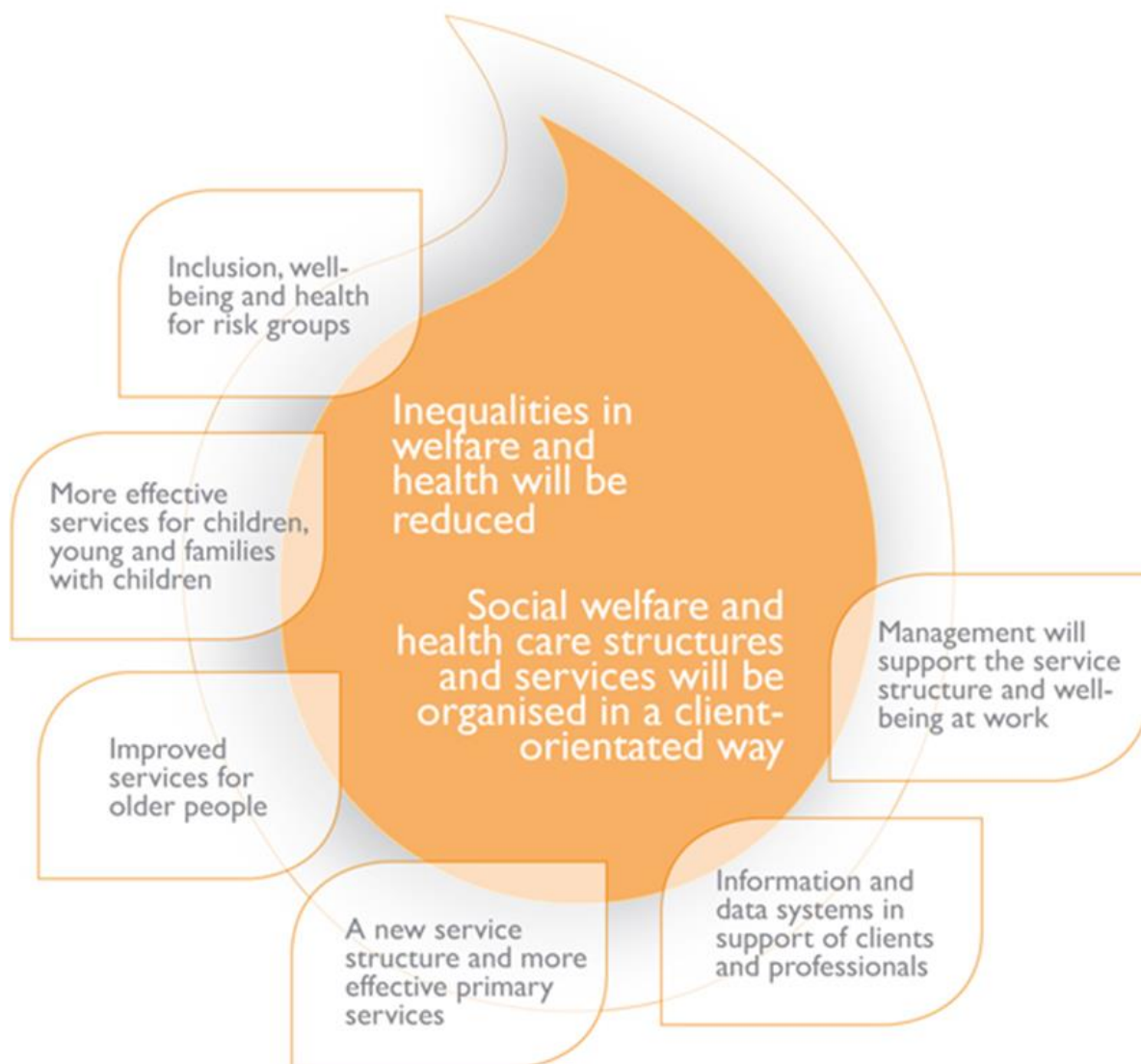


FIGURE 3. THE KASTE PROGRAMME 2012-2015. (SOURCE: FINNISH MINISTRY OF SOCIAL AND HEALTH AFFAIRS, 2012)

3.2 FUNDING MECHANISMS

We present below a selection of approaches to distributing funding for health promotion and disease prevention programming among our respondents. In truth, jurisdictions utilize several mechanisms concurrently, so each example should be considered as operating within the larger context of territorial resource allocation. In addition, it should be noted that the funding mechanisms described by our informants are quite general and

often apply to the whole of public health spending, within which action for the socioeconomically vulnerable could be included.

Funds for prevention and health promotion in Canadian provinces will often be allocated to regions as part of overall health funding, without distinguishing it from healthcare services funding. British Columbia, for example, will provide block fun-

ding to regional health authorities, whose boards will decide how much is allocated to health promotion versus health care, depending on the priorities they have articulated. The same is true of Quebec: regions are given block funding and depending on their priorities they may make faster or slower progress on different parts of their action plan by devoting more or less funding. Provincial ministries of health also fund projects directly through NGOs or local governments.

Quebec's Ministry of Health and Social Services has a program, "Programme de soutien aux organismes communautaires", which delivers three-year operating grants to local, regional and national health and social community and volunteer organizations. The program funds approximately 3000 organizations across the province. Along the same lines, the Finnish Slot Machine Association (RAY) exists to raise funds for Finnish health and social welfare organizations. The gaming organization's entire proceeds (from slot machine, online gaming and casino gaming operations) are used to support approximately 800 Finnish NGOs per year, with a small portion funneled to war veterans. RAY sets strategies over a four year period; the current (2012-2015) strategy prioritizes organizations that work on building self-sufficiency and reducing health inequities (<http://www2.ray.fi/en/ray/operations/funding/fundingstrategy>).

Another mechanism delivers funds to NGOs through a decision-making body that includes NGOs themselves. The Community Action Initiative in British Columbia, Canada is a group of community-based mental health NGOs that have traditionally competed against each other for funding and that have come together with government representatives. The group has received lump-sum funding from the province (\$10 million) and decides on where it should be directed.

This last example shows the benefits of transforming the usual competition over resources into coordination. A similar transformation is at work in the Girona province of the Catalan Autonomous Region. Through its "Health and Crisis" program, the provincial organization Dipsalut has established local committees in each county composed of representatives from the private and public sectors whose work concerns the social determinants (education, housing, social services). Each committee coordinates a single project that is designed and implemented by consensus. Dipsalut then funds this project. This funding mechanism encourages cooperation, generosity and trust between local actors.

BOX 2A: GRANTS AND CONTRIBUTIONS (CANADA)

The Public Health Agency of Canada (PHAC) has developed Grants and Contributions programs to fund activities that address prevention and health promotion and that aim to reduce inequities or target socially, economically and geographically vulnerable populations. 25 programs, including *Multi-sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease*, the *Healthy Living Fund*, *Community Action Program for Children* and the *Federal Tobacco Control Strategy*, currently fund around 1100 projects. Different departments and agencies are responsible for the programs, including actors outside health, but all programs are governed by the Canadian Treasury Board Policy on Transfer Payments. The Treasury Board approves Terms and Conditions for any new or renewing transfer payment program.

The projects funded through these programs can be run by community, voluntary, not-for-profit or private sector organizations. They can also be funded through partnerships with provinces. For example, the Healthy Living Fund has two funding streams: the national stream funds voluntary non-profit organizations while the regional stream takes the form of bilateral agreements between PHAC and provincial territorial governments. In this second stream, both levels of government set priorities jointly, issue solicitations, review project proposals jointly, and invest funds that go directly to non-governmental organizations in support of joint priorities. Each level of government invests approximately the same amount of funding over the life of the agreements.

The grants can be for one or several years, with amounts varying from a few thousand to several million dollars. For example, projects applying for funds under the program *Multi-sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease* can request between \$200,000 and \$5 million for a funding period ranging from 24 to 60 months. This program also contains a matching requirement of 1:1 to 1:3, meaning the project must be 25% or 50% funded by another entity.

For Grants and Contributions programs, one of three solicitation processes can be followed: open solicitation, whereby an 'Invitation to Submit Applications' (ISA) identifies a wide audience and the funding program launches an ISA on its Web page and any other means of communication to reach as many applicants as possible; a targeted solicitation, whereby an ISA identifies a specific type of applicant, discipline, or geographic area and the funding program communicates directly with the potential applicant(s); and a directed solicitation, whereby an ISA identifies a specific type of applicant from a specialized field and the program communicates directly with the potential applicant(s). At this time the program *Multi-sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease* uses open solicitation, while the others are closed or directed. (for more information: <http://www.phac-aspc.gc.ca/fo-fc/index-eng.php>)

BOX 2B: PUBLIC-PRIVATE PARTNERSHIP (QUEBEC, CANADA)

The Lucie and André Chagnon Foundation is a private philanthropic foundation whose mission is to prevent poverty. Over the years, it has evolved from being an entity that directly funds projects to one that solely operates through three public-private partnerships: *Avenir d'Enfants*, *Québec en Forme* and *Réunir Réussir*. The first two are particularly pertinent to our investigation.

In 2009, the Foundation signed a partnership agreement with the Government of Quebec that established a joint early childhood development fund, and subsequent non-profit organization named *Avenir d'Enfants* (Children's Future). This organization is responsible for managing the fund, valued at CAD\$400 million (\$250 million from the Foundation and \$150 million from the Quebec government) over the 10-year period from 2009 to 2019. *Avenir d'Enfants* strives to advance the overall development of children five and under living in poverty by helping local communities create and carry out action plans through funding and technical

support. Specifically, it funds 128 local (county level) intersectoral groups and 11 regional organizations.

Québec en Forme (Quebec in Shape) is a partnership that predates *Avenir d'Enfants*. It was initially established in 2002 and was renewed in 2007. In 2010, another fund (*Fonds pour la promotion des saines habitudes de vie*) was merged with *Québec en Forme*. The current organization manages CAD\$480 million over 10 years (CAD\$200 million from the Foundation and \$220 million from the Quebec government). Its objective is to encourage young people to adopt and maintain a physically active lifestyle and healthy eating habits through mobilizing communities, changing environments and transforming social norms. NGOs and local partner groups are funded, as with *Avenir d'Enfants*, to support the creation and implementation of local action plans. Regional and national projects can also be funded if they emerge from a regional consultation process and support the work being done by local partner groups.

3.3 INFORMATION USED TO MAKE DECISIONS ABOUT WHERE TO ALLOCATE FUNDS (RULES FOR ALLOCATION)

We have already discussed a few key examples of different strategies that governments have developed and implemented with respect to tackling health inequities and addressing the needs of socioeconomically vulnerable populations. We have also presented some of the funding mechanisms in place to provide resources to population health and health promotion interventions at the local, regional and national levels. This next section describes how decisions are made on whom and what to fund. While one could argue that in theory the strategies should directly inform decision-making, the examples below illustrate the complexity of

the reality, and how different countries have integrated competing interests.

The kind of evidence used to inform decision-making can be local or international in scale. Local and regional health and social information systems like those used in Saskatoon (the “Community View Collaboration”) allow decision makers from multiple sectors to see how small areas fare in terms of key health and social indicators (see Figure 4). Of particular importance is the ability to layer different data sources at small geographic area-level. At the national level, Quebec uses information on

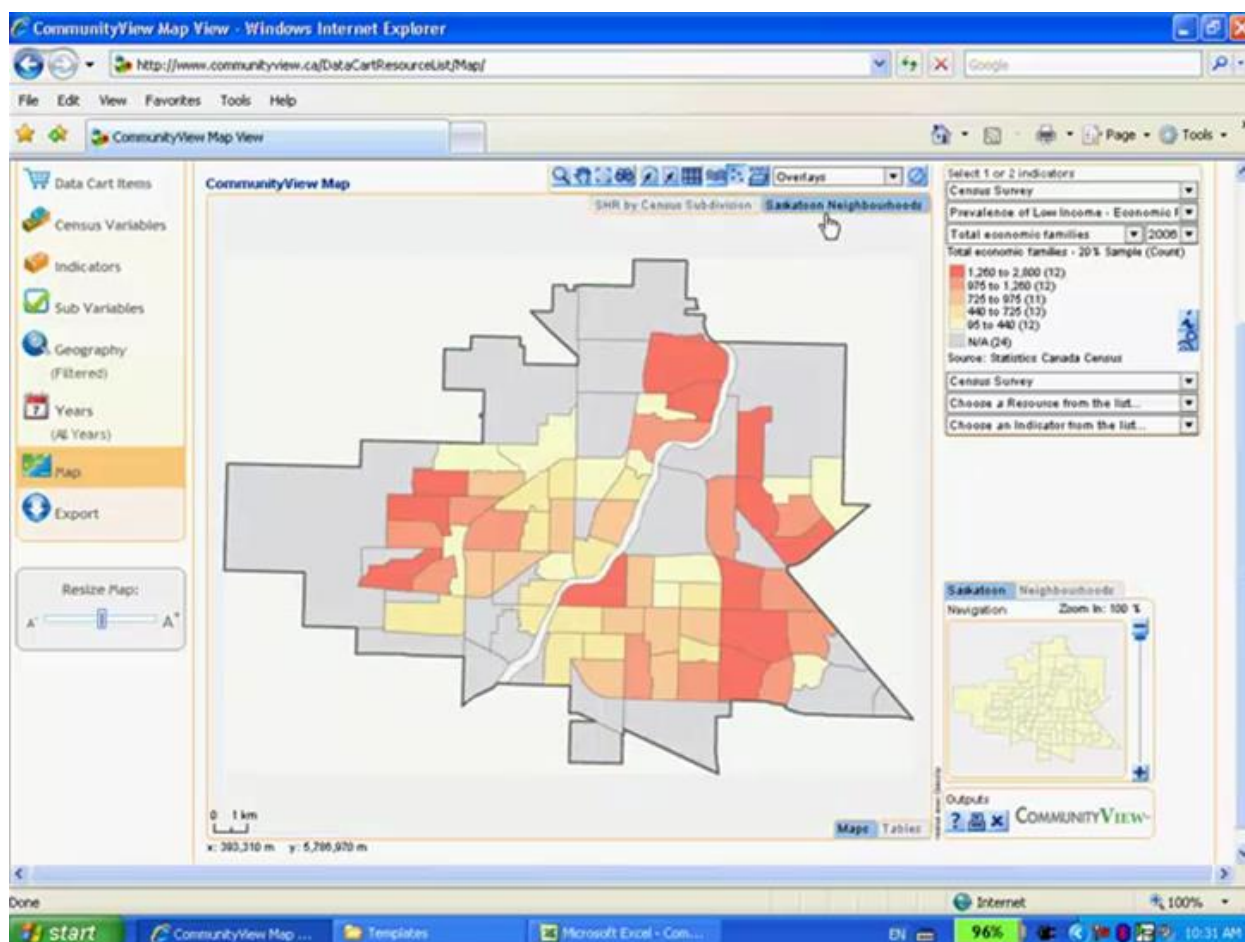


FIGURE 4. COMMUNITY VIEW COLLABORATION MAPPING TOOL.
(SOURCE: [HTTP://WWW.COMMUNITYVIEW.CA](http://www.communityview.ca))

population density and relative wealth to calculate how health funding should be equitably distributed among the regions. Furthermore, every single action in the National Public Health Program has a cost attached, calculated with the help of experts (*coûts normés*). These costs are produced using sophisticated calculations that require extensive negotiation and they are subject to constant updates. This tool helps regions decide how to allocate the block funding they receive in order to implement their regional public health plans.

The federal “Multi-sectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease” program of the Public Health Agency of Canada asks grant applicants to submit a Letter of Intent. The agency then assesses the project on the following criteria: inclusion of multi-sectoral partnerships, ability to demonstrate measureable

results, foundation in evidence and the potential to be expanded (scaled-up) into other areas of the country, other target populations (such as the socioeconomically vulnerable), different settings, or to address other chronic diseases or risk factors (<http://www.phac-aspc.gc.ca/fo-fc/mspphl-pppmvs-eng.php>). Applicants who meet these criteria are invited to then submit full proposals, which are only considered where funding can be tied to the completion of outputs/outcomes as measurable results. The program falls under two federal strategies, the Integrated Strategy on Healthy Living and Chronic Disease and the Federal Tobacco Control Strategy, which means funded projects are expected to “[focus] efforts on innovative, integrated approaches that promote healthy living, prevent chronic disease and address common risk factors.”

BOX 3: SASKATOON HEALTH REGION

An evidence base and consensus form the basis of decision-making in Saskatoon, Canada. The Chief Medical Health Officer of the Saskatoon Health Region published a major report in 2006 detailing the region's health disparities, from which emerged the link between the concentration of poverty in inner city neighborhoods and poorer health outcomes. An international review of evidence-based policies was then conducted to learn what had been done elsewhere in terms of improving health by reducing the income gap and/or improving education, housing and employment. The results of this review form the second half of the 2008 Saskatoon health disparities report, including 46 recommended policy options gleaned from the review (Lemstra & Neudorf, 2008). The Saskatoon health promotion department then presented early drafts of the report to the Regional Intersectoral Committee, city councilors, the board of the health region, members of the provincial legislative assembly, federal-level parliamentary committees and the federal Senate. They were given the chance to offer feedback on the data and recommendations before the report was released, garnering buy-in and avoiding a situation where the government would be embarrassed by the report. The report was also shared with intersectoral partners, including the business sector, community groups and First Nations groups. Through consultation and discussion with each, the department was able to identify 17 of the 46 recommendations that had *unanimous* support. These 17 evidence-based policy options, all of which benefit socioeconomically vulnerable people, became the starting point for action:

1. Develop a Multi-Year, Targeted Plan to Reduce Poverty
2. Remove Work Earning Clawbacks
3. Index Social Assistance Rates to Inflation

4. Increase Public Understanding of Social Determinants of Health
5. Increase Support for Community Schools
6. Universal Child Care for Low Income Parents
7. Reserve Education Placements for Low Income People
8. Expand Affordable Housing Projects
9. Support for Home Ownership
10. Develop a Long-term, Consolidated, Comprehensive, Interagency Social Housing System for Hard to House Individuals
11. Increase Monthly Shelter Allowances
12. Renewed Federal Responsibility for Social Housing
13. Setting Measurable Goals: More Work for Aboriginal People
14. Comprehensive Return to Work Programs
15. More Health Resources in Low Income Neighbourhoods
16. Resident-Led Neighbourhood Development
17. Broader Engagement with Labour and Business Communities

For all 46 original evidence-based policy options please see Appendix 4 on page 44.

3.4 HEALTH PROMOTION INTERVENTIONS THAT BENEFIT SOCIOECONOMICALLY VULNERABLE POPULATIONS

This section serves to highlight the different intervention approaches taken by different jurisdictions to improve health outcomes for the socioeconomically disadvantaged and reduce health inequities. Interventions mentioned by respondents tended to focus on the following topic areas: poverty reduction, housing, prenatal/early childhood, and healthy weights/nutrition/physical activity in schools.

The first two areas clearly tie to a social determinants agenda; acting on poverty and housing to improve health and reduce health

inequities are two central recommendations from the 2008 WHO Commission on Social Determinants of Health report. Informants presented interventions on poverty reduction and/or housing in Girona (Box 4a), Saskatoon (Box 4b), Quebec and Victoria. In all of these interventions, local partnerships with existing poverty and housing associations play a key role in implementation. The health promotion or public health authority can be the funder and/or the coordinator of these projects. In the case of a housing intervention in Victoria, VicHealth

Impact model: National Programme on Migration and Health

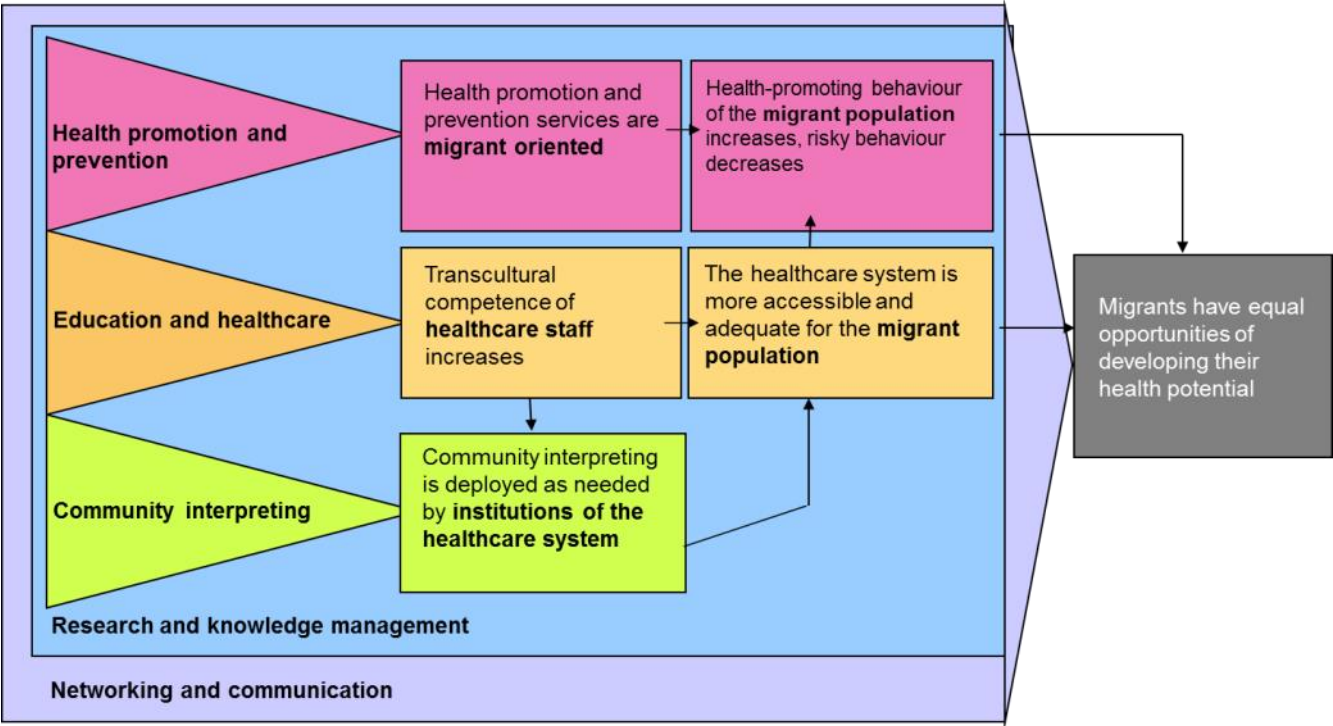


FIGURE 5. MIGRATION AND HEALTH LOGIC MODEL. (SOURCE: SWISS FEDERAL OFFICE OF PUBLIC HEALTH)

funded one of its employees to work full-time onsite to build the capacity of residents to govern their own community.

The other two areas point to a life-course approach, where efforts focus on a sub-population of the socioeconomically vulnerable; pregnant mothers, infants and children born into poverty are the focus of interventions not only to mitigate health inequities among this age group but also to bolster the health of the next generation of adults and hopefully prevent the creation of inequities. British Columbia, Saskatoon, Sudbury, Quebec and Finland all mentioned interventions in these areas when asked about what their jurisdictions do in health promotion and prevention for socioeconomically vulnerable populations. Finland, for example, presented the development of welfare clinics providing early health and social support

services to families in need in the city of Imatra.

In contrast, Switzerland, which has always enjoyed relatively low levels of health inequalities, chooses to focus its intervention efforts among its migrant population. “Migration and Health” is a set of programs intended to make the entire health system, including in prevention and health promotion, better adapted to the needs of migrants (see Figure 5). Specific interventions include the creation of a health information portal geared towards migrants and offered in a dozen languages (www.miges.ch), and needs assessments funded by the Federal Office of Public Health in order to assess whether or not cantons addressed the needs of migrant populations in their prevention and health promotion programs (with some post-assessment technical support for those cantons who need it).

BOX 4A: HEALTH AND CRISIS

The previously mentioned Health and Crisis program in the Girona province of Catalonia has three areas of intervention: basic necessities, housing, and emotional wellbeing. In the first category, projects ensure the supply of food, hygiene and clothing for vulnerable families. For housing, projects can subsidize rent or mortgage payments to avoid eviction or foreclosure; other actions can include reducing the impact of energy poverty (inability to pay for electricity and heating) by subsidizing utilities. Lastly, emotional wellbeing actions are included in the program in order to facilitate people's ability to understand the situation they are in, promote capacities (knowledge, skills and attitudes) to manage their situation and thirdly, promote the establishment of vital objectives allowing people to recover a sense of hope. The program has adopted the mandate not to violate the Universal Declaration of Human Rights and the Convention on the Rights of the Child as its foundational value. It is informed by evidence in the design, implementation and evaluation of projects, and uses salutogenic and health assets frameworks. The interventions target not only the empowerment of the socioeconomically vulnerable population but also that of the volunteers and professionals implementing the intervention. The ultimate impact of the program, beyond mitigating the health and equity impacts of the financial crisis, is to build capacity and networks for a new local governance.

A Health and Crisis project has been implemented by Ripollès County, a mountainous area covering 19 municipalities and a population of 10,904 inhabitants. Local social services and NGOs came together through the Bureau for Inclusion (a work space for territorial social exclusion-related program planning between professionals and local volunteers) and designed the six following activities:

1. Basic nutrition to children at risk: coordinated work between Social Services and Red Cross in order to ensure food to children (0-3 years old) in situations of vulnerability.
2. Food and hygiene: the aim is to complete food for families under the care of social services and non-profit organizations in the region. Also to supply hygiene products. Coordinated work between Social services, other administration services, Caritas and Red Cross.
3. Energy poverty: provide means of warmth to people without income. Coordinated work between social services and Caritas.
4. Grants for utilities (water, electricity), rental housing and mortgages. Grants access to a new home. The goal is to ensure vulnerable citizens live in sanitary and habitable conditions in their homes. Work between Social Services and Caritas.
5. Personal and family skills workshops: The aim is to motivate and improve the self-esteem of participants in the workshops to adopt a more positive attitude in their daily lives. Work between Social Services and Caritas.
6. Social Orchards and ecological horticulture: This activity relates basic needs, employability and emotional wellbeing. Non-profit organizations have made agreements with landowners for use of their land. The project's aim is to cultivate the land in order to:
 - a. Occupy people who have been unemployed for some time and who are in a vulnerable situation;
 - b. Obtain vegetables to complement dry food the participants receive from food banks; and
 - c. Improve emotional well-being of these people and their families, and reduce the negative impact that the crisis is having on health.

BOX 4B: POVERTY2POSSIBILITY

The Saskatoon Health Region's Poverty2Possibility poverty reduction program is an example of how health promotion can implicate several other sectors in improving the health of the socioeconomically disadvantaged through action on the social determinants of health, here poverty. A coalition composed of government representatives (from local, regional and provincial levels), NGOs representatives, and people with a lived experience of poverty, as well as people from First Nations groups, faith-based organizations and the business sector. They have developed an awareness-raising and advocacy plan to communicate and help opinions evolve around the fact that poverty impacts health and that it is possible to reduce poverty through action. They have also launched concrete initiatives in the areas of housing and employment. A "Housing First" initiative (whereby the homeless are immediately placed in

permanent housing rather than successively placed in shelters, transitional housing and lastly, permanent housing) is underway thanks to a partnership between the Saskatoon Health Promotion Department and the local United Way. The partners developed a comprehensive plan to end homelessness through a broad consultation process that included local representatives from all sectors. Their projects focus on populations that have fallen through the cracks of existing government programs, namely, the working poor, people on social assistance, and people with mental health needs. The role of the committees working on this initiative is one of advocacy, fundraising, working with local builders and architects, and working with city councils to amend by-laws so that housing projects may be built.

<http://www.saskatoonpoverty2possibility.ca>

3.5 ORGANIZATIONAL TRANSFORMATION, AN EMERGENT FACTOR

Shifting currents in health promotion and public health policy have created demands for entirely new ways of working. The ideological evolution of health promotion from primary prevention and individual-level behavior change to a focus on community and society level changes, social determinants of health and a consciousness of health equity has been an impetus for organizational overhaul in a few of the jurisdictions/entities we queried: Saskatoon Health Region, Sudbury and District Health Unit, and VicHealth. Others did not mention it, though it is unclear if this is because they have long completed the transformation; their constitutional mandate of equality, social protection and welfare meant that very little organizational transformation was required to accommodate and translate into action evolving health promotion ideals; or simply because they have chosen (or been impelled to

follow) the path of least resistance by trying to change or add activities without changing the structure of the department, agency, ministry, organization, etc. However, as organizational transformation was not specifically asked about in the questionnaires or interviews, analysis is limited to those respondents who spontaneously brought up the issue.

What does organizational transformation mean? For the purposes of this report, it means reorienting the mission, objectives, and activities of the authority/organization. The process of organizational transformation takes years and the informants who mentioned organizational transformation in their interviews or questionnaires were in very different places in the process. The process itself is not singular: there are as many processes as there are organizations.

BOX 5A. SUDBURY AND DISTRICT HEALTH UNIT

The Sudbury and District Health Unit in Ontario, Canada had already made several efforts to address health inequities, including equity-based planning, a cost shared operation budget with a focus on health equity, and various position and advocacy papers. A health equity mapping project was undertaken in 2007-2008 to assess how public health activities in the unit addressed health inequities. The project revealed “a high degree of staff readiness and enthusiasm to learn about and engage in local actions to reduce social inequities in health” (Sutcliffe, Snelling, & Laclé, 2010). Several staff members then engaged in an EXTRA (Executive Training for Research Application) training over two years wherein they performed a review of the literature and identified ten evidence-informed promising practices with potential to contribute to reductions in health inequities at the local public health level: targeting within universalism, intersectoral action, equity-focused health impact assessment, social marketing, early child development, purposeful reporting, competencies and organizational standards, contribution to evidence-base, community engagement, and health equity target setting

(Sudbury & District Health Unit, 2011). These ten promising practices became the core practices around which the entire health unit was re-oriented. A ten-year sequential action plan was drafted in 2011 to help the health unit understand what new or enhanced activities the SDHU needed to engage in in order to advance the 10 promising practices and achieve their vision. In addition to these practices, the EXTRA fellows also identified evidence-informed strategies to effectively transfer this knowledge into practice. Within the context of the unit, knowledge brokering within the organization and building community support were identified as the strategies to employ. Since 2011, the SDHU has been concentrating on implementing these promising practices and strategies. One result has been the creation of a multi-disciplinary Social Inequities in Health Steering Committee. Another has been the incorporation of consideration of social inequities in health in the program planning process for all programs. Lastly, a shift in attitudes is taking place whereby a sense of responsibility for working on health inequities is spreading among program managers.

BOX 5B. SASKATOON HEALTH PROMOTION DEPARTMENT

The entire Health Promotion Department of the Saskatoon Health Region has reorganized itself to concentrate on the social determinants of health. Formerly called the “Healthy Lifestyles” department, it had focused its work and activities on championing and educating about lifestyle behaviors that prevent chronic disease under four main program areas: food security; breastfeeding, infant, and preschool nutrition; healthy eating and active living; and tobacco use reduction. Starting in 2007, the department engaged in a five-year restructuring process to transition from a behavioral focus to a social determinants of health focus. Towards the beginning of these five years, the department identified core commitments; the roles the department would play; and a plan that included their context, lens, goal, desired outcomes, and what they considered to be the pre-conditions for

change. Extensive dialogues, workshops and consultations were held over the first two years to engage and include all staff in the change process. The hiring of a manager experienced in organizational development, systems theory and models of change leadership ensured that this transition was done in a skilled, deliberate manner. One new value that has brought about an entirely new set of practices is encapsulated by the phrase, “Nothing about us without us”. People who represent populations formerly seen as the “target” of interventions are formally and meaningfully included in every stage of program planning and implementation (Saskatoon Health Region, 2014). The systematic integration of this participation is unique among the responses we received.

3.6 ACCOUNTABILITY (EVALUATION, REPORTING MECHANISMS, EQUITY INDICATORS)

Accountability mechanisms vary widely depending on the type of entity and type of activity, though all respondents had defined accountability mechanisms for all of their funded activity. A general impression is that jurisdictions are still in the process of developing robust equity-related indicators, especially in the domain of organizational indicators (versus health outcomes).

One good practice that was mentioned by several respondents was building in funding for evaluation. For example, activities funded by VicHealth (Australia) allocate at least 10% of the value of total program funds to evaluation costs when evaluation is to be done externally. Evaluation may also be done systematically by a funding body for its own programs (under which external projects are funded): for example, PHAC evaluates all of its Grants and Contributions programs every five years for relevance and effectiveness.

Some organizations, like Söste in Finland and VicHealth, also provide technical support to organizations for program evaluation. This can take the form of reporting templates, trainings, tools, and direct support.

University partnerships are another way for interventions to include high quality evaluations. For instance, the B.C. Nurse-Family Partnership

is being carried out by the local public health authorities in conjunction with a research team at McMaster University. In this case, the very intervention is a trial. For the Health and Crisis intervention by Dipsalut (Girona, Catalonia), the organization is partnered with a local university to help evaluate the program, although the evaluation itself involves all of the agents in the program.

In terms of reporting mechanisms, which are more often cited by provincial and regional governments than by organizations, several jurisdictions mentioned key indicators that municipalities and regions had to report. The indicators have been developed with regards to the strategy in place in a given territory. For example, B.C. has its guiding framework indicators, whereas Ontario has developed indicators around the Ontario Public Health Standards. In terms of measuring progress on health inequities, the indicators can be stratified (by SES, geographically, or otherwise) in order to measure the relative improvement in the indicator among subgroups. There were no specific equity-focused indicators presented by respondents, although the province of Ontario is currently in the process of developing and testing indicators around health equity at the organizational level.

3.7 SUSTAINABILITY OF ACTIONS

Nearly all of our respondents underlined the necessity of ensuring that actions to tackle health inequities were sustainable, while conceding the difficulty of doing so. In fact, more challenges than successes were cited. Interventions to reduce health inequities may take several years to demonstrate an impact, while the policy cycle is much shorter. For example, in Finland most activities in this area are project-based and projects are often funded for three years. The length of contract and uncertainty of contract renewal was also cited as a challenge in Australia, with a change of government playing a significant role in the non-renewal of contracts. However, there is some hope that the use of

extensively participatory practices on the local level will help to build the capacity necessary to sustain initiatives beyond project periods, such as in Saskatoon and in Girona. Another promising approach mentioned in this area is conducting advocacy activities with both the public and policymakers, as state and non-state actors in several jurisdictions are endeavoring to do, VicHealth being perhaps the most explicit example (Box 7). These challenges point out the need for measuring short term results and not just the long term impact, in order to maintain the interest and support of policy makers and funding organizations.

BOX 7: THE VICHEALTH 'INTEGRATE' APPROACH (AUSTRALIA)

VicHealth's programs are delivered through three approaches: Inform, Innovate and Integrate. This third approach specifically aims to take successful VicHealth-funded activities and sustain them in mainstream policy and practice. There are several ways it does so, including scaling up pilot programs through co-investment with partner organizations, informing policy change within state government, or building the capacity of a group to whom VicHealth can transfer the leadership of a program or service. Another part of the Integrate approach involves working with other funding bodies (corporations and philanthropic organizations) to "deepen [their] commitments" towards health promotion.

In the case of its Prevention of Violence Against Women (PVAW) program, the centerpiece of VicHealth's Integrate approach is a formal and public partnership with the newly established Foundation to Prevent Violence Against Women and their Children. The establishment of the Foundation was a unique opportunity that represented the fruit of years spent seeding evidence-based PVAW activity in the state of Victoria. It was recognized that sustainability of this work in other organizations and systems was the key to success, driven by state policy and resources.

The partnership is in its early stages. In order to achieve the consolidation and complete transfer of the PVAW program and resources, the process will take about 18 months and will involve:

- Consolidation of VicHealth activity by Dec 2015
- Ceasing any new VicHealth funding of

activity by Dec 2014

- Formation of key partnerships to enable transfer of continuing activity
- Commencing transfer of continuing activities by Jan 2015

Formal liaison takes place with a selected panel of industry and academic leaders to advise of integration strategies being planned and to seek their support in the process. A publication will be developed which documents the history and outcomes of the VicHealth PVAW program, ensuring that knowledge is retained and that VicHealth's contribution to a public health approach to PVAW is documented.

Not only will VicHealth's local government, workplace, and capacity building activities will be transferred to the Foundation, but another transfer will occur within VicHealth: key knowledge outcomes of past PVAW program activity, namely program design learnings and conceptual design learnings, will be transferred into VicHealth's new Mental Wellbeing initiatives.

VicHealth has continually assisted the state government to develop a cross-departmental approach to drive activity not only regarding PVAW but many other health promotion issues. The core of the Integrate approach thus relies on long-term sustained dialogue that, while it does not always lead to the creation of a Foundation, paves the way for important policy changes and greater inclusion of health promotion priority work in the state government.

<https://www.vichealth.vic.gov.au/media-and-resources/publications/preventing-violence-against-women-vichealths-integration-approach>

3.8 KNOWLEDGE-SHARING

Part of the question on sustainability asked how actors pooled knowledge and disseminated best practices. We share the responses separately here as they are disassociated from the question of sustainability of a given activity but rather, speak more generally about how promising practices or potential pitfalls can be spread within and between jurisdictions.

The existence of provincial committees bringing together everyone who holds a given regional office (director of a health authority, for example) was cited in BC and Saskatchewan as a useful knowledge-sharing mechanism. On a federal level, the Canadian National Collaborating Centres are designed expressly for investigating and disseminating best practices—the National Collaborating Centre on Social Determinants of Health, in particular, was mentioned by Canadian respondents with respect to work on health inequities (see Box 8).

Another venue for knowledge sharing is the Internet, and respondents gave examples that ranged from purely informational to highly

interactive. The Canadian Best Practices Portal is a site run by the Public Health Agency of Canada that provides credible, evidence-based resources to help public health professionals implement programs in their own communities (<http://cbpp-pcpe.phac-aspc.gc.ca/fr>). British Columbia has developed an online Fact Sheet Generator that allows professionals to generate a fact sheet on the issue of their choice, tailored to (and already focus-tested on) the population of their choice (<https://bcfsg.healthlinkbc.ca/>). In Finland, Innovillage is an open innovation environment for health and welfare. Funded by the Ministry of Social Affairs and Health, the Finnish Agency for Technology and Innovation, and the Finnish Slot Machine Association, Innovillage provides tools, events and support for the collaborative and open development of different ways to promote health and welfare (<https://www.innokyla.fi/about-innovillage>).

BOX 8. NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

In 2005, Canada established six National Collaborating Centres for Public Health, funded through the Public Health Agency of Canada. One of these, the National Collaborating Centre for Determinants of Health (NCCDH), has as its mandate the advancement of social determinants of health and health equity through public health practice and policy. They achieve this through the following activities:

- translate and share knowledge and evidence to influence interrelated determinants
- support the uptake and exchange of information, products and services
- identify gaps in research and practice
- engage in collaborative learning projects and support translation of applied research
- support inter-personal and inter-organizational connections that enable strong relationships

The NCCDH regularly publishes resources (systematic reviews, case studies and practice guides, to name a few) and organizes knowledge -sharing activities with public health officials throughout the country. Their website also contains an interactive map of organizations in Canada according to the role they play to address the determinants of health, their operating level, and their domains of activity (<http://nccdh.ca/organizations>). Frequent public webinars on such topics as “Targeting within universalism for health equity” and “How do I get a health status report off the shelf? Moving from equity to action” are preceded by online discussion sessions.

4. DISCUSSION

Through the preceding examples we have endeavored to show how different countries approach funding and deploying initiatives and means (human, material, financial) to address socioeconomically vulnerable populations through a prevention and health promotion perspective. We found that countries tended not to specifically target the socioeconomically vulnerable, and that there is a wide range of targeted populations (the disadvantaged, the working poor, low-income families, the unemployed, to cite a few) that overlap to a greater or lesser extent with the French “*personnes précaires*”. The strategies to improve the health of these populations can be grounded in universal efforts to improve the health of the population as a whole while pushing for greatest improvement among the least well-off; this gradient-based targeting within universalism or proportionate universalism approach was most present in those jurisdictions who had an explicit mandate to tackle health inequities and enjoyed enabling structural (historic, economic, and/or political) factors. The kinds of actions that are prioritized through the aforementioned strategies vary but informants emphasized action on the social determinants of health (poverty reduction, housing) and on the life course (especially prenatal/early childhood intervention). These actions are funded through a variety of mechanisms, including joint funding between different levels of governance or different sectors, funding from territories to NGOs and public-

private partnerships, among others. One success factor that informants brought to light was designing funding mechanisms that brought organizations into coordination and cooperation instead of competition. In terms of how decisions are made to allocate funds within these mechanisms, relying upon evidence based on local socioeconomic and health surveillance data and the global academic literature and complementing this evidence base with multisectoral stakeholder consultations emerged as a promising practice. Having structural support for all of the above is a given prerequisite for integrated, concerted action, and a couple regional-level informants discussed how organizational transformation paved the way for health promotion to have a clear mandate to engage intersectoral actors to act on the social determinants of health. Structural support was also seen as a success factor for evaluating actions, be it through built-in funding, university partnership or other means. Lastly, nearly every jurisdiction had a mechanism in place to disseminate successful interventions and pool knowledge, but finding successful ways of sustaining individual actions that could withstand changes in the political climate constituted a universal challenge to which a participatory approach and sustained advocacy may constitute possible solutions.

Due to the factual nature of the questionnaire, informants largely presented a picture of what is currently being done or planned in their

jurisdictions. Through their responses, however, a sense of priorities and common values emerged. As already mentioned, a social determinants approach is perceived as a promising way of addressing the needs of the socioeconomically vulnerable while improving the gradient and population health as a whole, and that this falls within the mandate of health promotion. Secondly, informants felt that prevention/health promotion actors necessarily had to coordinate, collaborate with intersectoral partners in order to succeed in a SDH approach, and this through formalized structures. Lastly, a key asset was the capacity for lower levels of governance to autonomously manage national public health priorities, deciding in which order and how to implement actions to address priorities while remaining responsive to the local context, as well as maintaining the accountability for actions at the operational level, all while offering opportunities

for knowledge pooling among these regional/local actors.

These cross-cutting results are confirmed by a policy brief recently published by the European office of the WHO (Whitehead, Povall, & Loring, 2014). The document, which is guidance intended to help European policymakers better design and implement policies to reduce health inequities, particularly highlights “system components that support a comprehensive approach to reducing inequities through action on SDH” (p.22), which include intersectoral cooperation mechanisms; an SDH mandate with structural support through funding mechanisms, accountability structures and learning transfer systems; and the importance of specific political roles on equity and SDH at not only the national level but also the regional and local levels.

5. LIMITATIONS

This type of inquiry carries several challenges, some of which were brought to our attention early in the process. The first is that informants are necessarily biased by their position in the government or organization (or their position outside of said institutions, as researchers), as well as their judgment on whether their country's (or state's, province's, etc.) actions for vulnerable people are good, sufficient, fair, extensive enough, or inclusive enough. Secondly, we asked informants to focus specifically on best or promising mechanisms, so it is possible that barriers, difficult contexts and disadvantages were not made explicit, leading to an

unrealistically positive portrait of actions in the various jurisdictions. Relatedly, it would be impossible for our informants to offer a complete response, so we could not expect the information gleaned to be exhaustive. That being said, the aim of the present paper is to present a variety of examples in brief that could be of interest to France, with the contacts and resources to delve further and more systematically into a given project, process or policy.

Another major limitation is our low response rate from European countries. The resulting lack of geographical diversity puts a disproportionately

large amount of attention on what is being done in Canada, whereas several contextual factors, like the relative importance of NGOs and social

protection services in the provision of prevention and health promotion, might make European countries more comparable to France.

6. NEXT STEPS

The responses from our informants demonstrate a breadth of practices, mechanisms and tools that we were only able to touch upon in a superficial manner. In the next stage, consultation of French health and social welfare officials could identify one or more examples that seem particularly innovative and suited to

the French context. A more in-depth study could be carried out on each example, with a further possibility of active knowledge exchange between the jurisdiction in question and France, brokered by the IUHPE.

7. CONCLUSION

With the coming implementation of France's National Health Strategy, the country finds itself in an opportune position to integrate promising practices from around the world to further improve population health and tackle health inequities. In addition, it has the unique chance to bridge its longstanding lens on precariousness to the worldwide emerging

health equity evidence base and social determinants agenda. The richness and diversity of concrete practices brought together in this report offer a multitude of paths from which public health actors in France can be inspired, and then adapt, in order to forge France's own way forward to health equity.

REFERENCES

- Bambra, C., Gibson, M., Sowden, a, Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health*, 64(4), 284–91. doi:10.1136/jech.2008.082743
- Chauvin, P., & Estecahandy, P. (2010). Inégalités sociales de santé et précarité. *Actualité et Dossier En Santé Publique*, (73), 17–18.
- Lemstra, M., & Neudorf, C. (2008). *Health disparity in Saskatoon: analysis to intervention*. Saskatoon.
- Ministère de la Santé et des Services sociaux. *Project de loi n°36: Loi sur la santé publique (2001)*. Assemblée nationale du Québec.
- Ministère du Travail. *Loi visant à lutter contre la pauvreté et l'exclusion sociale (2002)*. Assemblée Nationale du Québec.
- Ministry of Social Affairs and Health. (2008). *National Action Plan to Reduce Health Inequalities 2008 – 2011*. Helsinki, Finland.
- Ministry of Social Affairs and Health. (2010). *Socially Sustainable Finland 2020*. Helsinki, Finland.
- Norwegian Ministry of Health and Care Services. (2007). *National strategy to reduce social inequalities in health* (Vol. 20). Oslo.
- Saskatoon Health Region. (2014). *Health Promotion Department Social Inclusion Guidelines [Draft]* (pp. 1–6).
- State of Victoria Department of Health. (2011). *Victorian Public Health and Wellbeing Plan 2011–2015*. Melbourne, Victoria, Australia.
- Sudbury & District Health Unit. (2011). *10 promising practices to guide local public health practice to reduce social inequities in health*. Sudbury, ON.
- Sutcliffe, P., Snelling, S., & Laclé, S. (2010). *Implementing local public health practices to reduce social inequities in health (EXTRA Intervention Project Final Report)*. Sudbury, ON.
- Whitehead, M., Povall, S., & Loring, B. (2014). *The equity action spectrum: taking a comprehensive approach*. Copenhagen.
- World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the Gap in a Generation*. Geneva.

APPENDICES

APPENDIX 1. QUESTIONNAIRE (ENGLISH)

Questionnaire: Exploratory cross-country study of delivery mechanisms of prevention and health promotion action for socioeconomically vulnerable populations

This questionnaire will help us reveal different countries' mechanisms of political, strategic and practical means of addressing prevention and health promotion for socioeconomically (meaning, in terms of income or employment) vulnerable populations. It is to be expected that there will be considerable variability/variation between and even within countries. The questions have been made as general as possible to accommodate this variation; however, we ask that you be very specific and thorough in describing your own country's situation.

Please return your responses no later than **31 January 2014**.

-
1. Please describe the **context** in which decisions are made regarding prevention/health promotion programs and services that focus on vulnerable populations in your country.
You may, for example, address the following questions:
Is there a legislative/ministerial mandate to act for socioeconomically vulnerable populations?
On health inequities in general? On targeted groups of people?
On the whole gradient (policies, universal services or proportionate universalism)? Is decision-making centralized or decentralized?
 2. Are there national/regional entities that allocate funds to address prevention and health promotion for vulnerable populations? Are they specialized or part of a broader public health mandate? Please describe coordination mechanisms, how funds are allocated; is there joint funding between national/regional levels?
 3. What criteria are considered by the different responsibility centers/officers for funding and delivery of actions in this area? (Evidence? Political priorities? Values? Is participation of the target group considered? What else is taken into consideration?)
 4. To whom are the programs, services, benefits, etc. being allocated?
For example:
To other levels of government (regional, provincial, territorial, local)?
To NGOs?
To health systems? Social service systems?
We realize that several cases may apply and there may be other entities not mentioned above. Please give as complete an answer as possible and elaborate as necessary.
 5. Could you elaborate on the different types of prevention and health promotion programs or services

for which funds are being allocated? An exhaustive list may not be possible but you may choose several illustrative examples on different levels.

6. For each case you described in Question 4-5, please explain the specific delivery mechanisms, in terms of the deployment of means (financial, material, and human), rather than in terms of intervention implementation. How, practically speaking, are these programs deployed, by whom (for example, is there a services catalogue)?
7. Are any efforts made to integrate the actions across sectors? If so, please describe them.
8. What accountability mechanisms are in place? Please consider the following questions:
Who conducts evaluation of actions?
How are actions evaluated?
Are any evaluative tools made available to those implementing the actions?
9. What is done for sustainability of actions?
How are decisions made for renewing funding? For how long are actions funded?
What mechanism, if any is in place to disseminate or scale up promising actions?
10. Are there any innovations or factors of success in the mechanisms currently in place in your country that you would like to share?

Is there anyone else you would recommend to fill out this questionnaire? Please give their names and contact information below.

Appendix 2. Questionnaire (French)

Questionnaire : étude comparative exploratoire de politiques d'autres pays de prise en charge des personnes précaires sous l'angle de la prévention et de la promotion de la santé

Ce questionnaire va nous aider à récolter des informations pertinentes pour l'action et permettre d'analyser les dispositifs politiques, stratégiques et pratiques d'autres pays de prise en charge des personnes socio économiquement précaires du point de vue de la prévention et de la promotion de la santé. Il faut s'attendre à de grandes variations d'un pays à l'autre y compris à l'intérieur même des pays. Les questions sont donc assez générales pour pouvoir prendre en compte les différences d'un pays à l'autre, mais nous vous demandons de bien vouloir être aussi spécifique que possible dans vos réponses en décrivant la situation et les dispositifs existants dans votre pays.

Merci de bien vouloir nous retourner le questionnaire rempli pour le **31 janvier au plus tard**.

1. Merci de bien vouloir décrire le **contexte** dans lequel les décisions sont prises concernant les programmes et services de prévention et promotion de la santé qui s'adressent aux personnes en état de précarité dans votre pays.
Vous pouvez par exemple répondre aux questions suivantes :
Existe-t-il un mandat législatif/ministériel pour agir auprès des personnes précaires ? Sur les inégalités de santé en général ; sur des groupes de populations cibles ? sur l'ensemble du gradient social (politiques/services universels ou universels proportionnés?, etc.)
Les décisions sont-elles prises au niveau central ou à celui décentralisé, ou encore aux deux ?
2. Existe-t-il des entités nationales/régionales qui allouent des financements pour prendre en charge des personnes précaires du point de vue de la prévention et de la promotion de la santé ? Est-ce que ce sont des agences spécialisées ou font-elles partie d'un mandat de santé publique plus large ? Merci de bien vouloir décrire les dispositifs de coordination, comment les fonds sont alloués et s'il existe des financements conjoints aux niveaux national et régional ?
3. Quels sont les critères pris en compte par les différents centres de décision du subventionnement et du déploiement des actions dans ce domaine (Données probantes ? Priorités politiques ? Valeurs ? La participation du groupe cible est-elle prise en compte ? effective ? Y a-t-il d'autres éléments pris en compte ?
4. Qui bénéficie de l'allocation de ces programmes, services, bénéfices ? Par exemple D'autres niveaux du gouvernement (régions, provinces, territoires, localités) ? ONGs ?
Les systèmes de santé ? les systèmes des services sociaux ?
Nous comprenons qu'il peut y avoir plusieurs cas et qu'il peut y avoir d'autres bénéficiaires qui ne sont pas mentionnés ici. Merci de bien vouloir nous adresser une réponse aussi complète que possible et aussi élaborée que nécessaire.
5. Pourriez-vous nous indiquer les différents types de programmes de promotion de la santé et de prévention s'adressant aux personnes précaires pour lesquels des fonds sont alloués ? Une liste exhaustive n'est évidemment ou probablement pas possible mais vous pouvez choisir plusieurs exemples illustratifs à différents niveaux.

6. Pour chacun des cas décrits répondant aux questions 3 et 4, merci de bien vouloir expliquer quels sont les dispositifs mis en place (par exemple, des catalogues de services), non pas tant en termes de mise en œuvre mais de déploiement des moyens (humains, matériels et financiers) ?
7. Y a-t-il des efforts réalisés pour intégrer les actions à travers plusieurs secteurs ? Si oui, merci de bien vouloir les décrire.
8. Quels dispositifs pour rendre compte des actions existe-t-il ? Merci de bien vouloir prendre en compte les questions suivantes :
Qui mène les actions d'évaluation ?
Comment les actions sont-elles évaluées ?
Est-ce que des outils d'évaluation sont mis à la disposition de ceux qui mettent en œuvre les actions ?
9. Comment les actions sont-elles pérennisées ?
Comment les décisions sont prises pour renouveler les financements ? Pendant combien de temps les actions sont-elles financées ?
Quels dispositifs sont mis en place pour diffuser ou étendre des actions qui marchent bien (actions prometteuses) ?
10. Quels sont les facteurs de succès ou innovants dans le dispositif actuellement mis en place dans votre pays/région que vous voudriez souligner et partager ?

Si vous connaissez d'autres personnes qui pourraient répondre à ce questionnaire, merci d'indiquer leur nom et leurs coordonnées ci-dessous :

Appendix 3. Informants

Country	Informant	Position, Organisation (as of March 2014)
Australia	Kellie Horton	Manager, Knowledge and Health Equity, VicHealth
	Kerryn O'Rourke	Principal Program Officer on Health Equity, VicHealth
	Michael Moore	CEO, Public Health Association of Australia
	Louise Sylvan	Australian National Preventive Health Agency
	Jennie Roe	Australian National Preventive Health Agency
Canada	Gerry Gallagher and staff	Interim executive director, Social determinants of health and science integration Directorate, Public Health Agency of Canada
	Cory Neudorf	Chief Medical Health Officer, Saskatoon Health Region
	Alain Poirier	Institut national de santé publique du Québec (INSPQ)
	Trevor Hancock	University of British Columbia, Victoria
	Arlene Paton	Assistant Deputy Minister of Health, British Columbia
Finland	Sandra Lacle and Renée St. Onge	Sudbury and District Health Unit, Sudbury, Ontario
	Kaarina Tamminiemi	SOSTE Suomen sosiaali ja terveys ry Helsinki, Finland
	Pau Batlle i Amat	Director, DIPSAUT Girona, Autonomous Region of Catalonia
Switzerland	Regula Ricka Martin Hosek	Federal Office of Public Health

Appendix 4. Summary of Evidence Based Policy Options to Reduce Health or Social Disparity—reproduced from “Health Disparity in Saskatoon: Analysis to Intervention” (2008)

A. Overall:

Evidence Based Policy Option #1 – Develop a Multi-Year, Targeted Plan to Reduce Poverty

Develop an effective plan to reduce poverty and health inequality for Saskatoon and Saskatchewan that includes a multi-year approach with concrete measurable targets, broad support and an evaluation plan.

B. Income Disparity:

Evidence Based Policy Option #2 – Set Measurable Goals to Reduce Poverty

The following goals should be considered for the City of Saskatoon:

- Reduce Low Income Cut-Off (LICO) households from 17.1% to 10% in five years
- Reduce the number of children living below LICO from 20.1% to 2% in five years

Evidence Based Policy Option #3 – Ensure no Child Lives in Poverty

Parents with children who are on social assistance should have their shelter allowances and their adult allowances (i.e., food, clothing) doubled in order to raise children to the LICO.

Evidence Based Policy Option #4 – Create a Child Poverty Protection Plan

Establish a Child Poverty Protection Plan to fund the reduction of poverty in children in Saskatchewan.

Evidence Based Policy Option #5 – New Legislation to Eliminate Child Poverty

Establish a legislative requirement in Saskatchewan to eliminate child poverty.

Evidence Based Policy Option #6 – Remove Work Earning Clawbacks

Work earning supplements should be coupled with the removal of work earning clawbacks to transition return to work and promote voluntary withdrawal from social assistance.

Evidence Based Policy Option #7 – Index Social Assistance Rates to Inflation

Social assistance rates should be increased as recommended in policy option #3 and then index future rates to inflation.

Evidence Based Policy Option #8 – Change Lower Limit Tax Exemptions

Change the lower limit tax exemption for low income workers and offset the revenue loss by removing the lower limit tax exemption for higher income earners.

Evidence Based Policy Option #9 – Review Program Effectiveness of Social Services

The Ministry of Social Services should consider reviewing the effectiveness of its programs in order to accomplish its long term objectives.

Evidence Based Policy Option #10 – Increase Public Understanding of Social Determinants of Health

Enhance the understanding of the general public about the determinants of health and the economic costs of not proactively addressing poverty.

Evidence Based Policy Option #11 – Increase Support for Parents on Leave

Increase the Employment Insurance rate for new parents on parental leave from 55% to 80% of employment income prior to leave.

Evidence Based Policy Option #12 – Create a Single Resource for Those Unable to Work

Consolidate income assistance and disability providers into one resource with identical and equitable assistance rates for those unable to work.

C. Education Disparity:

Evidence Based Policy Option #13 – Set a Measurable Goal to Reduce the Number of Children Not Attending School

We should set a goal to reduce the number of children not in school from 690 children under the age of 19 to no more than 100 children under the age of 19 by 2010.

Evidence Based Policy Option #14 – Increase High School Graduation Rates

We should set a goal that 90% of Aboriginal children graduate from high school within 10 years (or by 2017) up from the current graduation rate of 48%.

Evidence Based Policy Option #15 – Increase Support for Community Schools

Provide health and social services to schools in low income neighbourhoods in order to prevent school drop-out, encourage academic achievement, increase graduation rates and improve health.

Evidence Based Policy Option #16 – Universal Child Care for Low Income Parents

Child care should be provided to all low income parents at no direct cost in community schools in low income neighbourhoods. The pre-school and pre-kindergarten programs should be expanded in community schools in low income neighbourhoods and be provided at no direct cost to low income parents.

Evidence Based Policy Option #17 – *KidsFirst* should include children most in need

The *KidsFirst* program should include children and families that are in most need.

Evidence Based Policy Option #18 – Reserve Education Placements for Low Income Students

Learning institutions like SIAST should allocate 10% of their existing skills training vacancies to adults who have been on social assistance for more than one year to take the program at no cost.

In addition, free child care (policy option #16) should be provided to those who choose to enter school in order to better their chances to re-enter the workforce in a skilled vocation.

The skills training sessions should be adapted to include academic support and if required support from health services (i.e., mental health).

Evidence Based Policy Option #19 – Redirect Funds from Ineffective to Effective Programs

Re-allocate funding from job search initiatives with limited success to adapted skills enhancement programs as part of a comprehensive return to work strategy.

Evidence Based Policy Options #20 – Affordable Tuition for University Students

Cap the student portion of university tuition fees while increasing the provincial portion in funding.

The student portion for low income students should be waived altogether.

Evidence Based Policy Option #21 – Change the Legal Drop Out Age

Increase the age that a youth can legally stop attending school from 16 years old to 18 years old; unless high school graduation has already been obtained.

Evidence Based Policy Option #22 – Cap Annual Health Care Spending Increases

Cap the annual growth of the health care treatment sector at 5%, instead of 10%, in order to re-distribute financial resources to health enhancing activities like education.

D. Housing Disparity:**Evidence Based Policy Option #23 – Set Measurable Goals to Create More Access to Affordable Housing**

Reduce the number of people on the waiting list for affordable housing from 2,150 to zero in four years (2011).

Evidence Based Policy Option #24 – Expand Affordable Housing Projects

The City of Saskatoon should continue to examine the benefits of development of a Land Trust, designating surplus city land to affordable housing projects, inclusionary zoning, improving the speed of approval process for affordable housing and a five year tax abatement for affordable housing projects/units.

Evidence Based Policy Option #25 – Reserve 10% of New Development for Affordable Housing

Any developer that purchases land from the City of Saskatoon should set aside 10% of the new development for affordable housing.

Evidence Based Policy Option #26 – Expand Not-for-Profit Housing Authorities

The provincial government should consider purchasing 20 abandoned or neglected multifamily and apartment buildings in the heart of Saskatoon's six low income neighbourhoods, renovate them and transfer the title to not-for-profit housing authorities with the eventual goal of transferring title to home ownership. The provincial government should consider adopting this policy for at least four years to address chronic housing shortages.

Evidence Based Policy Option #27 – Support for Home Ownership

The provincial government should consider investing in a Saskatoon-based home ownership pilot program to convert 31 multi-units provincially owned affordable rental units to home ownership.

A long-term rent-to-own program should be considered to increase the number of households in stable, safe,

affordable housing.

Evidence Based Policy Option #28 – Create a Youth Homelessness Prevention Strategy

Develop and implement a permanent and comprehensive youth homelessness prevention strategy to eradicate youth homelessness in Saskatoon. In addition to the need for overall service coordination, the province of Saskatchewan should consider converting and targeting 125 affordable housing units to supportive housing for at risk and homeless youth.

Evidence Based Policy Option #29 – Develop a Long-term, Consolidated, Comprehensive, Interagency Social Housing System for Hard to House Individuals

Develop a long term, consolidated, comprehensive, interagency social housing system in Saskatoon and Saskatchewan for hard to house individuals; including those living with mental health problems and addictions.

Evidence Based Policy Option #30 – Build Community Acceptance for Affordable Housing

Develop a communication strategy to overcome the stigma of affordable housing in order to gain community acceptance.

Evidence Based Policy Option #31 – Increase Monthly Shelter Allowances

The Saskatchewan government should consider increasing monthly shelter allowances for all households receiving income assistance to match the 2008 average monthly rental rate and also include the total monthly cost for utilities. In addition, shelter allowance rates should be reviewed bi-annually and compared to current average monthly shelter rates and brought up to market standards when necessary.

Evidence Based Policy Option #32 – Renewed Federal Responsibility for Social Housing

The federal government needs to restore funding for social housing to the levels established prior to 1986.

E. Employment Disparity:

Evidence Based Policy Option #33 – Setting Measurable Goals: More Work for Aboriginal People

Aboriginal representation in the workforce should increase to 15% of full time service jobs, 15% of management positions and 15% of professional workplaces within 10 years; or by 2017.

Evidence Based Policy Option #34 – Increase Minimum Wage

The minimum wage should be increased to \$10 per hour in order to encourage employment, make work more attractive than employment assistance, and lower the amount of children living in poverty.

Evidence Based Policy Option #35 – More Control for Aboriginal People over Employment and Academic Programs

More control for Aboriginal people over their own employment and academic programs.

Evidence Based Policy Option #36 – Support Aboriginal Owned Businesses

Support the creation of Aboriginal owned businesses by signing preferred supplier contracts.

Evidence Based Policy Option #37 – Comprehensive Return to Work Programs

Return to work programs should include a comprehensive combination of adapted skills training, job search, job placement, on the job experience and life skills training in order to increase chances of transitional return to work. Health services should augment the return to work process when required.

Evidence Based Policy Option #38 – Social Assistance as a Transition to Work

Use Social Assistance as a Transition to Work when possible with enhanced benefits that are time sensitive (i.e., five years) to ensure that they achieve their intended results.

F. Disparity in Health Services:

Evidence Based Policy Option #39 – Health Disparity Reduction: A Health Sector Priority

Make health disparity reduction a health sector priority in the Saskatoon Health Region.

Evidence Based Policy Option #40 – Integrated Planning for Disparities Reduction

Integrate disparity reduction into all health programs and services in the Saskatoon Health Region.

Evidence Based Policy Option #41 – Intersectoral Action

Engage other sectors (i.e., education, social services) in health disparities reduction other than health care treatment.

Evidence Based Policy Option #42 – Knowledge Infrastructure

Strengthen knowledge development and exchange activities on the topic of health disparity.

Evidence Based Policy Option #43 – More Health Resources in Low Income Neighbourhoods

The number of health resources in Saskatoon's low income neighbourhoods should be proportionate to the size of the population; and its disproportionate number of health disorders.

Evidence Based Policy Option #44 – Integrated Health Services in Low Income Neighbourhoods

The Saskatoon Health Region should offer integrated and comprehensive services in Saskatoon's low income neighbourhoods including public health, mental health, addictions and primary care services.

G. Disparity within Cultural Groups**Evidence Based Policy Option #45 – Aboriginal Self Determination**

Aboriginal people in Saskatchewan should be afforded more control over health, social, education and justice policies and funding that disproportionately affect Aboriginal people.

Evidence Based Policy Option #46 – Ensure Federal Responsibility for “Registered Indians”

The federal government must assume its full constitutional responsibility for all “Registered Indians” under Section 91(24) of the Constitution Act, 1867. Jurisdiction and responsibility must go together.