Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice

- Findings from an Environmental Scan Conducted for the National Collaborating Centre for Determinants of Health

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  – 4-member expert reference group (Connie Clement; Lynn McIntyre; John Millar; Cory Neudorf)
  – Staff of the NCCDH
  – Information gathering participants:
    • Key informants (31)
    • Focus groups (4)
    • Online survey respondents (600)
National Collaborating Centres (NCC)

- Established concurrently with PHAC
- Purpose is to:
  - Promote and improve the use of the results of scientific research and other knowledge to strengthen public health practices and policies in Canada.
  - Identify knowledge gaps, foster networks and translate existing knowledge to produce and exchange relevant, accessible, and evidence-informed products with researchers, practitioners, and policy makers
- 6 NCCs: AH; EH; ID; M&T; HPP; DOH
Project Conceptual Overview

Approach:
- Scan of literature
- KI interviews
- Focus groups
- Online survey
Today’s Objectives

• Increased understanding of the context and state of public health action on determinants of health and health inequity
• Increased awareness of the four roles for public health action on determinants of health and health inequity
• Increased understanding of how these four roles can be used to improve current public health action
• Increased awareness of the role of the NCCDH to support greater action on determinants of health and health inequity.
Session Overview

• Presentation
  – Project overview
  – Context and state of public health action on health determinants and health inequities

• Discussion

• Presentation
  – Key public health action roles
  – Use of roles for organizational self-assessment and capacity building

• Discussion
Terminology

• **Determinants of Health:**
  – Range of factors that determine health status

• **Social Determinants:**
  – Social conditions in which people live and work

• **Health equality/inequality:**
  – Differences in health outcomes and determinants

• **Health equity/inequity:**
  – Inequalities deemed unfair or stemming from injustice

• **Health disparities:**
  – Differences in health status among population groups defined by specific characteristics

[Daghofer & Edwards, 2009]
Expectations for Public Health Action on Inequalities & Inequities

- Historical roots of public health
- Evolution of thinking – landmark reports
- Recent emphasis/guidance – core programs
Historical Roots of Public Health

– John Snow – why some Londoners dying of cholera and others not?
– Edwin Chadwick – marked differences in mortality rates among population groups → Sanitarians
– Early Canadian public health leaders – spoke eloquently of social conditions and their links with disease and wellbeing
Progression of Landmark Reports

• Understanding of health determinants
  – Ottawa Charter (1986)
  – Population Health Promotion Cube (1996)
  – Population Health Approach/Template (2001)
Landmark Reports - Issue of Inequities a Key Theme

• Epp Framework (1986)
  – Challenge 1: Reducing inequities
  – To find ways of reducing inequities in the health of low-versus high-income groups

• Population Health Approach (2001)
  – A population health approach focuses on improving the health status of the population.
  – Focusing on the health of populations also necessitates the reduction in inequalities in health status between population groups.
  – Reductions in health inequities require reductions in material and social inequities.
More Recently – Series of Major Reports (not exhaustive)

- Reducing Health Disparities – Roles of the Health Sector (ACPHHS, 2005)
- Population Health Policy: Issues and Options (Senate Subcommittee, 2008)
- Healthy People, Healthy Performance, Healthy Profits (Conf Board of Canada, 2008)
- Canadian CPHO Reports (PHAC, 2008, 2009)
- Reducing the Gaps in Health: a Focus on Socio-Economic Status in Urban Canada (CIHI, 2008)
Building Expectations into Public Health Core Programs

• QU:
  – Key strategies include:
    • community development;
    • participate in inter-sectoral action that promotes health and well-being;
    • support groups that are vulnerable

• BC:
  – Includes a lens to assess and address health inequalities
  – Identifies 8 ways public health can contribute to reducing health inequalities

• ON:
  – Active discussion to include a public health standard for health inequities
  – OPHS positions issue:
    • “reducing inequities are fundamental to the work of public health in Ontario.”
    • “identify and work with priority populations”
Summary – Thinking and Expectations for Public Health Action on Health Inequities

• This is not new

• Clearly builds on the historical foundations of public health practice and the evolution of thinking/theory of recent decades

• Increasingly reflected in programming (i.e., practice) expectations – at least in some jurisdictions
... But What About Public Health Action?

• Interest ++
• But **very mixed picture** (among/within provinces)
• More likely to describe inequities/inequalities versus taking action on them
• Several examples of public health organizations engaged in action to address DOHs to reduce inequities
  – BUT, **not** representative/typical
  – Even *within* early adopter organizations, not necessarily institutionalized
Public Health Action...

• “The land of pilot projects” [Monique Begin]
• Health promotion in Canada: 25 years of unfulfilled promise [Trevor Hancock]
• “Actual public health activities consistent with a [SDOH] approach are sporadic at best” [Raphael]
• Preoccupation with behaviour and lifestyle approaches
  – default is often services to middle class with emphasis on ‘education’ vs. structural or tailored approaches
But Why?

• Evidence-base is limited and complex –
  – Limited publishing by practitioners;
  – Limited evaluation
  – Evidence not easily retrievable nor actively disseminated - need for synthesis and tangible evidence-informed strategies
  – And from different fields (e.g., political science and policy change)

• Conceptual problems:
  – Belief that population health approach = target general population
  – Focus intently on small population and lose sight of bigger picture
  – Limited training opportunities
More Whys

• Unclear what public health could pragmatically do
  – Many reports too conceptual
  – Clearly defined within mandate? Accountability?
  – ‘Too big’ - outside our sphere of influence
  – ‘Extra work’ vs. intrinsic to practice
  – Awareness of the early adopters is limited

• Public health engagement with communities
  – Focus on service delivery and hard outcomes
  – Bureaucratic/controlling organizations – risk adverse
  – Structural changes impairing links with broader partners
And More Whys

• Infrastructure
  – Leadership – influences priority setting, allocation of resources, modeling of desired behaviours
  – Communication – need to strategically use information and its communication
  – Capacity – highly variable across organizations (assessment/surveillance, community development, managing change, etc.)
  – Political environment – can be highly unsupportive, leaders’ self-censorship, opposition to reallocating resources to address inequities
Opportunities

• Past experience
  – Rediscover our roots
  – Our successes including massive shifts in social norms

• Increase in research interest

• Innovators/early adopters

• Extent of interest
  – Within public health
  – In other sectors
Discussion

- Does any of this surprise you?
- Does it align with your experience?
- Any key points you would add?
Moving Forward

• Too big, too difficult → Simplify action
• But what could we do? → Leverage experience of early adopters
• But things are different here → Need to tailor action to local circumstances (internal, external, etc.)
4 Roles for Public Health Action

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

• **Modify/orient** public health interventions to reduce inequities including the consideration of the unique needs and capacities of priority populations (i.e., do planning and implementation of existing programs considering inequities)

• **Partner** with other service providers to collectively address health inequities (i.e., when look at the collectivity of our programming for ‘x’, where are the gaps?)

• **Lead/participate and support** other stakeholders in policy analysis, development and advocacy for improvements in the health determinant/inequities.
Assess & Report on Health of Populations

• Key Attributes:
  – Describe existence and impact of inequalities & inequities
  – Identify effective strategies to address those disparities

• Examples (illustrative, not exhaustive):
  – Health disparity in Saskatoon: analysis to intervention
  – The unequal city: income and health inequalities in Toronto
Modify/Orient Public Health Interventions [‘walk the talk’]

• Key Attribute:
  – consideration of the unique needs and capacities of priority populations in identifying needs, planning, and delivering programming (targeting with universalism; equity-focussed HIA)

• Examples:
  – Saskatoon: address large disparities in immunization coverage by neighbourhood
  – Sudbury: equity-focussed planning path
  – Waterloo: equity-based assessment and planning cycle
Partner with Other Service Providers

• Key Attribute:
  – Collectively address health inequities addressing barriers/Issues in coordinated and comprehensive manner

• Examples:
  – Saskatoon: partnering with other healthcare components, conducting healthcare equity audits (e.g., diabetes care across socio-economic determinants)
  – Sudbury: with local partners, mapped 20 child determinants to identify best location for establishing Best Start centre
Policy Analysis, Development and Advocacy

• Key Attributes:
  – Varying roles with other stakeholders - lead/participate/support
  – Seeking improvement in health determinants /inequities – inter-sectoral action to achieve healthier public policy

• Examples:
  – Quebec: legislating HIAs within Public Health Act
  – Saskatoon: community consultations to verify statistical findings and assess feasibility of evidence-based policy options
Feedback on 4 Public Health Roles

• Feedback sought during interviews, focus groups and survey
• Widespread agreement (e.g., >90% of survey respondents strongly agree or agree)
Alignment with More Detailed Lists of Public Health Actions

BC's Health Inequalities Lens

4 Public Health Roles

- Assess & Report
- Modify/Orient Our Programs
- Partner to Address Gaps
- Work with Stakeholders on Policy

Sudbury's 10 Promising Practices to Reduce Social Inequities in Health in Local Public Health
Other ‘Roles’

• Suggestions:
  – Leadership
  – Educating public and broader decision-makers
  – Research and evaluation
  – Improving staff and other service provider skills

• These suggestions apply to all of the four roles – how public health achieves/strengthens these roles
  – e.g., leadership to establish priorities, resource allocation, structural change, engaging others, modeling behaviours
Roles & Approaches

• Adapted existing capacity building frameworks (Europe, Australia) with following approaches:
  – Leadership
  – Develop/apply information & evidence
  – Education & awareness raising
  – Organizational & system development
  – Skill development
  – Partnership development

• These approaches can be applied to one or more roles to create a matrix to guide action
### “WHAT”

<table>
<thead>
<tr>
<th>Public Health Roles (What public health can do to address inequities)</th>
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<tbody>
<tr>
<td>Assess and report</td>
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<td>Modify/orient public health interventions</td>
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<td>Partner with other service providers</td>
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<td>Work with other stakeholders to address policy</td>
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### “HOW”

| Components to Public Health Action (How public health achieves/strengthens these roles) |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Leadership                      | Develop/Apply Information & Evidence | Education & Awareness Raising | Organizational and System Development | Skill Development | Partnership Development |
| Assess and report               |                                 |                                |                                 |                  |                       |
| Modify/orient public health interventions |                                 |                                |                                 |                  |                       |
| Partner with other service providers |                                 |                                |                                 |                  |                       |
| Work with other stakeholders to address policy            |                                 |                                |                                 |                  |                       |
Use of the Matrix by NCCDH

• Recall purpose of the NCCs is to:
  – Promote and improve the use of the results of scientific research and other knowledge to strengthen public health practices and policies in Canada.
  – Identify knowledge gaps, foster networks and translate existing knowledge to produce and exchange relevant, accessible, and evidence-informed products with researchers, practitioners, and policy makers
  – Environmental Scan findings being applied (online seminar; workshops; summer institute; etc.; further info: www.nccdh.ca
How Could Matrix be Used by Public Health Organizations?

• Key steps:
  1. Make decision* to improve organization’s actions to improve health determinants to reduce health inequities.
  2. Select one or more of the public health roles to pursue practice improvement.
  3. Take action to improve the selected practice(s).

*Adoption process: Awareness, Persuasion, Decision, Implementation, Continuation
How Select Role to Pursue?

• May be obvious
• Assess & Report tends to precede others
• A more deliberate approach could include the following for each action:
  – Characterize current practice (potential to use more detailed descriptions from BC/Sudbury)
  – SWOT analysis
  – Identify options for practice improvement
  – Prioritize options & decide which to pursue
<table>
<thead>
<tr>
<th>Roles</th>
<th>Current Practice</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
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<td><strong>Engage</strong> in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs</td>
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ID Options & Analysis
Now What?

• Implementing a new or improved practice to increase action on determinants/health inequities is an example of a quality improvement initiative.

• As such, a deliberate and defined process such as the Plan-Do-Check-Act cycle (PDCA) should be considered.

• As part of the ‘plan’ stage, carefully consider current practices, why desired practice not in place, potential improvements, etc. This is where capacity building part of matrix may help.
Getting Ready to Plan
- Seeking Understanding

• E.g., Why are health inequities not currently considered in the organization’s planning and delivery of our public health programs and services?
  – Not been identified as an organizational priority
  – Not an explicit part of program planning framework
  – Staff not sure of how to do this
  – Staff not sure how this aligns with provincial program standards/expectations
  – Staff not sure of evidence base to support such a practice.
# Identifying Potential Areas for Capacity Building

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<th>Capacity Building Actions/Approaches</th>
<th>Action</th>
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| Leadership                          | • Identify consideration of health inequities in program planning as a priority  
• Strike project team  
• Approve and allocate resources for implementation  
• Model behaviour (e.g., decisions made by organization) |
| Develop/Apply Information & Evidence | • Examine leading practices in other organizations  
• Summarize evidence base to support & inform practice |
| Education & Awareness Raising       | • Inform staff of intent, process and progress (regular updates) |
| Organizational & System Development | • Modify program planning framework  
• Plan for increased demands (e.g., epi group; planning support)  
• Identify how change in planning outputs will be assessed  
• Disseminate findings to other public health organizations |
| Skills Development                  | • Provide training sessions  
• Provide mentoring/technical assistance to program teams (ongoing) |
| Partnership Development              | • Identify impacts on partners (e.g., expectations for involvement)  
• Establish relationship with peer organizations who have pursued similar changes |
Decision to Pursue Greater Action on Health Determinants to Reduce Health Inequities

Prioritize Which Public Health Role(s) to Focus Upon

Prioritize Practice Area for Improvement Action

Apply PDCA Cycle

Identify Learnings & Decide to Adopt, Adapt or Abandon Improvement Intervention

Awareness & Persuasion

SWOT Analysis

Option Analysis

Capacity Building Framework

Pick Next Candidate for Improvement
Summary – 4 Key Public Health Roles & Their Application

• Condense options for public health action on health determinants and inequities into four roles
• Capacity building to improve public health action can be applied on systems basis (e.g., NCCDH) or within individual organizations
• Suggestion to view new/improved practices as a quality improvement initiative
Discussion
Further Information

• [www.nccdh.ca](http://www.nccdh.ca)

• Environmental Scan:

• [brent.moloughney@rogers.com](mailto:brent.moloughney@rogers.com)
Extra Slides
Environmental Scan - Purpose

• To inform the NCCDH’s future direction, priorities and activities through an analysis of the key challenges, needs, gaps, and opportunities in the determinants of health for public health.

• Note:
  – Not a review of existing NCCDH or to develop a strategic/operational plan
  – Context
Environmental Scan - Approach

• Four information gathering approaches:
  – Primary:
    • Scan of literature (key/seminal reports)
    • Key informant interviews (31 practice/research experts)
  – Additional:
    • Focus group teleconferences (4)
    • Online survey (>600 respondents)
• Four-member expert reference panel
• 10 week timeline and available resources led to splitting of responsibilities between project consultant and NCCDH
Diffusion Theory Key Components

• The innovation, its attributes (relative advantage, cost-efficiency) complexity, compatibility, observability, trialability)

• The adopter, its innovativeness

• The social system, structure, opinion leaders, social pressure to adopt

• The adoption process, Awareness, Persuasion, Decision, Implementation, Continuation

• The diffusion system, external change agency, change agents

[Dearing, 2008]
Findings – State of Public Health Action

• Analysis and action on determinants and inequities may not be new, it just seems to be
  – Either concepts/approaches never institutionalized; and/or,
  – Been lost due to pressures placed on public health over time

• There are early adopters/innovators, but overall, practices are not widespread