National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

PUBLIC HEALTH SPEAKS:

ORGANIZATIONAL STANDARDS AS A PROMISING PRACTICE TO ADVANCE HEALTH EQUITY

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

The National Collaborating Centre for Determinants of Health is one of six National Collaborating Centres (NCCs) for Public Health in Canada. Established in 2005 and funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their response to public health threats, chronic disease and injury, infectious diseases, and health inequities.

The National Collaborating Centre for Determinants of Health focuses on the social and economic factors that influence the health of Canadians. The Centre translates and shares information and evidence with public health organizations and practitioners to influence interrelated determinants and advance health equity.

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ABOUT THIS RESOURCE

Background

Based on an extensive literature review, the Sudbury & District Health Unit described the development and implementation of equity-oriented organizational standards as one of ten promising practices to address social inequities in health.[1]

The National Collaborating Centre for Determinants of Health (NCCDH) developed this resource in collaboration with four public health experts from across Canada to further explore the role of organizational standards as a strategy to advance health equity action in public health practice.

What do we mean by organizational standards?

For the purposes of this resource, ***organizational standards*** have been defined as internal guidelines used by organizations to outline expected levels of service and to provide benchmarks for performance and accountability. Organizational standards for public health organizations can be thought of as building blocks for effective public health practice and have the potential to address determinants of health and to advance health equity in our communities.[1]

Objectives

This resource aims to:

1. ***Share knowledge*** about organizational standards as a promising practice for health equity
2. ***Build capacity*** among public health leaders, practitioners, and researchers for the development and implementation of organizational standards
3. ***Inform change*** at all levels of the public health system to support organizational standards as an opportunity to advance health equity

Who is this resource for?

This resource is designed for public health leaders and decision makers who are interested in advancing capacity for health equity action at the organizational level. Researchers and practitioners with an interest in the relationship between organizational change and health equity will also find this resource valuable.

How is this resource organized?

This resource includes four interviews with public health experts. Each interview is a unique example, and the order of the conversations is deliberate.

- Interview one describes current research exploring public health renewal in two Canadian provinces.
- Interview two gives an example of organizational standard development at the provincial level.
- Interview three provides an example of provincial organizational standard implementation at the local level.
- Interview four discusses a conceptual framework to support organizations in developing capacity for health equity work.

This question and answer format is supplemented by links to key resources and tools shared by key informants and the NCCDH staff. The discussion section includes a summary of key themes, limitations, opportunities, and conclusions.

INTERVIEWS WITH FOUR PUBLIC HEALTH EXPERTS

The conversations featured were adapted from one-to-one interviews with four leaders in public health practice and research. These experts were selected from across Canada to share their experiences and reflections on the conceptualization, development, and implementation of organizational standards in varied contexts. The content of this resource reflects the perspectives and experiences of these experts as described in their words.

DR. BERNIE PAULY
Associate Professor, School of Nursing, University of Victoria, and Scientist, Centre for Addictions Research of British Columbia, Victoria, British Columbia on ***Comparing the Ontario and British Columbia Renewal of Public Health Systems***

DR. ROSANA PELLIZZARI
Medical Officer of Health, Peterborough County-City Health Unit, Peterborough, Ontario on ***Implementing Ontario's Public Health Standards at Peterborough County-City Health Unit***

JANET BRAUNSTEIN MOODY
Senior Director, Public Health Renewal, Department of Health and Wellness, Government of Nova Scotia, Halifax, Nova Scotia on ***Developing Nova Scotia's Public Health Standards***

DR. BENITA COHEN
Associate Professor, School of Nursing, University of Manitoba, Winnipeg, Manitoba on ***Developing a Conceptual Framework for Organizational Capacity for Public Health Equity Action***

Our interview process

Connie Clement

Hannah Moffatt

Two team members from the National Collaborating Centre for Determinants of Health - Connie Clement, Scientific Director, and Hannah Moffatt, Knowledge Translation Specialist - conducted the semi-structured interviews. A standardized interview guide was used for all participants, and adapted when necessary using probing questions to capture the varied roles and experiences.

These first-hand accounts speak to the development and execution of organizational standards in public health. Included are reflections on the current landscape and the future directions of organizational standards, more broadly. Together, they offer perspectives and a framework to consider organizational standards as a strategy to advance health equity; the factors that facilitate or constrain the development and implementation of organizational standards; lessons learned from experience; and suggestions for moving forward.

Each key informant reviewed their content prior to finalizing the resource to address any gaps and to ensure the information was reflected accurately.

Public Health Speaks: Comparing the Ontario and British Columbia Renewal of Public Health Systems

A conversation with Dr. Bernie Pauly, RN, PhD, Associate Professor, School of Nursing, University of Victoria, and Scientist, Centre for Addictions Research of British Columbia

Connie Clement, the Scientific Director of the National Collaborating Centre for the Determinants of Health (NCCDH) sat down with Dr. Bernie Pauly from the School of Nursing at the University of Victoria and co-principle investigator of the Renewal of Public Health Systems (RePHS) research program on December 5, 2012. They discussed organizational standards as a promising practice to address social inequities in health as well as Dr. Pauly's experience working on the RePHS team.

RePHS is a study to advance our renewal of public health systems knowledge. The project is co-led by Drs. Marjorie MacDonald and Trevor Hancock. The research involves examining public health renewal processes in Ontario (ON) and British Columbia (BC) that experienced investments and sought to strengthen the public health sector of the health system.

Connie Clement: Could you tell us a little bit about the renewal of public health systems (rephs) research initiative?

Dr. Bernie Pauly: *The Renewal of Public Health Systems project is a program of research comparing British Columbia and Ontario in terms of implementation of public health renewal. In Ontario specifically this was the introduction and renewal of the public health standards and in British Columbia the initial impetus was the introduction of the British Columbia core functions framework. This research arose out of the calls for public health renewal that were related to a series of crises, including SARS (Severe Acute Respiratory Syndrome) and calls to strengthen the public health system in our country. Part of the research involves looking at how health equity is being incorporated as part of public health standards in public health organizations in British Columbia and Ontario. The document review involved taking the standards in Ontario and the core functions documents in British Columbia and doing an analysis to try to understand how equity was being talked about and what kind of strategies were recommended or being implemented.*

Connie Clement: What were your key research findings about how health equity was conceptualized and incorporated into these two provincial sets of documents?

Dr. Bernie Pauly: *In the British Columbia core functions framework, there was a clear direction to incorporate a health equity lens into the delivery of public health programs. There was the overall intent to improve the health of the population and also to ensure that health equity was specifically addressed to avoid unintended consequences. This spawned a lot of activity and engaged people in asking the question, 'how do I integrate or implement a health equity lens in my work?'. Each of the regional health authorities in British Columbia interpreted and took that up a bit differently, and we are learning more about this in the Renewal of Public Health Systems project.*

The Renewal of Public Health Systems research team has published an article about how health equity is considered in public health renewal documents. They compared the standards and frameworks of public health organizations in these two provinces. The 2012 article by Pinto et al. "**Equity in public health standards: A qualitative document analysis of policies from two Canadian provinces**" can be found in the NCCDH Resource Library

TO LEARN MORE, VISIT THESE WEBSITES

The Renewal of Public Health Services in British Columbia and Ontario project

The British Columbia Ministry of Health, Core Public Health Functions

The Ontario Ministry of Health and Long-Term Care, Ontario Public Health Standards

In the British Columbia documents, there was a clear commitment around the importance of reducing health inequities. Health inequities were defined very much as Whitehead and Dahlgren (2006) have described them, in terms of being differences that are unfair and avoidable. There was also a focus on 'vulnerable populations' and identifying those people who because of their socio-cultural status, lack of economic resources, age or gender should be a focus. The actions to reduce health inequity included a focus on: measuring or quantifying the degree of health inequities; making the social determinants of health a priority; and identification of the need for specific action, particularly advocacy, to reduce health inequities. There was a fair bit of focus on the need for a political commitment to health equity and also the importance of working directly with communities and across sectors. In a subsequent project, the Equity Lens in Public Health (ELPH) project, we are more specific at answering the questions around 'how do we make health equity a priority?,' 'how do we work intersectorally?,' 'what are some of the tools that can support this?' and 'what are some of the ethical issues that public health practitioners face in promotion of health equity?'.

Comparatively, in the Ontario Public Health Standards there was an emphasis on the differences between health inequalities and health inequities but not an explicit equity lens. Ontario, like British Columbia, embraced the fact that they wanted to focus not just on differences but those differences that were unfair, unjust, and avoidable. So the way health inequities were defined was actually quite similar in Ontario and British Columbia and the term 'health inequities' is visible as you read through each of the documents. However health equity as a key pillar to improving population health may come out a bit more strongly in British Columbia because of the equity lens in the original British Columbia core functions framework.

A key difference between the two provinces was the choice of language used to talk about equity. In Ontario, 'priority populations' was used to identify those at risk, as opposed to the language of 'vulnerable populations' used in British Columbia. In British Columbia, there was a specific emphasis on Aboriginal people compared to Ontario. Another point of difference is that in British Columbia, the core functions framework was a means of informing public health planning processes as British Columbia does not have legislated standards. Whereas in Ontario, the standards were legislated, this made it more difficult to incorporate equity in the same way. However, implementation is a bit clearer in Ontario because the standards are mandated. In Ontario the activities to reduce health inequities focused on surveillance and measurement; removing barriers to access to public health programs; and developing partnerships and collaborations. There is a stronger focus on action and advocacy for health equity in the British Columbia documents. Both sets of documents do highlight that reducing health inequities is a responsibility that is shared by many sectors not just health.

The 2006 article from Whitehead and Dahlgren's **Concepts and principles for tackling social inequities in health** is available in the NCCDH Resource Library

Connie Clement: What do you think are the implications for practice between taking a vulnerable approach or a priority approach to defining populations? I think for many practitioners, they have seen a language shift about every five years

Dr. Bernie Pauly: *That is an excellent question. I think what we're starting to see is that the language of vulnerable or priority populations tends to lead people to say well '*who are the groups?*' or 'who are the people that are experiencing health inequities?' The focus tends to be placed on the groups rather than the broader conditions that create inequities. For example, "the homeless" may be viewed as a group of people without housing in need of individual-level intervention, as opposed to recognizing the effect of structural conditions that affect homelessness such as an inadequate supply of affordable housing or the history of colonization. We need to think about '*what are the structural conditions in which vulnerabilities are created?,*' instead of only the groups we see being affected and at risk. I think it can be a bit of a trap to start labelling.*

Connie Clement: Were you able to discern key elements that supported the integration of health equity into the standards or functions in each province?

Dr. Bernie Pauly: *I think one of the things that have supported the integration of health equity has been the 2008 World Health Organization Commission on the Social Determinants of Health* Closing the Gap in a Generation *report. It's fairly easy to see how that document had a tremendous influence on the provincial documents we reviewed, and the way in which people took that report up to try to say 'this is important for us, so how are we going to operationalize this?' In British Columbia, we've had a lot of activity around the equity lens and I think people in public health have been asking the questions -'what is an equity lens?,' and 'how do we analyze data from an equity perspective?.' Also in British Columbia, the Public Health Services Authority has started developing a specific set of health equity indicators which will be available to all health authorities. I think some of the documents in Ontario that were developed around health equity have also been influential, such as the* First Steps to Health Equity *concept paper. Further, Sudbury & District Health Unit's review of the literature on promising practices, and the increased availability of related resources such as their video focusing on the social determinants of health have improved our understand.*

FOR MORE INFORMATION...

The World Health Organization Commission on the Social Determinants of Health's **Closing the Gap in a Generation 2008 report** is available in the NCCDH Resource Library

The 2008 report from Patychuk and Seskar-Herncic **First Steps to Health Equity** is available online

The Sudbury & District Health Unit identified 10 promising practices to reduce social inequities in health through an extensive literature review. **A summary of their work is available in the NCCDH Resource Library**

[1] Page numbers reference the PDF Manual Core competencies for public health in Canada: Release 1.0 available from the PHAC website (www.phac-aspc.gc.ca/php-psp/ccph-cesp/pdfs/cc-manual-eng090407.pdf).

Connie Clement: What do you think some of the barriers were to getting health equity strongly integrated in public health, and what can be done to address those barriers?

Dr. Bernie Pauly: *I think one of the barriers is that public health is a fairly small part of any health care system. Getting health equity as a priority in that bigger system has been a specific challenge and I think that is a huge undertaking. Public health is a small, but powerful force to even say,* we're going to not only look at how we address health equity in public health but 'how are we going to further that concept in the broader healthcare system?.' *One example is Vancouver Coastal Health Authority and its incorporation of health equity indicators into its regional health report. I think people have viewed that as a tremendous success. I also think that public health has taken leadership and championing equity by doing things like raising awareness of the social determinants of health among all health system staff. It's about getting people to understand the importance first, and then being able to introduce actions, for example, incorporating health equity indicators into reporting.*

Another facilitator is that public health has a really key role in reviewing and analyzing population health data and being able to ask specific questions about health inequities– 'what if we looked at this data by gender or housing status or ethnic identity?' 'How would this data look different when asking those critical questions?,' *those are just a couple examples.*

The NCCDH has resources related to integrating **health equity into public health status reporting.**

Connie Clement: Would you say from what you've learned and your research that organizational standards are an effective strategy to advance health equity in public health practice and settings?

Dr. Bernie Pauly: *I think they are an important strategy because they explicitly make health equity a priority. But it is not just about the legislated public health standards, such as those in Ontario, but also the extent to which organizational missions, visions, values and system-wide policies and the programs make health equity explicit. I would say what is important is how the Ontario standards or in British Columbia the core functions, are taken up and operationalized at the organizational and front-line level. The outcome may become that practitioners who are already thinking and addressing health inequities in their practice are explicitly supported by such documents and the documents may promote thinking and action.*

Connie Clement: What do you think some of the lessons learned are from looking at British Columbia and Ontario when we start to think about other provinces and where they might go with similar initiatives?

Dr. Bernie Pauly: *I think one lesson learned is about how health equity is kind of that thorny problem that requires action across multiple sectors. I think public health people are very brave, but I sometimes feel that it is overwhelming to think about, for example, how do I work with the people that are doing housing policy or income policy?. I think we need to push ourselves to think through how that collaboration is actually going to happen.*

There's one more that I want to mention, and its been a bit implicit in our discussion, is our understanding of the social determinants of health. It gets taken up around things like housing or food or social support or empowerment which is great, but I think the one place that it in some ways is going to require a bigger shift are those processes and structures that create marginalization, such as racism or discrimination, and how we in public health are part of the system. I think that's going to be one of our challenges to deal with at the systemic level.

Connie Clement: Did you see different implications arising from the fact that British Columbia was more of a guidance document and Ontario was a legislative document? British Columbia was at a period where they were willing to invest some resources and Ontario was trying a resource neutral initiative. Did you see any implications if we think about lessons or things to think about going forward?

Dr. Bernie Pauly: *I think there are two issues that are tied together: (1) accountability, and (2) funding. In guidance documents, the accountability piece is often not as clear. The Ontario legislative standards were to be resource neutral so there wasn't the addition of funding, but there was that accountability in place. Those two factors influence how people are going to respond [to the documents].*

Connie Clement: Do you have advice for practitioners, managers or decision makers who are considering a move towards organizational standards either at their own organization or at a larger jurisdictional/ regional level?

Dr. Bernie Pauly: *When I start to think about standards, I think of them as the 'musts' and then how to implement those 'musts'. I am always a bit cautious to think that everything must be clearly laid out in the standards, but rather that the standards provide the overall direction and then within that we have policies and practices that allow us to operationalize the standards. I think they [organizational standards] are important, and have a clear role in establishing the overall framework that is in turn complemented by a series of policies, practices and even programs that are aligned.*

Connie Clement: Bernie, I've really enjoyed the conversation and thank you for sharing your thoughts and experiences. Good luck with the continuing research. I look forward to the outcomes.

Public Health Speaks: Developing Nova Scotia's Public Health Standards

A conversation with Janet Braunstein Moody, MPH, PNP, BSN, Senior Director, Public Health Renewal, Department of Health and Wellness, Government of Nova Scotia

Connie Clement, Scientific Director of the National Collaborating Centre for Determinants of Health (NCCDH) sat down on December 27, 2012 with Janet Braunstein Moody, Senior Director of Public Health Renewal with the Nova Scotia Department of Health and Wellness to speak about her experience of working on the collaborative initiative to develop the Nova Scotia (NS) Public Health Standards and about the state of public health renewal in Nova Scotia more broadly. Janet is also an adjunct faculty member with the School of Nursing and Community Health and Epidemiology at Dalhousie University.

Connie Clement: Could you tell us about the renewal process for public health in Nova Scotia?
Janet Braunstein Moody: *The review of our public health system followed the release of the National Advisory Committee on SARS and Public Health's report,* Learning from SARS *in 2003, and the multiple royal commissions that proceeded. Nova Scotia wanted to conduct an external review of its public health system to see how we stacked up in terms of being an effective, efficient, comprehensive, and responsive public health system. In 2005, we hired a public health consultant to conduct this external review. The review resulted in a document called,* The Renewal of Public Health in NS: Building a Public Health System to Meet the Needs of Nova Scotians. *This report put forward 21 recommendations or actions for system renewal. What the report generally found was that Nova Scotia was in the shallow end of the swimming pool in terms of effective system design and the ability to be responsive and effective.*

The 21 recommendations were divided into five main categories: (1) improve the structure and function of the provincial level system; (2) improve the structure and function of the local level of the system (i.e., district health authorities); (3) strengthen how those two bodies work together; (4) improve how public health works across the continuum of care within the health care system; and (5) improve infrastructure (i.e., people, structure, information). The first specific recommendation was to establish a common vision for public health. And that started us on our strategic planning journey, which is really the foundation of our standards and subsequent protocols.

Connie Clement: How are you using those standards and priorities in Nova Scotia at this time?
Janet Braunstein Moody: *Recommendation 11 of our renewal document identifies the establishment of evidence-based standards for our system, for the provincial and local levels. That has always been an intention of ours, but it required a clarified vision. Through the strategic planning process it became very evident that public health had a unique role in understanding population health assessment, surveillance as well as the qualitative elements of our communities. This process and understanding helped to clarify our vision and role.*

FOR MORE INFORMATION ABOUT THE RENEWAL OF PUBLIC HEALTH IN NOVA SCOTIA...

The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians (2006)

Six Stakes: Moving Forward A Commitment to Public Health's Future (2010)

Nova Scotia Public Health A Journey Towards Renewal (2010)

The Nova Scotia Public Health Standards 2011- 2016

The Learning from SARS: Renewal of Public Health in Canada 2003 report is available online

Over a two-year strategic planning process, we engaged 60 individuals; conducted interviews; and held five to seven stakeholder events involving more than 500 people. We asked people to tell us about their understanding of public health and what they wanted from us. We heard a lot about the complexity of the public health system; we heard some really hard things, but we also heard some really good things. This process allowed us to hear what we needed to hear - public health has a really unique position in the health system.

Public health is largely the only group that is well-poised to understand community health and health inequities. Therefore, a huge role of public health should be to shine the light on health equity issues and to encourage others to do the same. After the strategic planning process, we made a commitment through six stakes; one of which is the importance of understanding what was labelled 'social justice' in the document, but we're moving more to health equity language as a core consideration in all of our work.

Connie Clement: That's great. During your strategic planning process, how much did you reach out to sectors outside of public health?

Janet Braunstein Moody: *I would say that most of our interviews reached out beyond the public health sector. We interviewed people that we had not previously talked to or really thought were necessary to involve in the strategic planning process before. We talked to people who work in: municipalities (including mayors); the prison system; housing; child development; resource centres; NGOs; and government departments, including environment and agriculture, economic development, and finance. We also spoke to people experiencing homelessness, librarians, and teachers.*

Connie Clement: Could you tell us about how social justice, or health equity, is conceptualized within the Nova Scotia standards? What does it mean that one of those six priorities is around social justice?

Janet Braunstein Moody: *I think health equity or social justice was included as part of our six stakes to remind us that it is a core consideration in how we do our work. It was the foundation of our standards. During our discussions about focusing our programmatic areas, or areas of focus, we asked the question, 'should social justice be one of our programs or areas of focus?' There were lively debates among our leadership team in response to this question. Where we landed was that health equity was not something that stood alone as a separate program, but that if you did not have health equity incorporated into all of your program areas, we were not achieving our public health purpose. There were tears at that meeting, there was passion, and people were really wound up about it. We ultimately decided to keep our four programmatic areas as they were, but to then highlight health equity as the basis and common thread through all of them.*

Connie Clement: How do you determine successful execution of the standards? Specifically, what indicators have been identified for foundational versus program standards?

Janet Braunstein Moody: *That's a very good question and we don't have the answer to that yet. Right now our standards do not have any indicators. We are working on the first draft of the protocols, which is the next level of detail. However, we're having a lively debate about where the indicators best fit; either within the protocols or through an accountability framework. We want to ensure the indicators we select align with what Nova Scotia is doing across the rest of the health system; however, we also appreciate that the indicators used by the rest of the health system, and the indicators that public health would need, are different. We also have a specific health equity protocol in our draft and then in each subsequent protocol, there is a reflection of how the foundational standard of health equity needs to be considered in each programmatic area. One of the key questions we're asking in the protocol review process is, 'does our understanding and commitment to health equity come out strongly in the protocols?' I think they do. I'm quite excited about them.*

Connie Clement: What do you think some of the key factors or elements were that supported incorporating health equity so centrally within these new standards for Nova Scotia?

Janet Braunstein Moody: *I think one of the key elements was the strategic planning process. It was - I have to say - it was probably one of the more profound experiences that I've had in public health in terms of really being able to stop, sit, listen, wallow, and not try to fix what you've heard, but just let it emerge through a process. We interviewed the usual and unusual suspects and it just became clearer and clearer to us across the health system that there was no one area that really took on health equity.. And it became clearer and clearer through our process that this could be a very strong role for public health. We couldn't walk away from that role.*

Connie Clement: How have the local district health authorities responded to the Nova Scotia Public Health Standards? Given that the protocols are not available yet, how are you seeing the standards be used at this time?

Janet Braunstein Moody: *As the leadership team, we have led this process, of which the district health authorities were all members. They're not provincial standards, they're system standards. In engaging the district health authorities from the early stages, we feel we have promoted shared ownership. I think that the devil is in the details and we need to consider what the standards actually mean to the public health nurse on the front line or the nutritionist or the health educator. One step we're taking to better understand this is conducting dialogue interviews with front-line staff around change implementation and the introduction of the new protocols. One of the themes we're hearing a lot is around the complexities of public health and the broad scope of our work. For example, while you have some people working on policy issues, you also have people in one-to-one client services. Implementation of the standards will be different for different people based on their unique roles and needs.*

Connie Clement: What are some of the barriers you foresee as you move towards implementation? What strategies have you identified or are already using to minimize those barriers?

Janet Braunstein Moody: *Those are some of the questions we're currently asking in our dialogue interviews with front-line staff. A couple of the barriers are related to understanding and tailoring to the complexity of public health. Another barrier is that the background or foundational knowledge that practitioners have when they enter the public health system can sometimes be sparse. Knowledge and awareness of those fundamental principles is important for understanding the purpose and content of the standards and, therefore, that knowledge base among staff affects implementation.*

Another barrier is resistance to change. It's difficult to change practice, that sentiment of, 'we have been doing this for 25 years, so why are you telling us we need to change now?.' I think there's also a barrier around the increasingly common conceptualization that managers and directors need to be good managers and directors as opposed to having content expertise in public health, that tension between content and process experts. But in reality, you have to be both. One of the barriers we had, and will continue to have, is responding to the needs of a broad mix of management with different knowledge and skill sets. This will require a very thoughtful introduction of the standards and tailored training of management in terms of how to mentor and introduce the standards to staff in their varied contexts.

When we're talking about shifting our work further upstream, there's this huge overwhelming sense that we're going to dump more work on to others. The conversation at the local level has been 'well if public health stops doing that, who's going to pick it up?.' A common example we give in response to this concern is around breastfeeding- that public health's role is going to migrate from individual level breastfeeding support to addressing environmental factors that affect breastfeeding. For example, we can change the environment by promoting baby-friendly hospitals and communities and dispelling public perceptions around disadvantages of breastfeeding. If we [public health] don't change the environment, the individual breastfeeding mother is not going to be as successful.

Connie Clement: What are some of the lessons you've learned moving as far as you have in the implementation of the public health standards in Nova Scotia? What advice do you have for others who are considering developing and implementing standards for their organizations or in their own jurisdictions?

Janet Braunstein Moody: *It's not for the faint of heart. It's work that requires us to change internally as much as it is about changing a system. There's a personal change that needs to happen. For me, I needed to be able to understand and believe in the benefits of developing public health standards. I needed to understand it with every fiber of myself to be able to have an impact in the broader system. The magnitude of this effort is comparable to changing the direction of an ocean liner. It is about long-term change and there are going to be challenges along the way. But every little degree makes a difference.*

Another lesson learned is around the benefits of getting involved in various activities and on various committees, particularly if they are out of your sector or out of your comfort zone. This becomes more difficult as we have increasing demands, but you never know the impact you may have representing public health and health equity interests at these tables. For example, I represented public health on the Health Services Insurance Work Health Act working group. Every week I came to the committee meeting with two or three questions that we [as a working group] needed to ask such as, 'does this impact some groups more than others? If so, why?'. I had the lovely opportunity to keep asking those questions around that table for a year and a half. As a result, "health equity" is now in the preamble of the new act. So it's about being there, developing relationships with other sectors and within the health system and actively trying to influence the way big system decisions are made. If you don't embrace that with every fiber of yourself, you're not going to be able to achieve that. Finally, you need to be patient. Public health sees change in decades. We're the patient people.

Connie Clement: Based on your experience, to what extent do you think organizational standards are an effective strategy to advance health equity through public health?

Janet Braunstein Moody: *I think they're going to be an essential strategy. Furthermore, I think if you don't see the words "health equity" throughout the standards, then you're not going to have that impact. I think they really need to be strong in how they are understood and articulated across the system. It's fundamental.*

Connie Clement: Is there anything else that you'd like to share or add about the development of the standards in Nova Scotia or about organizational standards in general?

Janet Braunstein Moody: *I think what we're learning is that this is a process. It isn't a roll out and it isn't an implementation project. It is about being able to understand and integrate health equity into the way we think and into the culture of our system. And that's going to take time. We really need to be patient and recognize that there are skill sets that different people have and different people need to develop. That diversity is part of the richness of public health.*

Connie Clement: Thank you so much Janet for sharing your thoughts and experiences with the development of the Nova Scotia Public Health Standards and good luck with the next stages of your learning and your implementation. This has been a great conversation.

Public Health Speaks: Implementing Ontario's Public Health Standards at Peterborough County-City Health Unit

A conversation with Rosana Pellizzari, MD, MSC, CCFP, FRCPC, Medical Officer of Health, Peterborough County-City Health Unit

Connie Clement, Scientific Director of the National Collaborating Centre for Determinants of Health (NCCDH) had the opportunity to speak with Dr. Rosana Pellizzari, Medical Officer of Health for Peterborough County-City Health Unit (PCCHU) on December 21, 2012 about the Peterborough County-City Health Unit experience of operationalizing and implementing the Ontario Public Health Standards (OPHS) at the local level. Dr. Pellizzari is also Co-Chair of the Performance Management Working Group (PMWG), Public Health Division, Ministry of Health and Long-Term Care. The PMWG supports public health accountability agreements and is currently focused on the development of a measurement strategy for the OPHS.

Connie Clement: Could you tell us about your understanding of the history, development, and purpose of the Ontario Public Health Standards?

Dr. Rosana Pellizzari: *The Health Protection and Promotion Act in Ontario states that the Minister may publish guidelines for the provision of mandatory health programs and services and that every board of health shall comply with these published guidelines. Prior to the standards, Ontario had mandatory health programs but they were out of date and needed to be renewed. Consequently, the new Ontario Public Health Standards (OPHS) were developed. The OPHS are much more prescriptive in their description of the minimum scope required for boards of health and can be used to hold boards accountable for the delivery of these programs and services. The standards identify board of health outcomes and the societal goals that all of us, through partnership and collaboration, should be working toward.*

Connie Clement: How is health equity included in the new Ontario Public Health Standards?

Dr. Rosana Pellizzari: *Health equity is identified in the introduction to the standards. There is an acknowledgement that the health of individuals and communities is impacted and influenced by social and economic determinants, and it states in a very strong sentence that reducing health inequities is fundamental to the work of public health. The introduction and the foundational standard are explicit on health equity, but within the set of standards there is no specific standard addressing health equity or the social determinants of health. For me, that was a disappointment at the time.*

FOR MORE INFORMATION...

The Peterborough County-City Health Unit website

The Ontario Ministry of Health and Long-Term Care, Ontario Public Health Standards website

Public Health Division, Ontario Ministry of Health and Long Term Care, Initial Report on Public Health (2009)

Connie Clement: How have you approached implementation of the Ontario Public Health Standards at Peterborough County-City Health Unit?

Dr. Rosana Pellizzari: *When the standards were first published, Peterborough public health staff made sure we met with all of our stakeholders and partners. It was important for us that our stakeholders were aware that as a result of the new standards, we would be shifting our work to be more focused, and that there may be impacts as a result of that shift. For example, there may be things that we [PPCHU] would no longer do because of our need to focus on the minimum requirements as laid out in the standards. Internally, we did a couple of key things. The identification of priority populations within our community and the integration of health equity into our planning processes was an early piece of work that we did. We changed our operational planning by developing new tools to identify priority populations. We developed and implemented a reporting mechanism for the board of health, whereby we report on every requirement in the standards on a quarterly basis. At the end of the year, we provided an overview of areas of compliance and non-compliance, some of the challenges we faced, and present options for moving forward. Part of our rationale for such comprehensive reporting was to ensure our board of health became very familiar with the standards and knew what was expected of them. Our Social Determinants Of Health Working Group has used a health equity lens to assess our programs and activities as part of its work with internal staff.*

Connie Clement: How have the Ontario Public Health Standards influenced your practice, particularly in the area of health equity?

Dr. Rosana Pellizzari: *The Peterborough County-City Health Unit and the board of health were committed to health equity long before I arrived in 2008, and long before the standards were published. The health unit has a long-standing history of working in partnerships to address the social determinants of health and of being leaders on food insecurity issues, specifically. In our case, the standards served to reaffirm the work that we were already doing to address the determinants of health.*

We have also been able to use the standards as a bit of a rallying cry to encourage other partners to work with us. We've been able to leverage the requirements and the societal goals as a conversation starter to say, 'we need to work together on this', so that's been helpful. The standards have also helped us to "let go" of some work that was not mandated so that we can focus on the Ontario Public Health Standard requirements. For example, our board of health has a long history of providing genetics services as an outreach centre, and we have been able to successfully shift that work over to the local hospital using the standards as our rationale.

Connie Clement: What have some of the barriers been to implementation of the standards at the local level? How have these barriers been overcome?

Dr. Rosana Pellizzari: *The tension with the new standards was that it was conceived as a revenue-neutral initiative. We were to redefine our scope of programs and activities within the same envelope of funding. Public health in Ontario has been suffering from some neglect, and it took the E. coli outbreak in Walkerton and SARS (Severe acute respiratory syndrome) to appreciate that public health had become an antiquated system that was not sufficiently funded. As a result of this recognition, we've seen a reinvestment and a stronger commitment to the public health system in Ontario; however, we still experience barriers around inadequate resources to support the work we should be doing in the realm of primary prevention. I think the standards articulate that tension in that we certainly know that we could have gone further in some of the standards, but we recognized that increased resources would be needed. There is this ongoing tension between what we should be doing, what we could be doing, and what we've been mandated to do.*

Connie Clement: How are the standards enabling you to make more upstream choices or more choices that will help to close the gap between the least and the most healthy?

Dr. Rosana Pellizzari: *The Health Protection and Promotion Act is written in such a way that public health is responsible for both protecting and promoting health in our communities, and that can translate into a number of actions. Public health is often the "go-to" person for unmet needs in the community, and we often get lobbied to both identify and even fill these gaps. That was certainly the case in the 1990's when gaps in primary care were often filled by boards of health using nurse practitioners to do critical functions such as Well Baby Care, immunizations, and etc. The standards have helped us focus our efforts. They help guide us in decisions about what we take on as "public health" work and what we need to direct to others to do. They help us clarify our role and contributions in big issues, be it substance misuse, parenting, or even infection control.*

Connie Clement: Thinking about your experience as Co-Chair of the Performance Management Working Group, to what extent are the standards supporting health units across Ontario to advance their health equity work?

Dr. Rosana Pellizzari: *I have seen increased evidence of boards of health taking positions on health equity. I think an enormous help has been the infusion of capacity to the standards through the provincial funding of two social determinants of health nurses for each health unit. The fact that those nurses were funded provincially and offered to boards of health has encouraged and enabled boards to really make health equity work a possibility. It has provided us with that on the ground capacity that was lacking.*

The organizational standards that specifically relate to board strategic plans and the expectation that boards must address health equity as part of their strategic planning process, will encourage boards of health to incorporate health equity as an explicit consideration in these plans. In fact, many boards are currently working to renew their strategic plans. I know our board is. And I know that this time around, health equity will be a strong focus for us. The standards will act as catalysts in what I hope is a shared learning journey.

Connie Clement: The Performance Management Working Group is exploring a measurement strategy in relation to the standards. Can you describe how this strategy is being developed, and how health equity is being considered in the strategy?

Dr. Rosana Pellizzari: *It certainly is a challenge and I think the first way the working group tackled this was through the release of the Initial Report on Public Health in 2009. In this report, we published public health profiles for each of the 36 boards of health, and we grouped them according to peer groupings so that comparisons among similar boards could be made. We published health status indicators that could be used as measurements for health equity. This report made it easy to look at adolescent pregnancy rates, for example, and to note that the rate is lowest in the board of health with the highest per capita income and is highest where per capita incomes are reduced. We supplemented that report of hard indicators with narratives. We wanted to tell the story of what boards of health are actually doing to address health equity. The narratives are equally important as the indicators.*

Since then, as we have moved into a new era of accountability agreements with boards, there's been a great deal of effort in identifying performance indicators for health equity that could be incorporated into these accountability agreements. We may see a time when specific health equity indicators are incorporated into accountability agreements that boards of health will sign with the Ministry of Health.

Connie Clement: What are some of the lessons learned from Peterborough County-City Health Unit's implementation experience with the Ontario Public Health Standards that might be helpful for other health units and regional health authorities in Canada?

Dr. Rosana Pellizzari: *The importance of articulating the need to address health inequities and the social determinants of health in the mandate of public health is a critical lesson learned. We need to be waving health equity as our flag, and if it's not us, who's it going to be? The rest of the health care system has clinical care and the care of the ill as their mandated priority. They can certainly be allies, but I do think health equity work needs to be driven by public health, especially because we work so closely across sectors. Health equity must be a principle, and I personally hope that it will be made explicit as its own standard with identified outcomes and requirements. Additionally, health equity work must be supported by scientific and technical supports from our provincial agency, Public Health Ontario.*

The **Let's start a conversation about health... and not talk about health at all** video is available in the NCCDH Resource Library

I think the other lesson that I've learned is that the capacity needs to be there. As I said, the infusion of the social determinant of health nurses has really facilitated boards of health to do work in the area of health equity. The value of resource sharing and mentoring that can occur through communities of practice is also a valuable lesson. For example, the video that Sudbury & District Health Unit released called, Let's start a conversation about health… and not talk about health care at all *is being adapted by many boards of health, including the Peterborough County-City Health Unit, to utilize in our communities. It's great to see how this work can be shared among others.*

Connie Clement: Based on your experiences with Peterborough County-City Health Unit and as Co-Chair of the Performance Management Working Group, would you say that organizational standards are an effective strategy to advance health equity in public health settings?

Dr. Rosana Pellizzari: *Definitely. Because organizational standards can be mandated, the funder, in the case of Ontario, both provincial and municipal governments, can hold boards of health accountable to those standards. They're measurable. You can encourage better performance by choosing indicators and setting targets and performance corridors. So yes, I think organizational standards can help our work in health equity. This work could be further improved if organizational standards incorporate explicit requirements, with indicators and targets for health equity.*

Connie Clement: Perfect. Is there anything else that you would like to share or add about your experiences with organizational standards?

Dr. Rosana Pellizzari: *I am currently chairing the Ontario Public Health Association-Association of Local Public Health Agencies (OPHA-alPHa) joint Health Equity Working Group. Through this working group, we have identified a list of potential health equity indicators. Our next step is to circulate this list among the field for consultation purposes. In the process of creating this list, we discovered how challenging it is to actually measure health equity work. The working group members have come to a consensus that in light of these measurement challenges, indicators should support shared learning right now, rather than accountability. Before we can expect boards of health to be accountable to these indicators, we need to support them in learning more about this work.*

The understanding of health equity and the related public health interventions that can influence health equity are complex. It's not as easy, for example, as increasing physical activity or providing mass immunizations, for example. So rather than a stick, it's the carrot we need at this time. It's the encouragement, the support, the learning from peers and creating new knowledge as we go. We're forging the path here. It's still early days for us, so it's really important that we acknowledge that we're all learning, and that we stay positive rather than punitive. We need to help each other on this journey to achieving health equity in our communities.

Connie Clement: Thanks, that's a wonderful place to end. Thank you Rosana for sharing your thoughts and experiences, and overall for your leadership in advancing health equity through public health practice. It's always a pleasure to work with you.

Public Health Speaks: Developing a Conceptual Framework for Organizational Capacity for Public Health Equity Action

A conversation with Dr. Benita Cohen, RN, PhD, Associate Professor, Faculty of Nursing, University of Manitoba

Hannah Moffatt, Knowledge Translation Specialist at the National Collaborating Centre for Determinants of Health (NCCDH) spoke with Dr. Benita Cohen, Associate Professor with the Faculty of Nursing at the University of Manitoba on September 29, 2012 about the interdisciplinary team research project to develop the conceptual framework for Organizational Capacity for Public Health Equity Action (OC-PHEA). While this research project does not focus on organizational standards explicitly, it was selected as an important example to highlight a tool available to support public health capacity development. Specifically, this tool can be used to facilitate discussions and planning efforts, both within and outside of public health organizations, to support strategies for health equity action.

This project is part of Benita's larger program of research, which focuses on building public health capacity to address and reduce inequities using a social justice lens.

The Organizational Capacity for Public Health Equity Action conceptual framework will be in a forthcoming publication in the Canadian Journal of Public Health.

Hannah Moffatt: Could you tell us about the conceptualization of the Organizational Capacity for Public Health Equity Action research project?

Dr. Benita Cohen: The motivation for this research stemmed from my former experience as a public health nurse, and the shared passion among the research team to address social injustice and health inequities. It was also influenced by the final report released by the World Health Organization's Commission on Social Determinants of Health in 2008 Closing the Gap in a Generation. *One of the Commission's main conclusions was that addressing growing inequities in health— both between and within countries— was an ethical imperative and a matter of social justice. That really spoke to me. Since this report, I think there's been widespread recognition of the need to address the growing inequities and, similarly, there is recognition about the potential role of public health to engage in activities that advance health equity. There has also been a lot of emphasis on developing effective public health interventions to support practitioners in achieving this goal. However, there is also evidence, such as what was put forward in the NCCDH's environmental scan in 2010, that the capacity of public health organizations to engage in health equity action is quite variable across Canada.*

A few years ago, I identified an interdisciplinary team of academic researchers with a shared interest in promoting social justice and equity to form the Organizational Capacity for Public Health Equity Action (OC-PHEA) project team. We also involved some non-academic collaborators with similar interests, and we were successful in securing a Health Equity Catalyst Grant from the Canadian Institutes of Health Research. Our first objective was to develop a conceptual framework to ground our OC-PHEA work, which could eventually inform capacity-building research initiatives. A literature review yielded a number of conceptual frameworks related to organizational capacity; however, there really wasn't one specific to equity action and particularly not in the Canadian context. So, based on our review of the literature, and our knowledge of the public health system, our research team decided to develop a framework that was grounded in the experience of health equity champions within the Canadian public health sector.

Hannah Moffatt: How were these health equity champions identified and what was their role in the project?

Dr. Benita Cohen: We identified and interviewed ten individuals with strong reputations as equity champions in the public health community. We also asked the interviewees to suggest others from their networks who they considered to be health equity champions, which led to interviews with a total of 16 individuals (including, senior public health administrators, public health practitioners, and program managers) from seven provinces across Canada. We used the information obtained in these interviews, combined with key themes from our literature review, to develop a draft conceptual framework. The interviewees were invited to provide feedback on the framework to ensure that what they had talked about was reflected in the draft, and to provide an opportunity to elicit suggestions for improvement.

Hannah Moffatt: What were the main findings of this interview process and what surprised you?

Dr. Benita Cohen: We asked the health equity champions to describe the context of their work. The interviewees identified factors that enabled and constrained their work in the area of health equity. These identified facilitators and barriers were especially pertinent to the development of the conceptual framework, and formed the main findings of our qualitative research. For example, many of the interviewees spoke to the multiple dimensions of organizational capacity required for health equity work. This observation was supported by the literature. Factors identified that affect organizational capacity included motivation and commitment to action, presence of leadership, access to knowledge, and training to develop skills and attitudes of practitioners. The need for sufficient infrastructure, including access to resources as well as supportive policies and processes, was also identified. Many interviewees also described the central role of partnerships, collaborative relationships, and networks occurring among health organizations and between health organizations and other government sectors, all with the purpose of addressing social and, even more importantly, structural determinants of health and health inequities.

The thing that really stood out for me was that the champions spoke about the complexity of these factors, both internal to their organizations and externally. The complexities create unique organizational contexts, which in turn determine how and which aspects of capacity are developed. For example, tension of organizational priorities, role overload, dominance of acute care on policy agendas, and lack of readily available measurement tools can act to constrain organizational capacity for health equity action. Alternatively, a key facilitator that emerged through analysis is the powerful influence of equity champions, particularly those in senior management and governance positions. Equity champions or those people with credibility, respect, a commitment that is inspiring to others, and who consistently advocate to make health equity a priority, can significantly influence how capacity needs are identified and addressed. Those are some of the key findings that informed the development of the framework.

TO LEARN MORE...

The World Health Organization Commission on the Social Determinants of Health's **Closing the Gap in a Generation 2008 report**

The NCCDH's **2010 Environmental Scan Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice**

Hannah Moffatt: As a result of this process, could you describe what the conceptual framework looks like, and how it fits within the context of organizational settings?

Dr. Benita Cohen: We actually have a graphic that depicts the framework components and their interrelationship. Essentially, the framework contains two key domains of organizational capacity for public health equity action: (1) the internal context (i.e., those dimensions of the organization that determine its ability to take action on health equity); and (2) the enabling external environment (i.e., those dimensions of the local community and broader systems that determine the ability of public health as a sector to act). Both the internal and external domains are characterized by similar dimensions, for which there are three: (1) shared beliefs and values; (2) demonstrated commitment and will to act; and (3) supportive infrastructure. For each of the two broad domains, internal context and external environment, we identified an initial set of key elements, which could ultimately serve as capacity indicators.

To illustrate further, the OC-PHEA framework suggests that equity action requires internal capacity in three areas: (1) an identified organizational-level belief that promoting health equity is a priority; (2) a commitment to equity-focused action as expressed in strategic plans; and (3) provision of structures and resources necessary to support equity action, such as health equity champions at all levels of the organization. Elements of organizational infrastructure are factors like access and ability to interpret local data on inequities, advocacy skills among the workforce, and processes to ensure community engagement influences organizational decision-making. Equity action also requires similar capacity within the external environment. For example, if you were to look at the domain of external or community infrastructure, it would include others outside of public health that can access decision makers and resources for equity actions at all jurisdictional levels.

There is an important underlying assumption of the framework, and that is that there must be alignment and key linkages (e.g., coalitions) between the internal and external domains to strive for health equity. In other words, optimal capacity would exist if both the internal and external domains were strong and well supported. But in reality, we do recognize that differing levels of capacity exist within organizations at different points in time. Therefore, even in the absence of optimal capacity, an organization may have some ability to take effective action to address health inequities. We think that's very important— everyone can do something.

Hannah Moffatt: How do you think this framework could be applied in real world public health settings to help build organizational capacity for taking action on health equity?

Dr. Benita Cohen: In the broadest sense we hope that the conceptual framework will serve as a resource for public health organizations and practitioners. The framework can be used as an opportunity to reflect and to engage in a dialogue on factors that influence, or act as barriers to, health equity actions. Public health organizations could use the constructs presented to identify their own capacity indicators or identify indicators that could be used to measure or monitor capacity over time. The framework definitely can serve as a discussion and planning tool.

The second capacity in which the framework may be used is as a platform to engage other public health leaders and leaders from other sectors, as they strive to institutionalize their health equity practice. This could advance the health equity discourse and the integration (or mainstreaming) of social justice into public health practice.

We expect that as the framework is applied in various real world settings, the feedback from users will contribute to further revisions that will enhance the framework's applied use. We're hoping this will continue to be an iterative development process. We are not presenting the framework as the be-all and end-all¬; but it is a first jumping off point. Ultimately, we would like to obtain additional funding to identify a specific set of indicators, and then use those indicators to monitor changes in organizational capacity for public health equity action over time. Our team is hoping to engage public health units at the regional-local level to collaborate with us as we move forward.

Hannah Moffatt: What advice would you offer to practitioners or organizations interested in building their capacity to take action on health equity issues?
Dr. Benita Cohen: One piece of advice that really stands out to me is that addressing health inequities needs to be considered as an overall systems performance issue. It cannot be something that is viewed as the sole responsibility of one group, or simply as an additional factor in a list of public health priorities. Health equity action requires its own strategy; its own measurement plan including, the assessment of current capacity to take action; and a sustainability plan to ensure continued action and long-term impacts.

The literature identifies the assessment of organizational capacity as a first step in taking appropriate actions. The conceptual framework of Organizational Capacity for Public Health Equity Action is a tool that can help organizations to conduct this type of assessment. So, my parting words would be that on behalf of my research team, we encourage practitioners to use this framework and adapt it to their own needs. We anticipate it will be an effective tool to support practitioners as they move forward with their health equity work.

Hannah Moffatt: Thank you very much, Benita for sharing your thoughts and your research with us today. Best of luck as you move forward with this very important initiative to develop public health capacity in the area of public health equity action.

DISCUSSION

Key Themes

THE INFLUENCE OF PUBLIC HEALTH CRISES ON SYSTEM RENEWAL EFFORTS. Several of the experts cited public health crises, such as global epidemic of SARS in 2003 and the outbreak of waterborne disease in Walkerton in 2000, as a key catalyst for public health system renewal efforts in Canada. Renewal events have contributed to the recognition of public health as a unique and valuable sector within the greater health system, as well as increased funding.

"This research arose out of the calls for public health renewal that were related to a series of crises, including SARS and calls to strengthen the public health system in our country."
– Dr. Bernie Pauly

THE ROLE OF PUBLIC HEALTH AND PARTNERSHIP IN HEALTH EQUITY WORK. Each key informant identified a need for more broad and sustained action to take place, and recognized a niche role for public health in health equity work. Public health's mandate and core linkages with the community facilitate opportunities to act on the social determinants of health and reduce health inequities. However, the experts recognized that this work is not the sole responsibility of public health, and identified the need for action and alignment across sectors such as through coalitions, networks, and partnerships.

"We have also been able to use the standards as a bit of a rallying cry to encourage other partners to work with us. We've been able to leverage the requirements and the societal goals as a conversation starter to say, 'we need to work together on this' "
– Dr. Rosana Pellizzari

PUBLIC HEALTH LEADERSHIP. Effective and dynamic public health leaders and leadership was identified as facilitating the development and implementation of organizational standards and securing the organizational capacity needed for health equity work. The importance of leaders to act as champions for health equity both within and outside of the health sector was highlighted, and strong leadership was seen as a crucial element needed to move forward. This leadership role is further supported by the strong and unique linkages public health leaders have with policy makers, leaders in other sectors, and the community, extending their influence into multiple spheres. These attributes are especially important in complex areas such as that of health equity work, which requires both strong leadership and strong collaboration.

"We interviewed the usual and unusual suspects and it just became clearer and clearer to us across the health system that there was no one area that really took on health equity.. And it became clearer and clearer through our process that this could be a very strong role for public health. We couldn't walk away from that role."
– Janet Braunstein Moody

RESOURCES ARE REQUIRED FOR IMPLEMENTATION. Adequate resources are required to equip practitioners with the knowledge, skills, and attitudes required to achieve expected levels of service and outcomes. Lack of resources makes it difficult to implement the standards, leaving organizations feeling noncompliant and incapacitated.

"... we've seen a reinvestment and a stronger commitment to the public health system in Ontario; however, we still experience barriers around inadequate resources to support the work we should be doing in the realm of primary prevention."
– Dr. Rosana Pellizzari

NEED FOR SUPPORTIVE STRUCTURES. Organizational standards do not exist in isolation. They are an important component in the broader system wide response that is required to reduce health inequities. Their ability to increase accountability, inform strategic directions, and explicitly support public health practitioners in their health equity goals requires support by broader policies, programs, and priorities.

"One piece of advice that really stands out to me is that addressing health inequities needs to be considered as an overall systems performance issue. It cannot be something that is viewed as the sole responsibility of one group, or simply as an additional factor in a list of public health priorities."
- Dr. Benita Cohen

DIVERSITY OF PUBLIC HEALTH REQUIRES ADAPTATION. It is well recognized that the diversity of public health, with respect to its interdisciplinary workforce and scope of work, is one of its strongest assets. However, these unique and varied contexts (e.g., geopolitical differences, multiple professions, diverse communities with diverse needs) require that organizational standards be adapted to local contexts. Local experts must learn from others while also tailoring and refining organizational standards to suit their needs.

"That diversity is part of the richness of public health."
– Janet Braunstein Moody

THE COMPLEXITY OF HEALTH EQUITY. The complexity of health equity in terms of its multiple influences and impacts was addressed by each public health expert in their case example. This complexity can act as a barrier as it demands extensive capacity and multiple points of intervention, but it also emphasizes the importance of coordinated and timely action. Organizational standards can serve as a supportive structure for health equity work.

"We need to be waving health equity as our flag, and if it's not us, who's it going to be? The rest of the health care system has clinical care and the care of the ill as their mandated priority. They can certainly be allies, but I do think health equity work needs to be driven by public health, especially because we work so closely across sectors."
– Dr. Rosana Pellizzari

INCREASED UNDERSTANDING OF THE DETERMINANTS OF HEALTH. Health equity work across the country is informed by our understanding of the determinants of health. The public health experts acknowledged the influence of structural forces, such as social and economic marginalization, on health inequities. Understanding how the inequitable distribution of power and resources influences health inequities informs public health interventions and pushes activities further upstream.

"We need to think about 'what are the structural conditions in which vulnerabilities are created?', instead of only the groups we see being affected and at risk."
– Dr. Bernie Pauly

ORGANIZATIONAL STANDARDS AS AN EFFECTIVE STRATEGY TO ADVANCE HEALTH EQUITY IN PUBLIC HEALTH PRACTICE. All four experts believed organizational standards to be an effective strategy to advance health equity within public health practice. This assessment, informed by experience, research, and evaluation lends continued confidence to the development and implementation of organizational standards as a worthwhile strategy to explore, implement, and reflect upon health equity work in public health settings.

"I think they're going to be an essential strategy. Furthermore, I think if you don't see the words 'health equity' throughout the standards, then you're not going to have that impact."
– Janet Braunstein Moody

Limitations

This resource is based on the opinions and experiences of four selected public health experts. It is, therefore, not intended to portray an exhaustive inventory of the types of organizational standards and their implementation in various settings. The key informants represent their fields of research, practice, and public health leadership and offer valuable insights into the development and implementation of organizational standards in public health in Canada.

As with any data collection methodology, the analysis provided is open to biases and interpretations. However, early in the process the following measures were taken in an attempt to reduce the role of bias:

(1) a preliminary rapid environmental scan to inform our understanding of organizational standards across Canada's provinces and territories; and

(2) the use of internal and external reviewers at the NCCDH who are outside the data collection and the broader project to promote objective consensus on themes identified.

Opportunities

This resource highlights interesting and relevant opportunities for future investigation in this area. For example, there may be interest in conducting a more in-depth document review of organizational standards or requirements identified in other provinces and territories to determine key differences and similarities in conceptualization, implementation, and evaluation. This could also involve a broader consultation process to engage public health leaders and practitioners from each of these jurisdictions to learn about how these guidelines are both perceived and used in practice.

Conclusion

Within the four conversations are rich examples of how organizational standards have been conceived, developed, and implemented. In each of the conversations there are examples of change at multiple levels of the public health system. These changes occurred at individual (practitioner, researcher, and decision maker), and organizational (local and provincial) levels. Leadership was essential to support the development and use of organizational standards as an opportunity to advance health equity.

The expertise conveyed through this resource has provided additional support for organizational standards as a promising practice to address inequities in health, as initially identified by Sudbury & District Health Unit.[1] The experiences, knowledge, and reflections shared by these experts suggest that organizational standards have an important role to play to increase accountability of public health organizations; set targets; inform strategic directions; and support practitioners and boards of health in their health equity work.

RESOURCE LIST

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