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CASE 4

Returning to Our Roots: Building Capacity in Public Health for Action on the Social Determinants of Health

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BACKGROUND

“Public health professionals practice at that intersection where societal attitudes, governmental policies, and people’s lives meet. Such privilege creates a moral imperative to work to change social conditions contributing to poor health.”
– Adeline Falk Raphael

Canadians are healthier than ever before, and live longer. But improvements in health are not distributed evenly between population groups. Not only is this a Canadian phenomenon, but disparities in health are growing around the world.

In fact, studies show that only 25% of our health is determined by health care and 15% by our genetics. The remaining 60% is determined by factors outside the traditional health care system, such as our income and social status, education, employment and working conditions, social support networks, social and physical environments, and culture (Canadian Medical Association, 2012).

These factors are called the social determinants of health (SDOH). When they are distributed in ways that are unfair, unjust, or avoidable, they are termed health inequities. Health inequities act as risk conditions that disproportionately affect certain populations, creating situations where they may be:

- Unable to read
- Unable to afford the basic necessities
- Working a low-paying job with precarious hours, or are unemployed
- Living in sub-standard conditions
- Drinking poor quality water
- Suffering from high stress
- Being discriminated against based on culture or ethnic background
- Living far from a grocery store
- Feeling isolated in their own community

However, these determinants can also be protective when everyone is given fair opportunities to access them. The SDOH cut across the purview of many sectors, such as education, health,

and socio-economic and public policy. Therefore, understanding roles and responsibilities for health equity action remains a challenge.

HEALTH EQUITY ACTION IN CANADA

Since the advent of the Ottawa Charter for Health Promotion in 1986, reducing health inequities has been an ethical, social, and economic imperative for many countries worldwide (Whitehead & Dahlgren, 2006; Crombie, Irvine, Elliot, & Wallace, 2005; Commission on the Social Determinants of Health, 2008). However, within the Canadian public health sector, difficulty translating health equity rhetoric into action has been notable, despite the critical role public health organizations play in reducing health inequities (National Collaborating Centre for Determinants of Health, 2014).

The National Collaborating Centre for Determinants of Health (NCCDH) conducted an environmental scan in 2014 of public health sector practices, barriers, and opportunities to advance health equity in Canada. The scan discovered that professionals working at all levels of the public health system want more evidence to guide public health practice, especially regarding how to effectively reduce health inequities.

To date, many public health actions have been undertaken in order to reduce health inequities. These efforts include those within the traditional realm of the health sector, such as identifying those experiencing health inequities, enhancing provision of services to priority populations by reducing barriers to access and tailoring services, or those outside the traditional realm of the health sector, such as partnering with other sectors, forming coalitions, undertaking community development, and advocating for improved living conditions.

While some progress has been made, SDOH proponents argue that public health is well-positioned to do more, given their ability to mediate the relationship between the political and institutional systems that create health inequities, and their potential to build the capacity required to act on them.

While we have seen an increased commitment in dedicated organizational structures and processes in place for health equity across Canada, “the momentum has not yet resulted in significant, concrete actions to reduce health inequities” (NCCDH, 2014). Without these actions, many public health champions voiced concern that public health interest in health equity may become a passing fad.

Therefore, the challenge is no longer collecting evidence, but translating that evidence into concrete action.

This challenge points to a strong need for the renewal of public health efforts, including a clearer direction for action to promote health equity. Such efforts include:

- Improving the understanding of the contextual influences that promote the uptake of health equity as a priority in the health system;
- Expanding the engagement of public health with other sectors to reduce health inequities;
- Analysing the theoretical and practical utility of existing organizational structures, processes, outcomes and tools to promote health equity action;
- Enhancing the understanding of the ethical issues encountered by public health practitioners in their efforts to reduce health inequities and the process of managing

- those tensions (i.e. the tension created when health units who are funded by public sector resources are advocating for policy change); and
- Improving knowledge translation and exchange processes to strengthen and improve health sector innovation for reducing health inequities.

Ultimately, many in the field know that the SDOH are complex health issues that will require a stronger focus on identifying levels of influence for health equity action at the individual, organizational, and systems level. But someone has to take the lead, and who better to do so than public health.

THE ONTARIO SDOH NURSE INITIATIVE

On August 16th, 2012, Louisa Giovanni received a call from Diane, the supervisor of Health Promotion at the Lakeshore Public Health Department (LPHD). Diane gave her the great news that she would be one of two nurses hired to build capacity in the organization to address the social determinants of health (SDOH). Her position would begin at the end of October.

This position was part of the Ministry of Health and Long-Term Care's 9000 Nurses Initiative, where 72 nurses (two per health unit) would be given the title of full-time SDOH Public Health Nurse. The Ministry did not set standards for what this position would look like. It was up to each individual health unit to decide how the roles would unfold. Some of the other nurses had been hired six months ago, but everyone was required to provide a report on their activities by January 2013, giving Louisa only two months to show impact.

What was she going to do in such a short period of time, to address a complex issue, where interventions to address the SDOH often take years? Where could she start to make an impact on how the organization would address the SDOH? Where would she begin to look for advice?

At the time Louisa was hired, LPHD had a part-time Medical Officer of Health. LPHD's Board of Health, who essentially governed the programs and services delivered by the organization, was integrated with the local Municipality. Therefore, unlike some other independent health units in Ontario, any decisions made had to go through the Board of Health.

At the staff level, it quickly became clear that different departments operated in isolation, limiting their opportunities to collaborate with each other. Louisa also noticed that some departments seemed very cohesive, had great operational plans in place, and were highly skilled. Other departments appeared stressed, and had limited time to do anything other than front-line work with clients.

On Louisa's first day, many people were welcoming and did their best to introduce what their role in the organization was. As the day went on, many colleagues asked Louisa what her role would be, and what value her position would bring to the organization. Louisa attempted to suggest that she would work as a consultant within the organization to build capacity for action on the SDOH. However, many staff said they all worked on the SDOH in their own ways, and offered many examples. Some examples accurately reflected action on the SDOH, while others showed that many staff didn't have a clear understanding of what the SDOH were in the first place. She began to wonder how she could add value to their work, especially those who thought they were already doing enough.

SITUATIONAL ASSESSMENT

Louisa decided to meet with managers from the different departments to get a sense of the current level of capacity for equity action. While most claimed their programs were designed with the SDOH in mind, many were doing more downstream activities that impacted individual clients, rather than population groups. When she asked why the organization wasn't advocating for more upstream policy changes that impact health outcomes across the population; managers and staff were quick to point out the limitations of having a municipal Board of Health.

Many managers recognized that while public health advocacy is an important population health approach, there are various challenges faced, especially when the issues are complex (i.e. the determinants of health) and may relate to policies that are the responsibility of sectors other than health.

Some examples of challenges they described included:

- The political nature of fostering systemic change;
- The tension advocacy creates as LPHD was mostly funded by public sector resources;
- Limitations of advocacy efforts due to boundaries of professional roles (i.e. government employees), employer policy, or limited access to resources for advocacy activities; and
- The belief that public health should remain a value-free, mainly scientific activity. As a result, many feel that health equity is a philosophical principal - similar to social justice - that is heavily based on the values and ideology of individuals, organizations, and systems within any given society.

After talking to staff and management at the LPHD, Louisa was no further ahead. She decided to meet with key stakeholders within the community who were already working on the SDOH, such as the Poverty Reduction Network and the Community Homelessness Initiative Network. These coalitions were comprised of stakeholders from various sectors, including health, economics, education, and social services, which made them well positioned to influence policy choices that impacted vulnerable populations. However, once the meetings ended, very little was being done to work together. Most members just went back to their organizations and continued with their everyday activities.

Finally, Louisa decided to talk to some of the other SDOH nurses across the province. This group was unfolding to become a great source of networking and a community of practice for health equity. The group as a whole was beginning to discover that all health units had varying levels of capacity, inconsistent Board of Health structures, yet similar challenges. Overall, most nurses were encountering the same issues, but agreed upon one primary goal: to identify how to move health equity rhetoric into action.

Many of the nurses tried to link the need for equity action with organizational standards and competencies. Louisa decided to start with the Ontario Public Health Standards and Core Competencies for Public Health to get a sense of the organizational standards in place to identify the SDOH and promote action on health equity issues.

Louisa quickly identified the many opportunities and challenges the two core documents presented in setting the context for health equity action in public health.

1. The Ontario Public Health Standards (Ministry of Health and Long-Term Care, 2014)

In 2008, the Ontario Public Health Standards (OPHS) were created to guide the local planning and delivery of public health programs and services. They set the minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion, health protection, and community health surveillance legislated for Ontario Boards of Health, pursuant to section 7 of the *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7.

The OPHS state that "boards of health shall not only examine the accessibility of programs and services to address barriers (e.g. physical, social, geographic, cultural, or economic), but also assess, plan, deliver, manage, and evaluate programs to reduce inequities in health, while at the same time maximizing the health gain for the whole population" (p. 21).

Therefore, the OPHS (2014) are a practical agenda for addressing health inequities across all programs and services in public health. Specifically, the OPHS state that "addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario" (p. 4), and public health interventions shall acknowledge and aim to reduce existing health inequalities.

Action on health inequities are stated to be operationalized predominantly through the work on priority populations, defined as "those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level" (p. 4). Priority populations may be identified by surveillance, epidemiological, or other research studies, including community and stakeholder consultations.

Finally, the equity foundations in the OPHS outline principles that public health practitioners are required to follow, including:

- Need: use epidemiology and other methods of gathering information to identify priority populations.
- Impact: examine accessibility of the existing programs and reduce barriers; plan, deliver, manage, and evaluate the programs to reduce inequities in health.
- Capacity: allocate resources to address health inequities.
- Partnership and Collaboration: share knowledge and use partnerships and collaboration to engage the community.

While the equity foundations in the OPHS outline principles that public health practitioners must follow to reduce inequities in health, little guidance is given regarding interventions or pathways that are known to work. This lack of clarity in how to reduce health inequities leaves Boards of Health with varying interpretations of the where and to what extent action is required to reduce health inequities through the standards.

2. The Core Competencies for Public Health (Public Health Agency of Canada, 2008)

Not only do the public health standards specifically mandate that public health practitioners work towards the SDOH, but the Core Competencies for Public Health have focused on them as well.

The Core Competencies explicitly state that "public health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment. These, in combination, create different living conditions which impact on health" (p. 10).

Overall, there are 36 Core Competency statements introduced by the identification of shared attitudes and values of public health practitioners, which specifically describe the context within which the competencies are practiced. These attitudes and values contain significant and explicit content about the determinants of health. Examples of competency statements include "a commitment to equity, social justice, and sustainable development," "respect for diversity, self-determination, empowerment, and community participation," and "these values are rooted in an understanding of the broad determinants of health" (p. 3).

Despite the expressed importance of health equity, the set of attitudes and values is written as a preamble to the Core Competencies, not as specific competencies that are expected in public health practice. Following the preamble, the 36 competencies are arranged under seven categories. Out of these seven, five contain implicit information related to the determinants of health. Ultimately, a great need exists to develop Core Competencies more specific to health equity and the social determinants of health.

The newly developed Pan-Canadian Health Promoter Competencies published in 2014 may provide a foundational description of the competencies required to act on the SDOH in order to reduce health inequities that could be adapted for various disciplines within public health (Pan Canadian Network for Health Promotion Competences, 2014). For example, under the first competency of demonstrating knowledge and skills necessary for health promotion practice, health promoters are required to "apply a population health promotion approach, including health and health equity, to the analysis of health issues" (p. 1). With more explicit language, practitioners have a core document that can be leveraged to support their roles in health equity action.

Overall, Louisa quickly realized that there appeared to be a lack of clear, consistent direction on how to take action on health inequities. More importantly, there appeared to be a limited focus on measuring and defining organizational capacity for health equity action, where most efforts focused on the characteristics of the programs and services the health unit delivered, rather than the capacities needed to deliver the programs and services in the first place.

SETTING THE CONTEXT FOR CHANGE: AN OPPORTUNITY FOR EQUITY ACTION AT THE LPHD

After assessing the opportunities to gain momentum on health equity both within LPHD and externally, a crucial change within the LPHD occurred. A new Medical Officer of Health (MOH), Dr. Raj Subramaniya, was hired, which led to new and significant opportunities, including the need for a strategic plan. Louisa was quick to suggest that equity become embedded in the mission, vision, and values of the new strategic plan. If she could get Dr. Subramaniya to commit to this, many organizational structures would have to follow in order to achieve action on health equity at the LPHD. When Louisa approached Dr. Subramaniya, he was excited about her suggestion, and asked that she take on the task of outlining the various elements needed to build capacity for equity action at LPHD.

Louisa decided to take on a grounded theory approach to inform the need, challenges, and opportunities for health equity action, as well as construct a conceptual framework. Guided by her experiences and observations, Louisa conducted:

- A review of both grey and peer-reviewed literature; and
- Key informant consultations with LPHD senior managers and public health nurses working in positions dedicated to health equity across Ontario to explore the logical implications of the framework in practice and to validate and inform needed changes.

The literature review revealed that while organizational capacity was recognized as a critical determinant of system performance, capacity assessment was often neglected in favour of program development and performance, or evaluated within very narrow perspectives in public health. This was problematic because focusing on performance alone ignores other important elements of capacity that contribute to the ability to reduce inequities, such as the optimal configuration of resources associated with effective and efficient performance (Meyer, Davis, & Mays, 2012).

The literature suggested that public health performance *relative* to the capacity of the system or organization was a more useful concept to guide public health practitioners. This may enable public health practitioners to ask how well they are doing (process/performance), given what they had to work with (capacity) (Handler, Issel, & Turnock, 2001; Freudenberg, 2004; Israel et. al., 2010).

Therefore, capacity for equity action means having the knowledge, skills, commitment, and resources at the individual, organizational, and wider systems level to improve practice and lead to the reduction of health inequities.

Ultimately, in order to assess performance relative to the capacity of an organization to take action on health inequities, a great need existed to identify elements of capacity at three levels of influence (World Health Organization, 2010):

- **Individual-level**: can help understand the gaps in the skills and competencies of public health professionals that are required to uncover and analyze inequities.
- **Organizational-level**: can help organizations capture progress toward health equity objectives.
- **System-level**: can help monitor community action on the broader conditions that impact health equity.

Louisa, along with the other 71 nurses across Ontario, initially focused efforts on understanding what these capacity elements entailed, and spent most of their time sharing stories and solutions for how they attempted to build capacity for equity action.

CONTRIBUTION OF THE ONTARIO SDOH NURSE INITIATIVE

In two short years, the SDOH nurses became well known in Ontario, and their work became an influential contributor to public health capacity for equity action. The initiative led to the establishment of organizational processes, structures, and communities of practice for health equity (NCCDH, 2014). Having this commitment so far had been attributed to increased capacity for public health action at the organizational and municipal level; however, the level of commitment varied heavily between organizations due to several reported challenges. While each health unit was required to have a Board of Health that monitored all operations within the unit, and remained accountable to the community and the Ministry of Health and Long-Term Care, the governance structures could vary. With all 36 Boards of Health structures being unique, some argued that the capacity to take action on health equity was uneven, with some structures facilitating this capacity more than others.

Many began to recognize the need to level and scale up existing actions taking place among the “early adopters”, i.e. the organizations already engaged in health equity action.

What the SDOH nurses needed was a framework that would facilitate a greater understanding of the context, dynamics, and capacities within which public health organizations worked, in order to guide efforts towards reducing health inequities.

The framework could then be used to assist practitioners, managers, and decision-makers within public health organizations in assessing the critical elements for building health equity capacity, and identifying those areas that need strengthening or further development.

The literature suggests that organizational capacity frameworks have the potential to impact every aspect of how an organization operates. A framework would allow an organization to look at the multiple levels of influence on their capacity, including the individual, organizational, and systemic levels. Its application may affect how needs are assessed at the program level, thus influencing how programs are planned, implemented, and evaluated. At the organizational level, such a framework could affect the priority setting process, how partnerships are developed, and how leadership is enacted at the systems level (NCCDH, 2013).

It can also serve as a useful planning tool for consultants, evaluators, directors, and managers responsible for developing capacity for equity action.

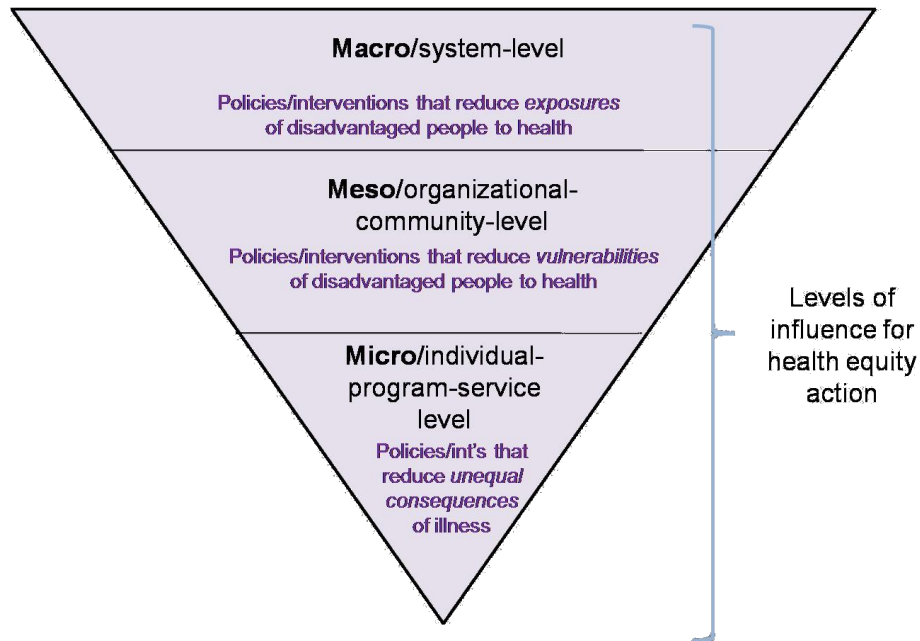
Overall, Louisa hoped that the creation and adoption of a framework and recommendations may provide public health organizations with a strategic direction for health equity.

What the SDOH nurse initiative demonstrated was that public health practitioners were well positioned to mediate the relationships between structures that create health inequities, and the organizational and individual capacity required to reduce health inequities. Therefore, public health policies and interventions could be aimed at three different levels of influence: micro (individual), meso (organizational), and macro (systems) (see Exhibit 1).

The biggest challenge Louisa and the SDOH nurses faced now was what was required to build organizational capacity for equity action? How could they influence health outcomes for

community members so that they were more equitable? What were the specific elements that were needed at each level of influence?

EXHIBIT 1
Levels of Influence for Health Equity Action



Source: Adapted from Solar & Irwin, 2010.

REFERENCES

1. Canadian Medical Association. (2012). 12th annual national report card on health care. Retrieved May 6, 2014, from <http://www.entitesante2.ca/wp-content/uploads/2012/05/Annual-national-report-card-on-Health-care.pdf>
2. Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: achieving health equity through action on the social determinants of health*. Geneva: World Health Organization.
3. Crombie, I., Irvine, I., Elliot, I., & Wallace, H. (2005). *Closing the health inequalities gap: an international perspective*. Copenhagen: World Health Organization.
4. Freudenberg, N. (2004). Community capacity for environmental health promotion: Determinants and implications for practice. *Health Education Behaviour*, 31(4), 472-490.
5. Handler, A., Issel, M., Turnock, B. (2001). A conceptual framework to measure performance of the public health system. *American Journal of Public Health*, 91(8), 1235-1239.
6. Israel, B., Coombe, C., Cheezum, R., Schulz, A., McGranaghan, R., Lichtenstein, R., ... Burris, A. (2010). Community based participatory research: A capacity-building approach for policy advocacy aimed at eliminating health disparities. *The American Journal of Public Health*, 100(11), 2094-2102.
7. Meyer, A., Davis, M., and Mays, G. (2012). Defining organizational capacity for public health services and systems research. *The Journal of Public Health Management Practice*, 18(6), 535-544.
8. Ministry of Health and Long-Term Care. (2014). The Ontario public health standards. Retrieved May 30, 2014, from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/
9. National Collaborating Center for Determinants of Health. (2014). Boosting momentum: Applying knowledge to advance health equity. Retrieved May 30, 2014, from <http://nccdh.ca/resources/entry/boosting-momentum>
10. National Collaborating Center for Determinants of Health. (2013). *Public health speaks: Organizational standards as a promising practice to advance health equity*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
11. Pan-Canadian Network for Health Promoter Competencies. (2014). Pan-Canadian health promoter competencies. Retrieved August 5, 2014, from <http://www.healthpromotercanada.com/hp-competencies>
12. Public Health Agency of Canada. (2008). Core competencies for public health in Canada: Release 1.0. Retrieved May 30, 2014, from http://www.phac-aspc.gc.ca/core_competencies
13. Solar, O., & Irwin, A. (2010). A conceptual framework for action on the social determinants of health. *Social determinants of health discussion paper 2 (policy and practice)*. Retrieved September 12, 2014 from http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf.
14. Whitehead, M., Dahlgren, G. (2006). Levelling up part one: A discussion paper on concepts and principles for tackling social inequities in health. *Studies on social and economic determinants of population health*. World Health Organization: Copenhagen

15. World Health Organization. (2010). A conceptual framework for action on the social determinants of health: Social determinants of health discussion paper two. Retrieved May 14, 2014, from http://www.who.int/social_determinants/corner/SDHDP2.pdf

INSTRUCTOR GUIDANCE

Returning to Our Roots: Building Capacity in Public Health for Action on the Social Determinants of Health

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BACKGROUND

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OBJECTIVES

1. Examine ways to develop core competencies more specific to health equity and the social determinants of health.
2. Explore elements of organizational capacity, and use them to move health equity rhetoric into action.
3. Explore ways to assess existing programs using an equity lens.
4. Explore the process of developing and getting buy-in for a health equity framework.

DISCUSSION QUESTIONS

1. What is required to build organizational capacity for equity action?
2. How can staff influence health outcomes for community members so that they are more equitable?
3. What are the specific elements that are needed at each level of influence?

KEYWORDS

Health equity; social determinants of health; conceptual frameworks; nursing leadership; organizational capacity building; grounded theory.