Social Inequities in Health and the Sudbury & District Health Unit

Building Our Path for the Next 10 Years

Sudbury & District

Health Unit

Service de santé publique

October 2010

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Developed in consultation with Sudbury & District Health Unit management and staff reflecting diverse cross-health unit representation.

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Building Our Path for the Next 10 Years

Sudbury & District Health Unit Vision

Healthier communities in which the Sudbury & District Health Unit plays a key role.

Sudbury & District Health Unit *Health Equity* Vision - 2020

The Sudbury & District Health Unit will work to improve the overall health and health equity of area citizens so that:

- systemic and avoidable health disparities are steadily reduced and the gap in health between the best and worst off is narrowed;
- all citizens have equal opportunities for good health and well-being; and
- all citizens have equitable access to a full range of high quality public health programs and services.*

The SDHU will know it has worked effectively to reduce social inequities in health if by 2020 . . . the SDHU has fully "normalized" the concepts of *evidence-informed local public health practice to reduce social inequities in health* so that we incorporate them seamlessly into our work. The competencies and diversity of the SDHU workforce and the established processes, structures, and core values all support these practices and contribute to their continuous improvement. The SDHU is recognized for this work, including our strong partnerships with community agencies and the way in which we meaningfully and purposefully engage citizens and priority populations in program planning, implementation, and evaluation.

The SDHU will know it has worked effectively to reduce social inequities in health if by 2020 . . . there is a sense of collective community ownership of the socio-economic issues that cause health inequities. Citizens, community agencies, and municipal leaders are *aware* of the issues, *expect* that they be addressed, and are *engaged* in taking action within their own spheres of influence. As a consequence, our communities are seen as models for others. We all celebrate and support diversity and we are connected to one another. Community members proudly describe themselves as non-judgemental, supportive, connected, resourceful, respectful, active, and just.

* Adapted from Toronto Central LHIN: Health Equity Discussion Paper (B. Gardner, July 2008)

Introduction

The Sudbury & District Health Unit (SDHU) is committed to public health efforts to reduce social inequities in health. From Board of Health motions to staff program activities, the SDHU has been on a path to change our public health culture and practice in support of health equity.

This current social inequities in health visioning initiative is a significant landmark for our organization. We recognize that our path to date has been purposeful yet opportunistic and that a 10-year vision with clearly articulated milestones and evolving action plans will help us to leverage the investments we have made to date. It will help us to more effectively use our public health resources to reduce health inequities and ultimately "level up" as we achieve our mission of *working with our communities to promote and protect health and prevent disease.*

This report describes the internal visioning process undertaken in the spring of 2010 and presents the resulting social inequities in health vision for our organization. From this vision, key milestones and actions will be developed as an "evergreen" document that will guide the work of the SDHU for the next 10 years.

At its meeting on October 21, 2010, the Sudbury & District Board of Health carried the following resolution #48-10 in support of this vision and 10-year plan:

> ***WHEREAS the Sudbury & District Board of Health demonstrated its formal support for work on social determinants of health in its 2005 position statement and later in its support for equity based planning; and***
>
> ***WHEREAS the Sudbury & District Board of Health strategic plan (2010-2012) further reflects the Board of Health's commitment to reducing social inequities in health and prioritizes the need to champion equitable opportunities for health in our communities; and***
>
> ***WHEREAS recent research conducted as part of a Canadian Health Services Research Foundation EXTRA fellowship outlines 10 promising practices to reduce social inequities in health and highlights tangible tools and approaches that can guide the Sudbury & District Board of Health efforts; and***
>
> ***WHEREAS a comprehensive vision and long-term plan to reduce social inequities in health will support effective and efficient use of public health resources; and***
>
> ***WHEREAS the vision document, Social Inequities in Health and the Sudbury & District Health Unit: Building our Path for the Next 10 Years, was developed and validated by Sudbury & District Health Unit management and staff reflecting diverse, cross-health unit representation.***

***THEREFORE BE IT RESOLVED THAT** the Sudbury & District Board of Health formally endorse the vision document, Social Inequities in Health and the Sudbury & District Health Unit: Building our Path for the Next 10 Years; and*

***FURTHER THAT,** the Sudbury & District Board of Health direct the Medical Officer of Health to develop a 10 year action plan based on the vision document, for the purposes of guiding the work of the SDHU to reduce social inequities in health.*

Background

Our History:

Appendix A illustrates our key milestones from the last decade. Noteworthy is the fact that the SDHU initiatives have spanned the organization. For example:

- The **Board of Health** demonstrated its formal support for work on social determinants of health in its 2005 position statement and later in its equity-based planning motion.

- The **Medical Officer of Health** testified regarding the health importance of adequate social assistance income at the coroner's inquest following the tragic death of Kimberly Rogers in 2001. The Medical Officer of Health and two senior Health Unit colleagues were Fellows in the Canadian Health Services Research Foundation (CHSRF) EXTRA (Executive Training for Research Application) Program, researching evidence-informed local public health activities to reduce social inequities in health.

- The **Director of Resources, Research, Evaluation and Development** lead a team of committed **planners** to develop the Ontario Public Health Standards (OPHS) Planning Path, which has social inequities in health at the centre of the process and incorporates equity-based planning tools such as the Priority Populations Primer and an assessment tracking form that documents equity considerations. In 2010, **program teams** developed three-year program logic models that explicitly identify equity-related activities.

- As a **management/staff** initiative, we sought to understand other public health units' challenges and successes in their work on social determinants by organizing an oversubscribed conference stream, *Determinants of Health: Developing an Action Plan for Public Health*, during the 2005 OPHA/alPHa joint conference. And, our **Policy and Planning Specialist** engaged with all staff in 2008 as part of the *Health Equity Mapping Project*. Among other activities, the Specialist is now leading the development of a social inequities in health social marketing campaign.

- We have **collectively** engaged with government ministries and agencies to advocate for the inclusion of social inequities in health language and expectations in the *Mandatory Health Programs and Services Guidelines*, the founding legislation for the *Ontario Agency for Health Protection and Promotion*, the policy documents of the newly established *Ministry of Health Promotion*, and most recently, in the *Ontario Public Health Standards*.

- We **collectively** participated in SDHU Staff Day education events, the Determinants of Health Task Group (2003-2005), the Poverty Game, Count Me In campaign, etc. to increase our internal knowledge and awareness of the impact of the health determinants.

We can be confident that the next leg of our journey to reduce social inequities in health will be informed by the experience, knowledge, and skills that we have gained over the first decade. Our rich history helps us to map out our vision—where we go to next—and the significant new milestones we need to keep track of along the way.

Our Environment:

Four recent developments in our public health environment serve as important guideposts for our work ahead:

1. The priorities of the 2010-2012 SDHU strategic plan
2. The 10 promising practices to reduce social inequities in health, identified as part of the CHSRF EXTRA project
3. The newly revised Ontario Public Health Standards (OPHS)
4. The Public Health Agency of Canada's Core Competencies for Public Health

These documents form the critical bearings for the journey ahead and are summarized below.

Box 1. Sudbury & District Health Unit Strategic Plan: 2010–2012

Vision: Healthier communities in which the SDHU plays a key role.

Mission: Working with our communities to promote and protect health and to prevent disease.

Strategic Priorities:
1. Champion equitable opportunities for health in our communities.
2. Strengthen relationships with priority neighbourhoods and communities, and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

Box 2. Ten Promising Practices for Local Public Health to Reduce Social Inequities in Health, from the CHSRF EXTRA Project

Specific Strategies	Individual lifestyle-focused practice	1. Targeting with universalism
	Policy-focused practice	2. Intersectoral action 3. Equity-focused health impact assessment
	Both lifestyle- and policy-relevant practice	4. Social marketing 5. Early child development 6. Purposeful reporting
Cross-cutting Enabling Strategies		7. Competencies and organizational standards 8. Contribution to evidence base 9. Community engagement 10. Health equity target setting

Box 3. Ontario Public Health Standards (OPHS)

Further supporting our efforts to reduce social inequities in health are the newly revised Ontario Public Health Standards. More specifically, the Foundational Standard and its associated Population Health Assessment and Surveillance (PHAS) Protocol explicitly requires local public health units to assess, address, and report health inequities within their communities.

Excerpts from the PHAS Protocol:
This protocol requires boards of health to consider the **determinants of health** when identifying priority populations and using population health data and information to focus public health action. Implicit in this protocol are the principles of Partnership and Collaboration, Need, and Impact, as outlined in the Foundations of the OPHS.

Data analysis and interpretation:
- The board of health shall analyze population health data and interpret the information to describe the distribution of health outcomes, preventive health practices, risk factors, determinants of health, and other relevant information to assess the overall health of its population.

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

Box 4. Public Health Agency of Canada Core Competencies for Public Health

Core competencies are the essential knowledge, skills, and attitudes necessary for the practice of public health that build on the larger context of public health values. Important values in public health include a commitment to equity, social justice and sustainable development; recognition of the importance of the health of the community as well as the individual; and respect for diversity, self-determination, empowerment, and community participation. These values are rooted in an understanding of the broad determinants of health and the historical principles, values, and strategies of public health and health promotion.

There are 36 core competencies organized under seven categories:
1. Public health sciences
2. Assessment and analysis
3. Policy and program planning, implementation, and evaluation
4. Partnerships, collaboration, and advocacy
5. Diversity and inclusiveness
6. Communication
7. Leadership

Visioning Process

At its March 24, 2010, meeting the SDHU's Social Inequities in Health Steering Committee (SIHSC) (see Appendix B for the Terms of Reference) reviewed an initial draft of a 10-year plan for SDHU work to reduce social inequities in health in our communities. It was recommended at that time to consult more broadly across the organization in order to develop a shared vision for reducing social inequities in health. This process would be inclusive and allow diverse staff to "see where they fit in and what their role is in the work to be done over the long term."

A sub-committee of the SIHSC met to plan for the visioning process. A consultant was hired to organize and facilitate a half-day visioning session with invited staff. Participants were invited based on their membership on the SIHSC, their individual experiences and interests, and their ability to provide cross-Health Unit representation. Pre-visioning session reading materials were identified and the following invitation was sent to 19 staff, all of whom accepted the invitation for the May 24, 2010, session (see Appendix C for a list of session participants and consultant):

> On behalf of the SIHSC, Dr. Sutcliffe is inviting you to participate in a half-day visioning workshop on social inequities in health . . .

> The purpose of this small workshop is to think creatively about the SDHU 10-year vision for our work to reduce social inequities in health. What will we do differently in 10 years time? How will our community partners perceive us? What are the key milestones in getting there? How do we need to grow and develop to move in this direction? What needs to happen across the organization/in specific teams?

> You are being invited because your particular insights are critical to this visioning work. You do not need to be an expert in this area—you just need to think creatively based on your own experiences and to participate actively . . .

At the meeting, participants were initially asked to brainstorm the **environmental factors** in 2020 expected to affect health. Specifically, groups of participants discussed and documented significant changes predicted within the next 10 years under the headings: International, North America, Canada, Ontario, Northeastern Ontario and Sudbury and Manitoulin districts (SDHU catchment area). Appendix D lists the ideas generated.

Participants were then asked to answer two **visioning** questions:

1. What will be different at the *SDHU* because we have been working effectively to reduce social inequities in health?
2. In 2020 what will the *community* look like because the SDHU has been so effective in reducing social inequities in health?

Responses were recorded on cards that were transcribed and organized by themes. The list of vision ideas is included in Appendix E of this report. The ideas were later reviewed and statements were drafted that reflect the participants' overall vision for SDHU work to improve health equity and their visions for how the community and the Health Unit would "look" by 2020 if we were successful in our work.

Participants were also asked to identify key **milestones** that would be necessary to achieve in order for the Health Unit, and communities, to reach their visions. The milestones were divided into two sections—one related to the SDHU as an organization (internal-oriented) and the other related to the community (externally oriented). Milestones were also sequenced along the 10-year time frame that participants felt would be appropriate.

Following the discussion on milestones, participants worked in small groups to identify some specific **actions** that will be necessary to achieve the milestones.

All discussions were recorded by the consultant facilitator.

The outcomes described below are the result of the visioning process and guidance from other relevant strategic documents. They have been further edited to reflect subsequent staff validation and consultation.

Outcomes

Health Equity Vision—2020

The Sudbury & District Health Unit will work to improve the overall health and health equity of area citizens so that:
- systemic and avoidable health disparities are steadily reduced and the gap in health between the best and worst off is narrowed;
- all citizens have equal opportunities for good health and well-being; and
- all citizens have equitable access to a full range of high quality public health programs and services.[1]

The SDHU will know that it has worked effectively to reduce social inequities in health if by 2020…

- The SDHU has fully "normalized" the concepts of *evidence-informed local public health practice to reduce social inequities in health* so that we incorporate them seamlessly into our work. The competencies and diversity of the SDHU workforce and the established processes, structures, and core values all support these practices and contribute to their continuous improvement. The SDHU is recognized for this work, including our strong partnerships with community agencies and the way in which we meaningfully and purposefully engage citizens and priority populations at all stages of program planning, implementation, and evaluation.

- There is a sense of collective community ownership of the socio-economic issues that cause health inequities. Citizens, community agencies, and municipal leaders are *aware* of the issues, *expect* that they be addressed, and are *engaged* in taking action within their own spheres of influence. As a consequence, our communities are seen as models for others. We all celebrate and support diversity and we are connected to one another. Community members proudly describe themselves as non-judgemental, supportive, connected, resourceful, respectful, active, and just.

Milestones and Action Plans

Preliminary **milestones** were identified for the 10-year period 2011 to 2020 as we work toward our vision. Milestones were separated into *internally oriented* and *externally oriented* milestones.

A 10-year plan incorporating the preliminary milestones, actions, and associated supports and timelines is currently under development.

> Milestones are constructed to provide reference points along the road. This can be used to reassure travellers that the proper path is being followed, and to indicate either distance travelled or the remaining distance to a destination. Such references are also used by maintenance engineers and emergency services to direct them to specific points where their presence is required.
>
> —Wikipedia

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[1] *Adapted from Toronto Central LHIN: Health Equity Discussion Paper (B. Gardner, July 2008)*

Outcomes

The Milestone Document will incorporate participant ideas and actions and priorities previously identified by the Social Inequities in Health Steering Committee. It will be organized using the "bearings" of the strategic priorities of the 2011-2012 strategic plan and the 10 promising practices identified as part of the EXTRA program.

It is recognized that the 10-Year Milestone Document will be "evergreen" and will continue to evolve as the SDHU works to achieve its vision of health equity. It is further recognized that the Milestone Document largely provides high-level guidance about major organizational or policy initiatives. It is expected that Heath Unit program teams will be aware of these major initiatives and that they may contribute to them to varying degrees. It is not the intention of the Milestone Document to capture all SDHU activities aimed at reducing health inequities.

Next Steps

This report describes the internal visioning process undertaken in the spring of 2010 and presents the resulting social inequities in health vision that will guide the key milestones and actions of the SDHU's work over the next 10 years. These outcomes have undergone a validation and consultation process with SDHU staff.

Following Board of Health endorsement, the document will guide the SDHU's work to improve health equity. This work will be overseen by the Social Inequities in Health Steering Committee under the ultimate responsibility of the Medical Officer of Health. Planning groups, teams and divisions will engage in discussions to also further this work as feasible, as well as share their practices.

The development of this vision to achieve health equity is a significant undertaking. The achievement of this vision, and ultimately, the reduction of social inequities in health represents a core *raison d'être* of public health systems. The SDHU is committed, with the full engagement and support of the Sudbury & District Board of Health, SDHU staff, and the community as a whole, to do its part to improve health and health equity.

Resources

The following documents and resources have helped to inform the development of the Sudbury & District Health Unit's vision and plan related to social inequities in health.

- **2010–2012 Strategic Plan**
  www.sdhu.com/SDHU_Stra_Plan-BRO_PDFVERSION_ENG.pdf

- **EXTRA Intervention Project Final Report: Implementing Local Public Health Practices to Reduce Social Inequities in Health, May, 2010**
  www.sdhu.com/uploads/content/listings/FINALIPPRSDHUMay2010.pdf

- **EXTRA Intervention Project Progress Report 2: Research-Oriented Decision-Making to Guide Local Public Health Practice to Reduce Social Inequities in Health, July, 2009**
  www.sdhu.com/uploads/content/listings/EXTRAProgressReport2SDHUJuly2009_External.pdf

- **Sudbury & District Board of Health Determinants of Health Position Statement, May, 2005**
  http://www.sdhu.com/uploads/content/listings/PositionStatement_DeterminantsofHealth_May2005a1.pdf

- **A Framework to Integrate Social and Economic Determinants of Health into the Ontario Public Health Mandate: A Discussion Paper, March, 2006**
  http://www.sdhu.com/uploads/content/listings/SDOHFrameworkDiscussionPaper_March_2006.pdf

- **Social Inequities in Health and Ontario Public Health Background Document, January, 2007**
  www.sdhu.com/uploads/content/listings/SocialInequitiesinHealthandOntarioPublicHealth_Jan15-07_Rev_jv_jm.pdf

- **Overview of the Health Equity Mapping Project Report, January, 2009**
  http://www.sdhu.com/uploads/content/listings/OverviewoftheHealthEquityMappingProject_January2009_Final.pdf

- **Sudbury & District Health Unit OPHS Planning Path: Pilot Version for 2010 Planning, January, 2010**
  www.sdhu.com/uploads/content/listings/OPHSPlanningPathPublicVersion_Feb2010.pdf

- **Priority Populations Primer: A Few Things You Should Know about Social Inequities in Health in SDHU Communities, August, 2009**
  http://www.sdhu.com/uploads/content/listings/prioritypopprimer.pdf

- **Toronto Central LHIN Health Equity Discussion Paper (B. Gardner), July, 2008**
  www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf

- **Addressing Health Inequities and Access: An Engagement Process between the SDHU and Community Agencies in the City of Greater Sudbury, May, 2007**
  http://www.sdhu.com/uploads/content/listings/AddressingHealthInequitiesandAccess-AnEngagementProcessbetweentheSudburyDistrictHealthUnitandCommunityAgenciesintheCityofGreaterSudbury.pdf

Appendix A
Sudbury & District Health Unit (SDHU)
Actions at a Glance

Sudbury & District

Health Unit

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Social Inequities in Health
Sudbury & District Health Unit Highlights from the Last Decade

2000-04

- Multiple community and staff presentations on social determinants of health (e.g. Social Planning Council, Rotary Club, Registered Nurses Association of Ontario, workplaces, Romanow Commission, etc.)
- Testimony at the Inquest into the death of Kimberly Rogers (house arrest for welfare fraud)

2005

- Board of Health Determinants of Health Position Statement
- SDHU OPHA/alPHa conference stream, November 2005
  Determinants of Health: Developing an Action Plan for Public Health
- Resulting alPHa AGM resolution A05-4, November 2005
  Determinants of Health as a Mandatory Public Health Program
- Resulting OPHA AGM resolution, November 2005
  Determinants of Health
- SDHU Working Poor Needs Assessment and Conference
- Board of Health motion 73-05: Equity Based Planning

2006

- SDHU discussion paper:
  A Framework to Integrate Social and Economic Determinants of Health into the Ontario Public Health Mandate
- Board of Health motion 63-06: Cost shared operation budget with a focus on health equity

2007

- Advocacy Paper:
  Social Inequalities in Health and Ontario Public Health
- Review of Ontario's public health programs/mandate: specific equity-focused recommendations for the new Ontario Public Health Standards

2008

- Internal scan: Health Equity Mapping Project
- CHSRF EXTRA Program Fellowship: intervention project on social inequities and public health practice (2008-2010)
- Board of Health endorsement of the Greater Sudbury Community Strategy for Poverty Reduction (Social Planning Council of Sudbury)
- SDHU coordination: Social Inequities in Health Steering Committee
- Mayor's Expert Panel on Health Cluster Development: formal liaison with health sector leaders on opportunities for action on poverty

2009

- Board of Health motion 15-09: Put Food in the Budget campaign
- Board of Heatlh motion 25-09: WHO Commission on Social Determinants of Health: Call to Action for Ontario Public Health

Appendix B
Social Inequities in Health Steering Committee (SIHSC) Terms of Reference

Committee Members: Medical Officer of Health and Chief Executive Officer (Chair)
Two Program Directors
Director, Resources, Research, Evaluation and Development
Manager, Professional Practice and Development
Manager, Research and Evaluation
Manager, Organizational Development and Volunteer Resources
Policy and Planning Specialist
Research and Development Specialist
Program Management Committee (PMC) Co-Chairs
Manager, Communications or designate

Purpose:
To optimize Health Unit initiatives to affect determinants of social inequities in health

Guiding Principles:
The Social Inequities in Health Steering Committee (SIHSC) will embrace and adhere to the following guiding principles:

- All members are committed to the SDHU vision, mission, and strategic priorities identified in the current Strategic Plan document.
- All members will work in a respectful, professional, collaborative, consensual, and empowering manner to model excellent diversity and equity practices.
- All members will recognize and respect the diversity of personal experiences, skills, expertise, communication styles, and leadership styles within the group.
- The SIHSC will make every reasonable effort to ensure the effective, meaningful, and fair participation of all members.

Responsibilities:
1. To provide strategic direction and substantive input into Health Unit activities to affect determinants of social inequities in health.
2. To ensure synergy and coordination of Health Unit activities to affect determinants of social inequities in health.

Proceedings:
- Standing committee of EC with reports to EC and PMC through the Chairs.
- Minutes will be shared with committee members and will be posted on the intranet.
- Meeting frequency—every month on the fourth Wednesday of the month from 12:30 to 2 p.m. The meetings will generally alternate between business-type agendas and focused working meetings.
- Minutes to be taken by a DAA/AA on a six-month rotating basis.
- Agenda items shall be submitted in writing to the MOH's office at least one week prior to a scheduled meeting. A limited number of items may be added to the agenda during the meeting at the call of the Chair.
- The MOH will chair all meetings. In the absence of the Chair, she will appoint a designate from the Social Inequities in Health Steering Committee.
- Requests for additional meetings shall be made by submitting a request to the Chair.

O: JANUARY 2009
R: APRIL 2010

Appendix C
Social Inequities in Health (SIH)
Visioning Session Participant List

Facilitator: Mary Ellen Szadkowski, ZAD Consulting Inc.

Dr. Penny Sutcliffe
Medical Officer of Health and Chief Executive Officer (Chair)

Rachelle Arbour-Gagnon
Health Promoter, Environmental Health

Linda Belton
Public Health Nurse, Health Promotion

Annie Berthiaume
Public Health Nurse, Clinical Services

Tammy Cheguis
Dietician, Health Promotion

Ted Korzeniecki
Public Health Inspector, Environmental Health

Erik Labrosse
Manager, Health Promotion

Sandra Labrosse
Public Health Nurse, Clinical Services

Sandra Laclé
Director, Health Promotion

Jamie Lamothe
Communications Officer, Resources, Research, Evaluation and Development

Stephanie Lefebvre
Policy and Planning Specialist, Resources, Research, Evaluation and Development

Patrick Moores
Health Promoter, Health Promotion

Isabelle Michel
Director, Resources, Research, Evaluation and Development

Tina Pilon
Manager, Staff Development and Volunteer Resources, Corporate Services

Renée St. Onge
Research and Development Specialist, Resources, Research, Evaluation and Development

Susan Snelling
Manager, Research and Evaluation, Resources, Research, Evaluation and Development

Claire Warren
Manager, Professional Practice and Development, Resources, Research, Evaluation and Development

Shelley Westhaver
Director, Clinical Services

Appendix D
Environmental Scan

At the meeting, participants were asked to consider the *environmental factors* in 2020 that will affect health.

International Perspective

- Re-emergence of former diseases and development of novel diseases
- Increase in non-communicable disease: diabetes, obesity
- Increase in travel-related diseases
- Greater emphasis on health equity
- Change in economic super powers with emergence of countries such as China, India, and Brazil
- Demographic shifts with increased numbers of aging populations around the world
- Global climate change and related direct (e.g. heat-related) and indirect (e.g. political outfall) challenges
- Changing needs for food and water around the globe in terms of quantity and quality
- Influence of the United States globally and the leadership of the current president
- Technological advancements and the influence of technology in making the world "smaller" and more connected, the sense that borders are becoming less clear
- Risks of continuing wars around the world
- More forms of energy and struggles with and competition for resources

North American Perspective

- Climate change: more hurricanes and extreme weather, with needs for adaptation
- Change in diseases: new diseases and mutations of others
- Decline in birth rates: increases in immigration resulting in a changing makeup of the population
- High numbers of seniors and concerns about economic stability of this group (e.g. issues of pensions, home ownership)
- Water concerns: exporting of fresh water, water supply, water quality
- Energy concerns: changes to new sources of energy to replace fossil fuels
- Change in agriculture: impact on food security (e.g. massive commercial farms)
- Crime rates: concern re the impact of shortages and Poverty and homelessness increases
- Effects of oil spills/disasters: need for more fossil fuels, more drilling and more damage, less concern for the environmental impact inequities
- South American Free Trade Agreement: could new economic arrangements be made and what will be the repercussions?

Canadian Perspective

- Increasing numbers of seniors and increased poverty among seniors due to changes in CPP
- Pressures to privatize the Canadian health care system as a sustainability measure
- Increasing diversity of population
- Aboriginal issues: land claims, protection of natural resources
- Increasing emphasis on environmental issues and protection of natural resources
- Pressure for economic diversification

- Increasing health issues with children and youth, parents outliving children
- Increasing incidence of chronic disease
- Less reliance on imports
- Increasing pressure to consider issues of environmental and economic sustainability
- Smaller energy distribution systems (i.e. the possibility of more local systems of energy production), pressures to further exploit the environment for energy (e.g. more oil drilling offshore)
- Food security concerns leading to increased local food production
- Climate change: natural and human-made disasters
- Increasing cost of education: concerns regarding accessibility of education and impact on equity

Ontario Perspective

- Outmigration and urbanization: people moving to larger cities
- Increasing disparity due to immigration and urbanization
- Changing Aboriginal populations: concern regarding maintenance of traditions, issues of land ownership and land development, concerns about increasing disparities, increasing political voice of Aboriginal people
- Major changes in the demographic profile with lower birth rates and increased immigration
- Environmental pressures: water, greener policies, advancements in green energy
- Significant water concerns: how to manage among the provinces
- Changing social programs resulting from economic recovery
- Concern re the repercussions of the HST
- Local Health Integration Networks (LHIN) structures and possible changes to this: questions re how health care resources will be managed
- Increasing disparities between the north and south of the province regarding industries, increasing financial difficulties in the regions (e.g. resource base in northern Ontario and manufacturing in southern)
- Increasing education expectations but it is less affordable, more disparity, possible shift toward trades

Northeastern Ontario Perspective

- Informed sustainability with partnerships
- Demographics: aging of population, outmigration of young adults
- Increasing urban Aboriginal populations
- Social housing needs are increasing and are not being met
- Changing school environments with large super schools being developed
- Shifting industries: questions of what the economic base for NE Ontario will be as the resource-based industries are under significant strain (e.g. mining, forestry, pulp and paper)
- Reduced wages and increased income gap
- Increased demands on post-secondary schools, need for diverse education opportunities
- Energy needs and types have an impact on community design, more mixed use
- Transportation and connectivity across the region: more infrastructure and public transit
- Awareness and commitment to "buy local", not supported by government policy
- Designs of communities

Sudbury and Manitoulin Districts Perspective

- Arts community: very vibrant and active
- Mining industry is changing
- Multicultural: increased Aboriginal population, many Aboriginals moving back to First Nations although also increasing urbanization
- More seniors: potential to work with challenges, by 2020 the early baby boomers will be in their 70's and may place high demands on health services
- Increased expectations for people to pay for more health services than today
- Many seniors on fixed incomes have difficulty paying for health services
- Increased reliance on technology: those without access will fall further behind others
- Active transportation focus: bike trails
- Large super schools
- Changes to drinking water: pollution of lakes
- Francophone population is stable in size
- Increased centralization of health care
- Concern about the role of public health
- Entertainment quicker, better: influence of baby boomers, healthy focus
- Increased urbanization and reduction in farming
- Economic strain: not enough money
- Increased expectations re accountability and partnerships
- Increased environmental consciousness

Appendix E
Social Inequities in Health Vision Ideas

Participants were asked to answer two *visioning* questions:

1. What will be different *at the SDHU* because we have been working effectively to reduce social inequities in health?

2. In 2020 what will the *community* look like because SDHU has been so effective in reducing social inequities in health?

1. Sudbury & District Health Unit Vision Ideas

Services and Programs
- Increased focus on programs that have or can have an increased impact on SIH, i.e. early child development programs and supporting youth (building resilience throughout early/child/youth years)
- More demand for health promotion programming
- Chronic disease
- Increased community development
- More national/international speaking engagements to reveal our innovative strategies for reducing inequities
- Maybe we will be able to cycle back to focus on lifestyles since environmental and policy supports will be in place
- Reports and decisions made have a SIH lens
- We don't provide services that others already do
- Mental health agencies are a part of public health
- Opportunity to re-focus on more universal population health type promotion
- An increased emphasis on work related to the health inequities—reallocated resources

Staffing
- Increase health promotion staff
- Diverse workforce
- Different skill mix among staff
- Different staff demographic profile: more reflective of the community
- Hiring of social workers
- Workforce is multi-generational
- Multicultural staff
- More diverse workforce: culturally and in terms of skills
- Makeup of staff: employing social workers and other specialists—certain skill sets will be required

Attitudes and Skills
- Staff feeling more content that they are making a difference for the people in their community
- Confidence among staff in how to address social determinants of health
- Leadership
- We want to help improve the lives of those who need us most
- We will care more about how well we do our work
- Increased staff buy-in toward their work at reducing SIH
- Staff feel that they are really making a difference because they see the results
- All employees feel satisfied and rewarded because their actions are benefitting those who need it most
- Employees report positive, mutually beneficial relationships with diverse community partners and individuals

- All of our staff will have a high comfort level with working with and identifying priority populations
- We will be proud of our efforts
- Labour force that recognizes social inequities and knows what to do to tackle them
- Diversification of staff skills
- Staff has increased awareness of SIH impact and resultantly have changed their work
- The value placed on SIH will be "naturalized": we will not question the priority and perspective but will just know that it is part of our work
- Clear sense of our role
- Everyone will be better informed on the steps necessary to maintain this reduction and will be able to focus more efficiently on totally removing social inequities in health
- Clearer understanding of our role re mental health
- Skills in policy, advocacy, working in coalitions
- Significant staff competencies in community development and empowerment, policy development, and political involvement
- Staff can identify community resources and opportunities
- Skills in equity-based health impact assessments
- More knowledge and professional capacity for working with diverse groups
- Applying a social inequities in health lens will be a natural part of how we do business

Partnerships
- Increased community involvement: input driving our programs
- Increased work with partners
- Increase in diverse partnerships: increased credibility in the community
- Buy-in from government because the benefits become obvious
- Effective community partnerships: equal decision-making no power struggles
- Greater connection with our community
- Strong partnerships
- Working with the community: engaging priority populations in planning and program development, more community development
- Working with different partners (Ontario Works, disability, and mental health groups—partnerships that have never been developed in the past)
- Listen to what the community wants and not necessarily tell them what they want or need
- Some of our workforce is "blended" with another agency's staff and they may work off-site at their agency
- Listen to the children: they have an important voice now and in the future, they are still innocent enough to tell the truth
- We provide our expertise to those providing services to groups/agencies (who are the experts)
- More community input and voice at our planning tables
- Significant community involvement in the planning, delivery, and evaluation of our programs and services
- We will actively engage community members from priority groups in our planning and implementation
- Closer links with local government: policy link, fewer preventable hospitalizations

Structure
- Increased cohesiveness of program delivery in the community
- We will have "bodies of excellence" that staff can refer to for assistance and who will help spread new knowledge, connected with Laurentian University for relevant applied research

- Streamlined
- Programs working more closely together to achieve the above goals, less silos in programming
- Staff will be increasingly out in the communities, very few in the building
- Possibly increased decentralized physical locations
- Divisions are less in silos, more interdisciplinary working groups, teams, etc.
- A shift in power: not afraid to let others take the lead and be involved in decisions
- A shift in structure where the staff is more in the community and less in the office
- Larger communications department because social marketing will be a key component of what we do
- Mental health/physical health divide is reduced—mental/emotional health team?
- Departments will be working better together across issues
- Clearer understanding of what works and our roles
- Ability to focus collectively on large priorities
- Less emphasis on clinical services and control of infectious diseases
- There shouldn't be any reduction in staff, as proactive work is sometimes more important than reactive work
- Decentralized decision making and staff empowerment to try innovative strategies
- Reallocation of resources (human and financial) to address specific needs of priority populations, i.e. those who really need and would benefit most from services want to be supported through programming
- More staff empowered to be leaders in the community
- Increased use of website

Recognition

- Our organization will continue to be seen as a community leader in this
- Increased recognition by the public/community, agencies, and government for public health in this field (i.e. less or balanced recognition for work done in areas related to specific diseases)
- Increased recognition of the work we do

Other

- Social agencies are umbrella organizations with coordinated services
- Increased voices for populations: First Nations, seniors, single-parent families, immigrants, with health needs, leading to better policies and more inclusive planning
- Going somewhat beyond the mandate: not every community has the same needs (e.g. Some clients require medical exams to enter detox facilities and many do not have family doctors and need to pay for this service. Having in-kind contributions from our NPs' and MDs to assist with this on occasion)

2. Community Vision Ideas

Social Inequities in Health

- Better understanding of local needs as they relate to SIH
- The community will be more aware of SIH and will expect that more be done to address them
- Agencies will have common tables at which they meet to address SIH together: community members from vulnerable groups will actively participate at these tables
- Social inequities in health lens will be understood and applied by all and social inequities will be reduced
- Policies and bylaws are determined through the SIH lens

- Increased understanding of social inequities in health among local municipal governments and positive impact on policies (i.e. increased lobbying of provincial government for socially equitable policies, increased debate on SIH issues during local elections)
- Significant percentage of community is knowledgeable about health determinants and is supportive of policies that create health in a broader sense

Community
- Community invested in progress based on principles of social integration and links between SDHU and the community
- Community goals and objectives are set
- Sudbury and Manitoulin districts are seen as a model
- Increased population on Manitoulin Island due to Sudbury retirees
- Municipal governments will advocate and be asked for input on provincial policies to address SIH
- Enlightened political leaders and planners who utilize health equity lens when making decisions
- Strengthened connections with neighbourhoods and schools
- More policies that make health more accessible to all: bike lanes, paths to grocery stores, walks to school, affordability of nutritious foods
- More priority given to vulnerable population engagement in planning for programs and services and more engagement of priority population in those services
- Increased youth health because our child parenting programs and community planning have been effective
- More social cohesion, more youth centres, more parks, and free or subsidized recreation or arts opportunities for all people to participate in
- Community planning bodies
- All members have a voice

Health and Health Services
- Coordinated services without duplication
- Community members can identify and relate to the diverse factors that influence health
- All members of our community perceive and actually have the opportunity to access resources for health: health service programs, adequate income, housing, etc.
- Same service in branch offices as in the city: equity for all
- Many voices outside public health speaking for health (prevention and promotion)
- No barriers to health care: all will have a health card number, most will have family doctors, all will have access to primary care
- Targeting certain groups in addition to more generalized health promotion activities (high-risk, hard-to-reach). Those needing to be reached will be reached
- More cohesive programs in the community
- Reduced stigma of Health Unit programs (i.e. increased participation because they feel programs are more inclusive)
- Increase in the value of the diverse community in SDHU planning and program design and delivery
- All age cohorts who live in poverty have support for health opportunities

Measurement
- Reduced disparity in health
- Increased resilience
- Increased and equitable health status
- Increased self-reliance: food, energy, transportation, education

- Increased innovative solutions
- General population will be healthier as they will be better able to take preventative steps to reduce chronic disease
- Health of priority populations (Aboriginal, single parents, low-income) has improved to that of higher income groups
- Increased economic opportunities, policies which will allow people to own their own homes as well (i.e. mortgage policies)
- Increased employment opportunities for all ages (meaningful work with adequate compensation)
- Increased involvement of seniors in community planning
- Increased use of education: elementary, secondary, and post-secondary
- Our children will be among the healthiest, happiest, most resilient in the world
- Senior population will be thriving, living longer and healthier
- Health in all policies: equity-focussed health impact assessments applied to diverse community programs and services

Partnerships
- Increased partnership among community groups/members
- Intergenerational opportunities leveraged
- Diverse community partners and individuals report positive, mutually beneficial relationships with the SDHU
- Less generalized services: more focus on community as partner
- Our community members will be fully engaged at all levels and will actively participate in planning for initiatives that impact their health and social inequities in health
- Opportunity for all members' voices to be heard

Economic, educational, and cultural opportunities
- Fair access to opportunities
- More access to opportunities such as education, employment, etc.
- Overall increase in opportunities for all
- Vibrant, economically diverse community
- Income gap reduced: more social connection between different income and ethnic groups
- Diversity is maintained—without being a reason for inequity
- Increased integration and inclusion among all ethnic/cultural groups

Housing
- Housing for everyone, active senior population
- Capitalize on residential potential
- Enough housing, no condos
- Using old buildings to make housing
- Adequate assisted living and/or low-rent buildings
- Everyone will have a decent income; a safe, comfortable place to live; and a good job
- Increased affordable housing
- Increased social housing opportunities and mixed land use, mixed income neighbourhoods
- No homelessness
- Mixed neighbourhoods

Environment
- Smoking, alcohol, and drug abuse should be on the decline
- Smoke-free environment: smoke-free recreation areas, reduced smoking rates
- Control over contraband cigarettes
- Reduced smoking rates
- More green spaces (including space for growing food)
- Everyone will have the desire and ability to care for and protect the natural environment
- Everyone will have access to clean, safe drinking water
- Movement towards more free public space vs. private

Transportation
- Increased tourism: bike lanes on most streets
- More bicycles and infrastructure
- Less reliance on single operator motor vehicles; movement toward sustainable, inviting public transportation (e.g. rapid transit)

Food
- More reliance on volunteerism for programming
- Locally grown foods sold locally at reasonable prices so that everybody could afford them
- Community gardens
- Vegetarian restaurants increase in popularity
- Adequate amounts of safe, healthy, culturally appropriate foods that are produced and distributed in a sustainable and equitable manner
- Farming will return being to a noble profession, with a School of Agriculture opening in Sudbury
- Ensuring farmers and farm workers make a living wage and working conditions are safe and just
- Decreased reliance on food banks (and other emergency feeding programs) but more access to basic necessities
- Affordable food and sustainable food sources
- Most people have the knowledge and skills to prepare basic healthy meals and families eat together more often (i.e. the return of the home-cooked family meal)

Supports
- Social supports and structures in place
- People are supportive and not judgemental of those accessing support, no stigma for adults accessing support
- Integrated, comprehensive child service focused on early years
- Families are supported
- Not all resources are supporting just children

Recreation
- Increased emphasis on recreational opportunities
- More choices for physical activity
- Many vibrant local community projects: re food, arts, political activism

Attitudes
- Pride
- Feeling of "I am important. I am of value." is common
- Supportive
- Connected

- Resourceful
- Respecting and respectful
- Active
- SIH is unacceptable, attitude and belief

Belonging
- Increased cohesion and sense of community belonging
- Greater feeling of belonging
- Increased sense of belonging to the community, inclusiveness