How is a Health Equity Lens Being Applied in British Columbia?

In 2011, Canada and other United Nations member states endorsed the Rio Declaration on the Social Determinants of Health. This reiterated that a key strategy for achieving social and health equity is the reorientation of the health care sector towards action on the social determinants of health, with health equity as a central goal[1]. This includes identifying and reducing health inequities, which are the result of unfair structural and potentially remediable conditions[2]. Thus a health equity lens should bring to light the sources of inequities, as well as actions that promote health equity.

In the BC Guiding Framework For Public Health[3], public health providers are advised to apply an equity lens to all public health programs. In the Equity Lens in Public Health (ELPH) program of research, we examined understandings and application of a health equity lens in BC health authorities at two time points (Time 1: 2013/2014 and Time 2: 2015/2016) through a series of interviews with health authority staff. The distinct differences in understanding and application of a health equity lens at each of these time points are described below. Critical analysis of the strengths and limitations of each application informs recommendations, including the need for a systems level health equity lens.

Time 1*: A Diffuse Lens*

Understandings of health equity at Time 1 (2013/2014) were broad and diffuse (Figure 1). There was a general lack of clarity as to what constitutes a health equity lens, and a lack of guidance as to how it could be applied [4,5]. As a result, participants predominantly used proxy terms for health equity, such as vulnerable and marginalized populations.

Participants asserted health equity as an important value in their work, but found it challenging to discuss or take action on health inequities in concrete ways. Although there was some mention of addressing the social determinants of health to promote health equity, there was limited consideration as to how people are positioned in relation to accessing the social determinants of health.

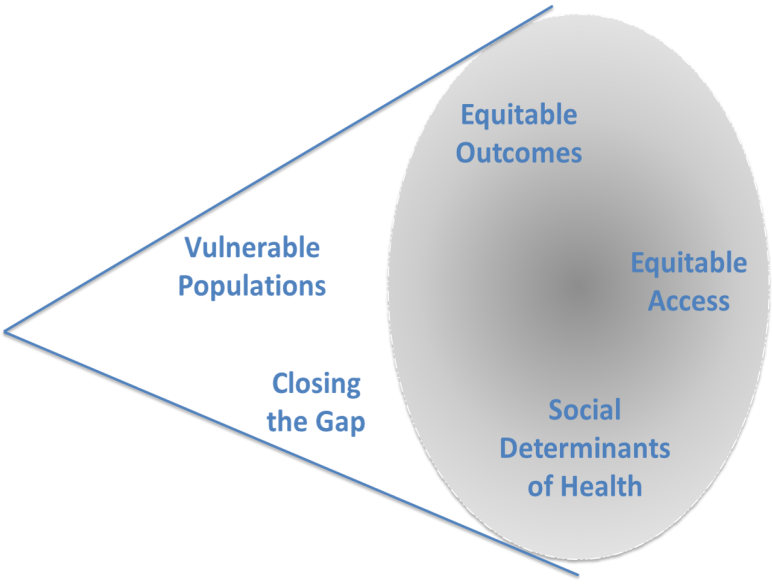

Figure 1. Time 1 (2013/14): A Diffuse Health Equity Lens

Discussions around the structural conditions that produce inequities such as racism, gender bias, ageism, ethnicity, and classism, were virtually absent, as was an understanding of how care within the health systems is impacted by these factors. The primary focus of applying a health equity lens at Time 1 was to achieve equitable access to health services with little mention of equitable outcomes.

Time 2*: A Narrow Lens*

Understandings of a health equity lens at Time 2 had narrowed to focus on targeting populations perceived to be impacted by health inequities (Figure 2). Populations most often identified as 'vulnerable' or 'marginalized' included: Indigenous people; people who use substances; people experiencing mental illness; and immigrants.

The primary focus of actions to address health inequities was on enhancing equitable access to care for these groups. Thus the application of a health equity lens had narrowed to one that focused on targeting populations perceived to be the 'worst off', with limited reach across the social gradient.

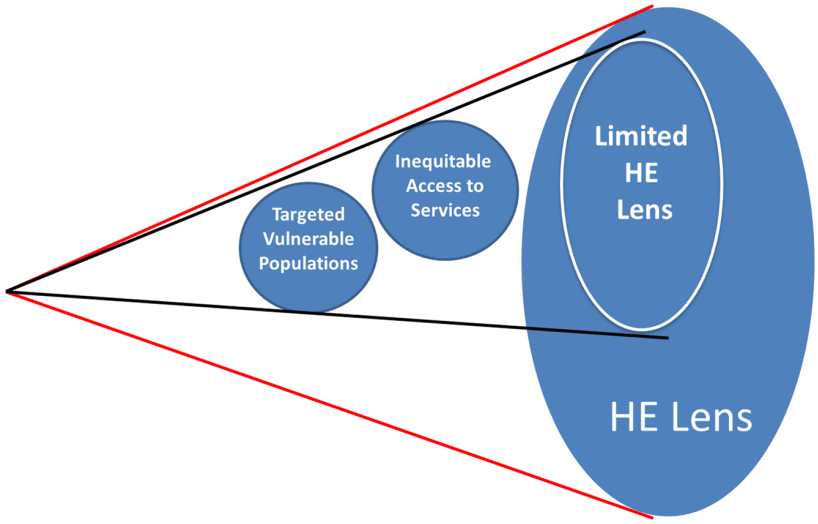

Figure 2. Time 2 (2015/16): A Narrow Health Equity Lens

Addressing the social determinants of health was perceived to be outside the scope of participants' work and that of the health care system. Although there was emphasis on geographical access to services, there was little emphasis on the way in which racism, gender bias, ageism and classism impact the achievement of equity through interactions with the determinants of health. This limited response focuses on identifying groups experiencing health inequities and often targeting the worst off, without addressing social conditions within and outside the health care system that produce health inequities.

The Influence of Health Care Context

We identified a number of factors influencing this shift from a broad though diffuse understanding of a health equity lens to a targeted and narrow approach. This shift followed provincial policy changes that mandated targeted public health programs and a discontinuation of universal services. Dominant health system values emphasized individual-focused and biomedical approaches to care, that were reinforced through values related to efficiency, scarcity, patient-centered care and acute-care priorities (Figure 3).

These values permeate health systems and compete with public health values related to health equity and social justice. Public health approaches such as health promotion, disease and injury prevention, and health protection aim to strengthen the capacity of individuals, families, and communities for the achievement of health, as well as address important consideration of the social, political, historical, and economic determinants of health that are the root of inequities. Inclusion of these is critical for a robust health equity lens.

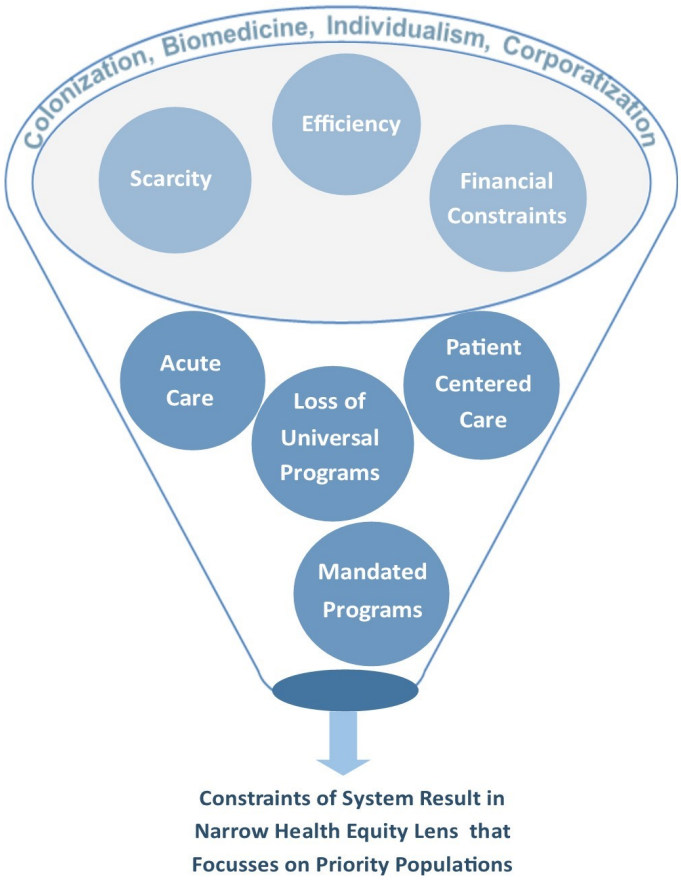

Figure 3. Health Equity Lens Resulting from System Constraints

What did we learn and where do we go from here?

We found that participants in BC health authorities were attempting to implement a health equity lens without adequate guidance, resulting in limited application of a health equity lens and response to health inequities. Current applications of a health equity lens have limited effectiveness in improving health equity and targeting may serve to inadvertently contribute to health inequities. To effectively reorient the health sector toward health equity, we need:

1. To acknowledge, challenge and engage with health system values. Dominant health system values of patient-centered care, efficiency and scarcity often mask values of social justice, limiting promotion of health equity and the application of a health equity lens in public health, as well as other areas of the health care system.
2. To consider how people are positioned both in relation to accessing the social determinants of health outside of the health system, as well as how care within the health systems is impacted by factors that produce health inequities such as racism, gender bias, ageism, and classism among others.
3. To apply a well-defined and robust systems-level health equity lens, based on social justice, that takes into consideration both complexity and intersectionality, as well guidance on its application. Such a lens has yet to be articulated, and the ELPH research team is currently working to develop one.

The ELPH Program of Research

ELPH is a 5 year program of research dedicated to the development and application of an equity lens in public health, to increase health equity and reduce health inequities. ELPH commenced in 2011, and is funded by the CIHR and PHAC. It is led by principal investigators Bernie Pauly, Marjorie MacDonald, and Trevor Hancock of the University of Victoria, and Warren O'Briain of the Ministry of Health, and includes partners from six of British Columbia's health authorities, British Columbia Ministry of Health, Public Health Association of BC, Public Health Agency of Canada, the National Collaborating Centre for the Determinants of Health and Public Health Ontario.

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